

**Clinical supervision of the treatment of depression:**

**The role of supervisor, supervisee, and patient characteristics**

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# Abstract

This thesis investigated the use of clinical supervision in therapy for depression and other disorders. The Introduction addresses the relevant existing literature, leading to this work. Initially, a content analysis indicated that the models literature is unclear, often lacking patient focus. Few models are based on empirical evidence and fewer are empirically tested. Meta-analyses of the empirical literature indicated that supervision has a moderate, positive impact on supervisees, but no impact on patients. Three experimental studies were carried out to investigate the content of supervision sessions for cognitive behavioural therapists treating depression. Results indicated supervisors often lack focus in supervision. There is a tendency for supervisors to hold back on therapeutic techniques or to encourage focus on the alliance or case management aspects of supervision. This pattern of focus often occurs when the patient has a diffuse depression presentation, the therapist is female and anxious, or when the supervisor themselves is more anxious. Findings indicate that supervisors have biases and can drift in their practice, as therapists do. There needs to be greater monitoring of clinical supervision in practice, and the influence of patient, therapist, and supervisor characteristics should be acknowledged in training and protocols. Future research would benefit from similar investigations into other disorders and therapies, and the inclusion of observational and clinical data.

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# Publications

The following work from this thesis is published. Reprinting these as part of this thesis is permitted by the journals in question.

Chapter 2 is based on: Simpson-Southward, C., Waller, G., & Hardy, G. E. (2017). How do we know what makes for “best practice” in clinical supervision for psychological therapists? A content analysis of supervisory models and approaches. *Clinical Psychology and Psychotherapy*, *24*, 1228–1245.

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# – The status of psychological treatments for depression

**1.1 Chapter overview**

In this introductory chapter, I will provide the context for my research, starting by outlining the characteristics of depression, detailing the current psychological treatments for this disorder, and exploring how effective and reliable those treatments are. I will then move on to discussing factors that influence treatment outcomes, such as patient characteristics, therapist characteristics, and the correct use of therapy protocols. Finally, I will focus on the accepted way to help therapy stay on track and ensure positive patient outcomes – clinical supervision. At the end of this chapter, there will be brief thesis overview.

**1.2 The nature of depression**

While this overview will focus on major depressive disorder, it is worth noting that depression comes in many forms and these each bring different diagnoses. Table 1.1 outlines some common diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013). The disorders in Table 1.1 are the three with the highest prevalence rates when excluding disorders only affecting a subsample of the population (e.g. disruptive mood dysregulation disorder, which is only applied to those under the age of 18, and premenstrual dysphoric disorder, which only affects females [DSM-5, 2013]). There are ten other relevant (but less common) diagnoses outlined in DSM-5 (2013): bipolar II disorder; cyclothymic disorder; substance/medication-induced bipolar and related disorder; bipolar and related disorder due to another medical condition; other specified bipolar and related disorder; unspecified bipolar and related disorder; substance/medication-induced depressive disorder; depressive disorder due to another medical condition; other specified depressive disorder; and unspecified depressive disorder.

Disorders are often classified by severity, based on the number of criterion symptoms, the severity of those symptoms, and the degree of functional disability. Mild severity is identified when few, if any, symptoms in excess of those required for a diagnosis are present, and when those symptoms are distressing but manageable, resulting in only minor impairment in social or occupational functioning. Severe cases are those where the number of symptoms is substantially in excess of that required for a diagnosis, intensity is seriously distressing and unmanageable, and symptoms markedly interfere with social and occupational functioning. Finally, moderate severity cases are those when the symptoms, symptom intensity and functional impairment are between ‘mild’ and ‘severe’ classifications (DSM-5, 2013).

Table 1.1. Common depressive and bipolar disorders with their diagnostic criteria in the DSM-5.

|  |  |  |
| --- | --- | --- |
| **Disorder** | **Symptoms** | **Duration of symptoms required for diagnosis** |
| Major Depressive Disorder | Symptoms include: depressed mood; diminished interest or pleasure in activities; weight loss or gain; insomnia or hypersomnia; psychomotor agitation or retardation; loss of energy; feelings of worthlessness; lack of concentration; and thoughts of death including suicide ideation. | At least five symptoms must be present during a two-week period. One of the symptoms must be a depressed mood or loss of interest or pleasure. |
| Persistent Depressive Disorder (Dysthymia) | Symptoms are similar to those of major depressive disorder however, they are less intense. | Symptoms must be present for at least two years (one year for children and adolescents) for diagnosis. |

|  |  |  |
| --- | --- | --- |
| **Disorder** | **Symptoms** | **Duration of symptoms required for diagnosis** |
| Bipolar I Disorder | An individual must experience both major depressive episodes (as described above) and manic episodes. Symptoms of a manic episode include: abnormally and persistently elevated mood; increased energy; inflated self-esteem; decreased need for sleep; increased talking; feelings of racing thoughts; distractibility; increased goal-directed activity or psychomotor agitation; and excessive involvement in activities that have a high potential for painful consequences. | Symptoms of a manic episode must be present for most of the day, every day for at least one week. At least five symptoms of a major depressive episode must be present during a two-week period. One of the symptoms must be a depressed mood or loss of interest or pleasure. |

The DSM-5 criteria for clinical depression have been criticised (Greenberg, 2013). Although clinical depression is considered distinct from general sadness, it has been argued that the DSM-5 does not clearly separate the two. This lack of clarity might elevate prevalence rates and cause harm by resulting in our treating those who do not need treatment (Horwitz, 2015). According to Wakefield (2016), the DSM-5 statement that “Careful consideration is given to the delineation of normal sadness and grief from a major depressive episode”(DSM-5, 2013, p.155) does not go far enough. He argues that context should be taken into account through the use of inclusion or exclusion guidelines, such as excluding those who have recently experienced loss. However, it has also been argued that loss often precedes episodes of major depression; therefore, additional contextual criteria might exclude many who need treatment (Maj, 2010).

In a further criticism of the use of the DSM, Kendler (2016) argues that while the DSM is a practical way to diagnosis in practice, we are at risk of taking the index of the disorder as the disorder itself. He suggests that reducing depression to the DSM criteria would be akin to reducing intelligence to IQ score. Kendler (2016) identified that descriptions of depression symptomology are much broader in key textbooks than the DSM. For example, authors often place greater emphasis on cognitive and attitudinal changes associated with depression than do the DSM criteria. The symptomatology of depression is explored further in the next section.

***1.2.1 Symptomatology***

According to the medical model of depression – outlined in DSM-5 (2013) – the core characteristics that everyone with depression will experience are an abnormally low mood and a lack of ability to find things pleasurable or interesting that would usually be enjoyable, known as anhedonia (Hammen, & Watkins, 2008; Klinger, 1993). This pattern suggests that those with depression are resistant to the influence of positive events or activities due to their persistent and enduring low mood. However, comparing the emotional states and activities of individuals with depression and those without, Nelson, Klumparendt, Doebler and Ehring (2020) found that emotions in depression are not that rigid. While the negative affect of those with depression was found to be more static than those without, it was also found to be more reactive to positive events (mood brightening in response to positive activities). A possible explanation for this finding is that those with depression experience fewer positive events than those without depression, so when these events do occur it is a greater contrast to the norm. Therefore, a greater reduction in negative affect is experienced.

While depression is considered by most to be a mood disorder, a major aspect of the disorder is faulty cognitive processing. Some call depression a disorder of thought as much as it is a disorder of mood (Hammen & Watkins, 2008). There are multiple psychological models of depression. The focus here will be on the cognitive model of depression (Beck, 1967). This model views all other symptoms of depression as consequences of negative thinking. Other models include psychodynamic theory, suggesting that depression is associated with loss (Freud, 1917), and interpersonal theory, suggesting that the reactions of others play a key role in maintaining depression (Coyne 1976).

The cognitive model has three core elements: the cognitive triad; cognitive errors; and schemas. The cognitive triad refers to the negative thought patterns that those with depression have about themselves, the world and the future (Beck, 1976). These thought patterns often contain problematic information processing or cognitive errors that leave a person feeling incompetent, guilty and hopeless (Hammen & Watkins, 2008). Cognitive schemas explain why an individual maintains pain-inducing attitudes despite objective evidence. Schemas are organised representations of experiences, which guide information processing based on what is expected (Beck, 1967). If an individual has a dysfunctional, negative schema based on past experiences, then this will continue to guide the processing of new experiences, even when it is not appropriate. In addition to negativistic thinking, depression is associated with problems in mental processes such as concentration and memory (Willner, 1984). These problems can exacerbate feelings of incompetency and lead to worry about losing one’s mind.

Other symptoms of depression can manifest themselves in different ways for different people. Where there are actual changes in motor behaviours, most patients appear to be slowed down (Sobin & Sackeim, 1997). This slowing (psychomotor retardation) can manifest itself as, for example, slowed speech (Szabadi, Bradshaw, & Besson, 1976) or fewer facial movements (Jones & Pansa, 1979). In contrast, others display psychomotor agitation, appearing restless or fidgety (Hammen & Watkins, 2008). A key behavioural characteristic for most people with depression is withdrawal from society (Fennell, 1989). This is due to both the loss of pleasure in such activities and the incorrect belief that others see them as aversive.

As with behavioural symptoms, physical symptoms can also manifest themselves in very different ways. Many patients experience sleep disturbances (Kupfer, 1995) and loss of appetite (Paykel, 1977), whereas others experience increased sleep and appetite. The latter combination has been labelled atypical depression (Davidson, Miller, Turnbull, & Sullivan, 1982).

The relationship between sleep and depressive symptoms is complex. Depression can cause sleep disturbances, but sleep disturbances can also lead to depressive symptoms. Lorenz, Sander, Ivanova and Hegerl (2020) found that total sleep time was related to depression core symptoms for only nine of the 22 patients in their study, and time in bed was related to symptoms for only seven patients. Regarding the direction of the relationship, results were quite heterogeneous. Total sleep time was the cause of depression symptoms for most patients, rather than the effect. However, time in bed was the cause of symptoms for only around half of the patients rather than the effect. The relationship was in the opposite direction for the other half.

The Hot Cross Bun model, devised by Padesky and Mooney (1990), depicts the interaction of these four core aspects of depression (affective, cognitive, behavioural, and physical). While this general model can be applied to multiple disorders, Figure 1.1 shows how it is applied to a depressive disorder. This model is often used in therapy to help clients understand the manifestation of their disorder, its maintenance through interaction of the elements, and the treatment plan.

**Emotion**

*e.g., sadness*

**Cognition**

*e.g., ‘I’m worthless’*

**Physiology**

*e.g., insomnia*

**Behaviour**

*e.g., withdrawal*

**Environment**

Figure 1.1. Hot-cross bun model showing the symptomatology of depression (adapted from Padesky, & Mooney, 1990).

***1.2.2 Prevalence***

Depression is so widespread that Seligman (1975) described the disorder as the *‘common cold’* of psychiatry. It is difficult to gauge the number of people who have depression, as only a portion of those with mental health disorders will seek out treatment (Bebbington et al., 2000; Bland, Newman, & Orn, 1997). However, we can estimate prevalence using survey methods. The World Health Organisation (2012a) estimates that depression affects around 350 million people worldwide. The one-year prevalence rate in the USA is estimated to be 4.5% (Narrow, Rae, Robbins, & Regier, 2002), and this rate is supported by worldwide data from the World Mental Health Survey (Marcus, Yasamy, van Ommeren, Chrisholm, & Saxena, 2012).

Certain people have a greater risk of developing depression than others. There are nearly twice as many incidences of depression amongst women as men (Fennell, 1989; Roth, & Fonagy, 2005). One-year prevalence rates are 24.2% for women and 14.2% for men (Patten, 2009), and lifetime prevalence rates are 21.3% and 12.7% respectively (Blazer, Kessler, McGonagle, & Swartz, 1994). After analysing interview data from the National Comorbidity Survey-Replication, Silverstein et al. (2013) suggested that this gender difference is due to the difference within a subcategory of depression – somatic depression (depression specifically with somatic symptoms e.g., disordered eating). Even more specifically, it was attributable to the subcategory of those with somatic depression without a relative with depression (Silverstein, Ajdacic-Gross, Rossler & Angst, 2017).

There has been some indication that there are increased depression rates among younger birth cohorts (Fennell, 1989; Kessler et al., 2003). This increase might partly be due to older adults having forgotten previous depressions (Paykel, Brugha, & Fryers, 2005). However, longitudinal data indicate increased rates of depression in younger women (Murphy, Laird, Monson, Sobol, & Leighton, 2000). This change might reflect a greater willingness of younger adults to admit to mental health issues (Hammen, & Watkins, 2008). Other factors that are associated with a higher risk of developing depression are low socio-economic status (Fryers, Melzer, & Jenkins, 2003), living in an urban area (Wang, 2004), and being from an ethnic minority (Missinne, & Bracke, 2012; Weich, et al., 2004).

***1.2.3 Life course and consequences***

The life course of depression is variable across individuals. First incidence of the disorder is usually at an early age (Hammen, & Watkins, 2008), but it can occur at any time (Blazer at al., 1994). Median age of onset is disputed. Andrade et al. (2003) found it ranged between 20 and 25 years across different countries, whereas Kessler et al. (2005) found the median age to be 32 years. There is also evidence that the average age of onset is younger for females than for males (Burke, Burke, Regier, & Rae, 1990).

The majority of individuals with depression will experience more than one depressive episode over their lifetime (Hammen & Watkins, 2008; Leahy, Holland, & McGinn, 2012). Around 30% of people relapse in the first year, and 70-80% will experience at least one further depressive episode (Paykel et al., 2005). Time to first recurrence is significantly longer than time to subsequent recurrences and the risk of recurrence increases by 16% after each successive episode (Solomon et al., 2000). A younger age of onset has also been associated with greater chance of recurrence (Hollon et al., 2006).

The chronicity and recurrence of depression impact on a person’s ability to function in the workplace and maintain a job. It is the leading cause of disability worldwide (World Health Organisation, 2012a), and on average costs 5.6 hours of productive work per person per week (Stewart, Ricci, Chee, Hahn, & Morganstein, 2003). This translates to a workplace cost of depression estimated to be $51.5 billion in the United States alone (Greenberg et al., 2003). Recurrent depression is particularly costly to society. In a review of the literature, Mrazek, Hornberger, Altar and Degtiar (2014) calculated the annual societal costs of major depression for all patients in the US as $106-$118 billion when factoring in the impact of recurrent depression. Amos et al. (2018) found that direct and indirect healthcare resource utilisation and costs for patients with recurrent depression were double those of non-recurrent major depressive disorder (MDD) patients and quadruple those of non-MDD patients.

The World Health Organisation (2014) estimates an annual suicide rate of 11.4 per 100,000 of the general population, and states that there are 20 or more attempts for every suicide that is completed (World Health Organisation, 2012b). Diagnosable depressive disorders have been implicated in approximately 59% of suicides (Henriksson et al., 1993), and suicidal thoughts are a symptom of these disorders (Hammen & Watkins, 2008).

***1.2.4 Summary***

Depression is a far-reaching disorder that affects the lives of billions of people around the world (World Health Organisation, 2012a). It is not only a disorder of mood, but also has cognitive, behavioural and physical symptoms (Hammen & Watkins, 2008). The disorder has a high rate of recurrence (Paykel et al., 2005), bringing with it a feeling of despair and hopelessness which can often result in suicide (Henriksson et al., 1993). There is an economic burden of depression on a global scale (Greenberg et al., 2003). The way that this disorder diminishes quality of life combined with the high prevalence rate highlights the necessity for reliable, effective treatments. In the following section, I will discuss some of the key treatments that are currently available for depression.

**1.3 Treatment**

There are a few different lines of treatment for depressive disorders. This overview will cover the two most widely used treatments – pharmacological and psychological. Two less commonly used treatments that will not be covered in this review are ECT (electroconvulsive therapy) and rTMS (repetitive transcranial magnetic stimulation). ECT has been found to be effective (The UK ECT Review Group, 2003) but can have severe side-effects (e.g., memory loss - Squire, 1974). rTMS seems to have fewer side effects than ECT (Hansen et al., 2011), and has been found to be efficacious for depression, but it is a relatively new treatment and currently has limited clinical effectiveness (Lepping et al., 2014; Loo & Mitchell, 2005).

This overview will touch on the pharmacological literature before turning to the main aspect of this review – psychological treatments. Finally, I will discuss the comparative effectiveness of treatments, and outline which ones are currently recommended in the UK for different severities of depression.

***1.3.1 Pharmacological treatment***

Usually, treatment with antidepressant drugs is only recommended for those with moderate to severe depression, but it can be recommended for more mild cases in certain circumstances (e.g., when depression persists even after the use of other treatments; National Institute for Health and Care Excellence; NICE, 2011). While there are many different classes of antidepressant medication, the most commonly prescribed are selective serotonin reuptake inhibitors (SSRIs; NICE, 2009). These drugs block the reuptake of serotonin from synapses in the brain, thereby increasing the time that serotonin stays in the synapse (Healy, 2009). Other classes of antidepressant are tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs), which are both used less often than SSRIs.

Remission rates for patients being treated with citalopram (an SSRI) have been found to be around 28% (Trivedi et al., 2006), and switching to different medication or a psychotherapy if remission is not achieved can increase remission rates to around 67% (Rush et al., 2006). While different classes of antidepressants have their own mechanism of action, many of them have similar therapeutic benefits (Kirsch, 2014). This similarity might be due, in part, to the placebo effect, which has been found to account for 82% of the antidepressant response (Kirsch et al., 2008). A recent meta-analysis of 21 antidepressant drugs found that all were more effective than placebo for adults with major depressive disorder. However, there was variation in acceptability and efficacy between drugs (Cipriani et al., 2018).owevre there was The efficacy of antidepressant medication also appears to vary as a function of clinical severity. The advantage of antidepressants over placebo has been found to be negligible for mild, moderate and even some cases of severe depression. However, effects are large for very severe cases (Fournier et al., 2010; Kirsch, 2014).

A major problem with antidepressants is the side effects of the medication, such as tremors, dry mouth, sedation, weight gain and tooth grinding. In addition, there are some intrapsychic side effects, for example depersonalisation, confusion, internal turmoil (akathisia), and emotional blunting (Healy, 2009). Such side effects account, in part, for why many individuals opt for psychological therapies rather than medication.

***1.3.2 Psychodynamic therapy***

Psychodynamic therapy originated in the late 1800s (Breuer & Freud, 1895). While it is not a recommended treatment for depression, it is still used by many therapists. The basic assumption of the therapy is that unconscious conflicts, alongside historical relationships and childhood experiences impact an individual’s present functioning (Cuijpers, van Straten, Andersson, & van Oppen, 2008). Therefore, the goal of this therapy is resolution of unconscious conflict (Roth & Fonagy, 2005). To identify such conflict, therapy focuses on the interpretation of the client’s behaviours and verbalisations during therapy (Roth & Fonagy, 2005). In the UK, IAPT (Improving Access to Psychological Therapies) offers a psychodynamic therapy model, known as Dynamic Interpersonal Therapy (DIT), as one treatment for depression. DIT is formed from evidence-based psychoanalytic/psychodynamic approaches, pooled together to form a brief individual therapy protocol for depression (Lemma, Target, & Fonagy, 2010).

***1.3.3 Counselling***

Counselling for depression does not have a strict framework and is usually defined by the setting in which it is conducted (Roth, & Fonagy, 2005). The overall aim of this approach is for the client to live more fully and satisfyingly (Barkham & Hardy, 2001). Therefore, the focus is usually very much client-centred (Pearce, Sewell, Hill, & Coles, 2012) and seeks to address their current problems and relationships (Barkham & Hardy, 2001; Roth & Fonagy, 2005). In the UK, a commonly used counselling framework is the IAPT approved Counselling for Depression (CfD) which is derived from person-centred and experiential approaches (Roth, Hill, & Pilling, 2009). The key focus of CfD is the discrepancy between how a person feels they should be and how they feel they actually are (Improving Access to Psychological Therapies, 2010a).

***1.3.4 Interpersonal psychotherapy***

Interpersonal psychotherapy (IPT) is a brief intervention that is based on interpersonal theory by Sullivan (1953). The focus is on current interpersonal interactions and how these develop when the individual experiences depression (Barkham & Hardy, 2001; Roth & Fonagy, 2005). IPT aims to help a person identify how they are feeling in their relationships and to find new ways to interact with others (Improving Access to Psychological Therapies, 2010b).

***1.3.5 Cognitive behavioural therapy***

Cognitive behavioural therapy (CBT, also labelled cognitive therapy or CT by Beck) focuses on a client’s present dysfunctional thoughts and behaviours, and future functioning (Beck, Rush, Shaw, & Emery, 1979; Cuijpers et al., 2008). An underlying assumption of CBT is that cognitions have been learnt and maintained through reinforcement (Roth, & Fonagy, 2005). These cognitions can be challenged when they are irrational (as can be the case in depression). Modifying a client’s dysfunctional beliefs and behaviours takes the form of both behavioural techniques (e.g., behavioural experiments that can challenge thoughts about the self) and cognitive techniques (e.g., reattribution, which helps a client to take a more objective stance) (Beck et al., 1979; Leahy et al., 2012).

Some research suggests that not all aspects of CBT are necessary for clinical improvement. Jacobson et al. (1996) found comparable outcomes for patients receiving only the behavioural activation (BA) component, patients receiving BA plus teaching of skills to modify automatic thoughts (AT), and patients receiving full CBT. Similarly, Gortner, Gollan, Dobson, & Jacobson (1998) found no outcome differences for patients treated with BA, AT, or CBT.

***1.3.6 Comparisons of treatments for depression***

A variety ofresearch has shown that psychotherapies produce better outcomes than no therapy (e.g., *d* = 0.73; Robinson, Berman, & Neimeyer, 1990). This effect remains even when only high quality studies are analysed (*d* = 0.22; Cuijpers, van Straten, Bohlmeijer, Hollon, & Andersson, 2010). However, there is conflicting evidence for which specific psychotherapy produces superior outcomes (Roth & Fonagy, 2005). Gloaguen, Cottraux, Cucherat, & Blackburn (1998) conducted a meta-analysis comparing therapy outcomes and found cognitive therapy to be superior to other therapies. However, Wampold, Minami, Baskin, & Callen-Tierney (2002) suggest that this meta-analysis failed to separate bona fide interventions from non-bona fide interventions. When non-bona fide interventions were removed, there was no longer a benefit of cognitive therapy over other treatments. Churchill et al. (2001) found that CBT produced equal outcomes to IPT but they were both superior to psychodynamic therapy. However, in another meta-analysis Cuijpers et al. (2008) found that while other therapies (CBT, behavioural activation therapy, psychodynamic therapy, problem-solving therapy, and social skills training) had similar outcomes, IPT was slightly more efficacious.

Studies comparing psychological treatments to pharmacological often find that they have similar outcomes in the short term. However, long-term outcome data indicate that psychotherapies might be a more effective treatment, as patients are less likely to relapse (Evans at al., 1992; Spielmans, Berman, & Usitalo, 2011). Combining pharmacological treatment and psychotherapy reduces relapse rates and improves recovery rates compared to either treatment alone (Friedman et al., 2004). Combination treatment seems to be particularly effective for patients with depression that is more difficult to treat, such as chronic depression (Keller et al., 2000), or more severe depression cases (Thase et al., 1997).

### 1.3.7 Temporal changes in treatment effect sizes

When looking at which therapies produce greater treatment effects, it is important to take into account when the study was conducted. A meta-analysis by Johnsen & Friborg (2015) highlights this. They found that the effects of CBT have declined linearly since the therapy was introduced. The authors suggest that a potential reason for this is that adherence to the original treatment manual from Beck et al. (1979) has reduced over time. Often trials of CBT are published without fully describing the contents of the treatment, possibly indicating a reduction in adherence (Johnsen & Friborg, 2015). An alternative explanation that Johnsen and Friborg (2015) propose is the placebo effect. They suggest that the placebo effect is typically stronger for newer treatments and so as we become more familiar with CBT, expectations begin to wane.

Johnsen and Friborg’s (2015) meta-analysis has received a number of criticisms. Cristea et al. (2017) argue that the meta-analysis has methodological flaws. These include a possible impact of attrition bias due to a focus on completer analysis rather than intent-to-treat analysis, and the inclusion of within-group effect sizes (which can inflate effectiveness estimations through the possibility of extraneous influences, e.g., spontaneous remission). Cristea et al.’s re-analysis of the data showed no overall relationship between publication year and effect size. However, they do note a decrease over time of effect size specifically in the US. In a second re-analysis, Ljótsson, Hedman, Mattsson and Andersson (2017) argue that effect sizes decrease between 1977 and 1995 but remain constant after that. An effect which they suggest could be due to strong allegiance to the therapy in early trials.

A further criticism from Cristea et al. (2017), is that although sample size, trial quality, and publication year appear to be intercorrelated, they are not included in the same meta-regression model. Larger studies generally yield smaller effect sizes, as do higher quality studies. Low quality studies are more open to biases that can artificially inflate effect sizes (Cuijpers et al., 2010). Earlier studies tended to be of lower quality (Chen et al., 2014) and have smaller sample sizes. This could explain the higher effect sizes of such studies.

Recent studies are often higher in quality because they seek to emulate ‘real-world’ settings more than earlier trials. Such trials are known as pragmatic randomised controlled trials. They are more often conducted in primary care or community settings (Gamerman, Cai & Elsäßer, 2018). For example, A-Tjak, Morina, Topper and Emmelkamp (2018) found both CBT and ACT (Acceptance and Commitment Therapy) to be equally effective when treating depression in routine clinical practice. Such studies also seek to recruit a heterogeneous ‘real world’ population (Gamerman et al., 2018), and are more likely to include patients with comorbidities (Chen et al., 2014).

***1.3.8 Recommended treatment***

As depression can be treated in a number of different ways, it is necessary to have clear guidelines that aid healthcare professionals working with the disorder. In the UK, the National Health Service (NHS) takes guidance and recommendations from NICE. These guidelines are based on the best available empirical evidence, often in the form of meta-analyses of randomised controlled trials (RCTs), but can also be supplemented with clinical opinion where clear empirical evidence is lacking (NICE, 2009). A brief overview of the clinical guidance for adults with depression is outlined in Table 1.2 (NICE, 2009).

Table 1.2. NICE guidelines (CG90) - Depression in adults: The treatment and management of depression in adults.

|  |  |
| --- | --- |
| **Depression type** | **Recommended psychological treatment** |
| Persistent subthreshold depressive symptoms or mild to moderate depression | One or more of the following low-intensity psychological interventions:   * Individual guided self-help CBT * Computerised cognitive behaviour therapy (CCBT) * Structured group physical activity programme * Group-based CBT (for those who decline other options) |
| Persistent subthreshold depressive symptoms or mild to moderate depression who have not benefited from a low-intensity psychosocial intervention | An antidepressant (usually an SSRI)  OR  A high-intensity psychological intervention, normally one of the following:   * CBT * IPT * Behavioural activation * Behavioural couples therapy (for people who have a regular partner and where the relationship may contribute to the depression, or where involving the partner is considered to be of potential therapeutic benefit) |

|  |  |
| --- | --- |
| **Depression type** | **Recommended psychological treatment** |
| Moderate or severe depression | An antidepressant  AND  A high-intensity psychological intervention (CBT or IPT) |
| Those with depression who decline an antidepressant, CBT, IPT, behavioural activation and behavioural couples therapy | Counselling  OR  Short-term psychodynamic psychotherapy |

The guideline is based on a stepped-care model in which the least intrusive, most effective treatment is offered first. Then, if the patient does not benefit from this intervention, they are ‘stepped-up’ to a more complex intervention (NICE, 2009). This is a model that has been adopted by the IAPT programme and rolled out across the UK to offer patients a routine first-line treatment for depression and anxiety disorders (Clark, 2011). An analysis of recovery rates within IAPT services found that compliance with NICE guidance is associated with higher reliable recovery rates (Gyani, Shafran, Layard, & Clark, 2013).

***1.3.9 Summary***

Treatments available for depression are varied, and only the most commonly used interventions (drug therapy, psychodynamic therapy, counselling, IPT, and CBT) have been outlined in this review. Research into which treatment is the most effective has mixed findings, but it is generally agreed that pharmacotherapy and psychotherapy have similar recovery rates and that combination treatment is slightly superior (Roth & Fonagy, 2005). In the UK, there is a clear set of guidelines telling us which treatments are appropriate for each presentation of depression (NICE, 2009). While these guidelines cover a range of treatments, the most commonly recommended treatment for most forms of depression is CBT.

**1.4 Factors influencing psychotherapy outcomes**

Treatment guidelines for depression are based on the highest quality evidence available, usually in the form of RCTs (NICE, 2009). Unfortunately, it is very difficult to get the same conditions seen in RCTs in other settings (e.g., routine clinical practice). RCT settings are often far removed from the context in which psychotherapy is usually conducted (Gibbons et al., 2010). Although, more recent RCTs attempt to emulate ‘real world’ settings as best they can (Gamerman et al., 2018). As their name suggests, RCTs have much tighter controls than standard clinical practice. For example, they only recruit specific populations of patients, therapy sessions are fixed in number and content, and there is constant monitoring of therapists (Gibbons, Stirman, DeRubeis, Newman, & Beck, 2013; Kazdin, 2008). These and other aspects of therapy can vary in clinical practice, potentially affecting patient outcomes. Indeed, there is a discrepancy in patient outcomes between RCTs and clinical practice (Gibbons et al., 2013). However, this does not always have to be the case. Studies by Persons et al. (1999) and Persons, Roberts, Zalecki, and Brechwald (2006) have shown that treatment of depression and anxious-depression in routine clinical practice can yield similar outcomes to those in research trials. This review will now look at factors that can influence therapy processes and patient outcomes.

***1.4.1 Therapy format***

The format of therapy in RCT settings is very tightly controlled and therefore it is unlikely to vary across patients in the trial. In clinical practice, however, therapy format can vary both across and within practices, and certain aspects of therapy format can have an impact on patient outcome. For example, Braun, Gregor, & Tran (2013) suggest that therapy session length moderates patient outcome. They found that CBT for depression was superior to other psychotherapies, but only when the treatment sessions lasted 90 minutes or longer. Research investigating group CBT for depression also found an effect of session length, which indicated that the optimum length is between 60 and 90 minutes (Feng et al., 2012).

The number of therapy sessions that an individual receives also varies across practices, and patients might not recover because they do not receive enough sessions. Hansen, Lambert, & Forman (2002) explain that while 13 to 18 sessions are required for 50% of patients to improve, the average number received in clinical practice is actually fewer than five. Similarly, within IAPT services, those practices with a higher average number of therapy sessions also have higher numbers of recovered patients (Gyani et al., 2013). However, it is possible that this is partly due to patients dropping out before recovery, rather than there being limited available therapy sessions.

***1.4.2 Therapeutic alliance***

The term ‘therapeutic alliance’ was originally coined by Zetzel (1956) to refer to the relationship between client and therapist within a psychoanalytic context. Bordin (1979) broadened the definition of this term to apply to other psychotherapies, and outlined the three core aspects of the working alliance – an agreement on goals, an agreement on tasks, and the development of attachment bonds. The alliance is seen as an important aspect of therapy that contributes to client outcome (Roth & Fonagy, 2005). Many factors can contribute to a positive therapeutic alliance, including therapist attributes (e.g., honesty, flexibility, and experience - Ackerman & Hilsenroth, 2003), patient attributes (e.g. lack of hostility - Johansson & Jansson, 2010), and therapist techniques (e.g. reflection, attending to experience - Ackerman & Hilsenroth, 2003). Martin, Garske, and Davis (2000) found the therapeutic alliance to be consistently and moderately related to patient outcome (*r* = .22).

However, there might be a more complex interaction between alliance and outcome (Webb et al., 2011), as some research suggests that symptom change actually predicts later therapeutic alliance (DeRubeis & Feeley, 1990). There is also an additional alliance aspect within most psychotherapy settings – the supervisory alliance (the relationship between the therapist and their supervisor). Patton and Kivlighan (1997) found that the supervisory working alliance was positively related to the therapeutic working alliance.

***1.4.3 Selection of patients***

There has been criticism of RCTs for using homogeneous patient samples and excluding more difficult-to-treat patients (e.g., Seligman, 1995; Westen & Morrison, 2001). Due to the settings of many RCTs and the higher depression prevalence in women, the majority of participants in RCTs of psychotherapy for depression are Caucasian females with a diagnosis of acute major depressive disorder (Scott & Watkins, 2004). Often such highly selective RCT samples do not include patients with comorbid diagnoses (Westen, Novotny, & Thompson-Brenner, 2004), even though most cases of depression are comorbid with other Axis I or Axis II disorders (Kessler et al., 1996; Zimmerman, McDermut, & Mattia, 2000). As comorbidity can complicate treatment and lead to poorer outcomes (Shea, Widiger, & Klein, 1992), excluding these patients can mean that RCT outcomes are not representative of general psychotherapy outcomes. The greater variety of patients in non-RCT samples might lead to therapists varying their practice more in such settings, meaning that they drift from protocols. For example, within panic disorder research, patient individual differences have been found to affect therapist competence and adherence (Boswell et al., 2013).

In a meta-analysis, Westen and Morrison (2001) found that the majority of patients are excluded from RCTs – on average only 32% of potential participants with depression meet the strict inclusion criteria. The authors also found that the more potential patients excluded in a given study, the higher percentage of patients showed improvement. Although Westen and Morrison (2001) found that a large number of potential participants are excluded from RCTs, why they are excluded is often unclear.

Stirman, DeRubeis, Crits-Christoph, & Brody (2003) applied RCT criteria to an outpatient sample. Although many patients did not meet RCT criteria, this was mainly because their primary diagnosis had never been studied using RCT methodology. Where their primary diagnosis was the subject of an RCT, 80% matched the criteria. The authors conclude that the problem with RCTs is not that they are unrepresentative of patient samples for the disorder that is being studied, but that they fail to study some common but unrepresented diagnoses, e.g., dysthymia. Similar results have been found when the patient sample is more diverse, and more patients have comorbid diagnoses (Stirman, DeRubeis, Crits-Christoph, & Rothman, 2005). To investigate whether RCT inclusion criteria systematically exclude patients who are more difficult to treat, Schindler, Hiller, & Witthöft (2011) applied RCT criteria to an outpatient sample, creating a subsample of patients who were RCT eligible. They then compared the outcomes of the whole group with the subsample and found the outcomes to be comparable, indicating that there is no systematic bias due to patient selection in RCTs.

***1.4.4 Patient effects***

In addition to patient selection, patient characteristics can impact overall therapy outcome. Such characteristics can include disorder presentation, such as chronicity (Thase et al., 1994), and patient attitudes e.g., expectation (Sotsky et al., 1991). Demographic characteristics seem to have little effect on outcomes (Hamilton & Dobson, 2002). Cuijpers, van Straten, Smit, & Andersson (2009) conducted a meta-regression analysis and found that psychotherapy is equally effective for both younger and older adults. Patient gender is also not a predictor of outcome in CBT for depression (Cuijpers et al., 2014; Jarrett, Eaves, Grannemann, & Rush, 1991).

Turning to disorder presentation, there is some indication that depression chronicity impacts therapy outcome (Roth & Fonagy, 2005). Thase et al. (1994) found that those with chronic depression had poorer responses to CBT. However, looking at outcomes in dynamic psychotherapy, Luborsky et al. (1996) found no differences between chronic and non-chronic cases. Depression severity can also impact on patient outcome. Higher pre-treatment depression scores predict a poorer response to cognitive therapy (Jarrett et al., 1991; Persons, Burns, & Perloff, 1988). It might be that those with more severe presentations need longer in therapy. Severe cases improve substantially more after 16, rather than eight, sessions of psychodynamic-interpersonal psychotherapy. This was not the case for patients of other severity levels (Shapiro et al., 1994). There is also a possibility that severe cases have greater symptom improvement with more experienced therapists, as has been found with treatment for anxiety disorders (Mason, Grey, & Veale, 2016). In addition to severity, case complexity can also have an impact on treatment outcome. When depression is comorbid with other disorders, such as personality disorders (Diguer, Barber, & Luborsky, 1993; Hoffart & Martinsen, 1993), patients make smaller gains. In contrast, those with a low level of complexity make greater gains in treatment (Piette et al. 2011).

Patient attitudes are associated with therapy outcomes (Hamilton & Dobson, 2002). In particular, attitudes with the potential to be maladaptive (e.g., perfectionism) are associated with poorer outcomes (Simons, Gordon, Monroe, & Thase, 1995; Sotsky et al., 1991). A lack of motivation can negatively affect treatment outcome (Keijsers, Schaap, & Hoogduin, 2000), Furthermore, when patients do not believe that a therapy is credible, they are more prone to poor outcomes (Carter et al., 2011). Finally, patients’ expectation of improvement is a predictor of a positive outcome (Sotsky et al., 1991).

***1.4.5 Therapist effects***

Therapists themselves can influence patient outcome, but this is often minimised in RCTs because they are controlled through, for example, the use of manuals and strict guidance (Crits-Christoph & Mintz, 1991; Roth & Fonagy, 2005). Saxon & Barkham (2012) found that in standard clinical settings, around 6.6% of the variance in patient outcomes is due to the therapist, and this increases to 10% for more severe cases. In addition, recovery rates for individual therapists can vary from 23.5% to 95.6% (Saxon & Barkham, 2012). The reason for this variation can be due to a number of factors, such as competence (O’Malley et al., 1988), adherence (DeRubeis & Feely, 1990), personality characteristics (Meyer, Farrell, Kemp, Blakey, & Deacon, 2014, Green, Barkham, Kellett, & Saxon, 2014), experience (Mason et al., 2016), and therapy allegiance (Shaw, 1999).

There is some evidence that greater therapist competence is related to superior patient outcomes (e.g., O’Malley et al., 1988; Trepka, Rees, Shapiro, Hardy, & Barkham, 2004). However, Barber, Sharpless, Klostermann, and McCarthy (2007) suggest that this relationship is much weaker than might be expected. The authors suggest that there are a few possible explanations for this. First, the range of therapeutic competence within trials is small (all therapists within trials are expected to be competent). Therefore, it is difficult to test for the relationship between competence and outcome. Second, therapist competence is closely linked to therapist adherence. Barber et al. (2007) consider adherence to be the ability to demonstrate knowledge of ‘how’ to intervene, and competence to be demonstration of both ‘how’ and ‘when’ to intervene. Therefore, competence measures are sometimes mistakenly measuring aspects of adherence as well.

A lack of adherence to therapy protocols can be referred to as ‘therapist drift’ (Waller, 2009). Even when the patient is told that they are receiving a specific therapy, this does not necessarily happen. Stobie, Taylor, Quigley, Ewing, and Salkovskis (2007) found that only 40% of patients who were told they were receiving CBT or behaviour therapy (BT) were actually receiving a form of therapy that met basic CBT or BT criteria. Similarly, Waller, Stringer and Meyer (2012) found that in a sample of CBT clinicians, no single core CBT technique was being regularly used by at least half of the group. This lack of adherence to protocols often leads to poorer patient outcomes (DeRubeis & Feely, 1990). Therapist adherence interacts with other therapy variables, e.g. adherence positively predicts therapeutic alliance (Brauhardt et al., 2014; Loeb et al., 2005). Adherence also interacts with patient motivation in such a way that high adherence is actually detrimental for patients with low motivation (Huppert, Barlow, Gorman, Shear, & Woods, 2006).

Unfortunately, whether therapists stick to protocols and manuals seems to be somewhat attributable to their own characteristics, rather than the patients’ characteristics. Effective therapists, who consistently yielded a greater change in their patients, were more resilient, had more confidence in their skills, and had a more proactive approach to therapy than less effective therapists (Green et al., 2014). Waller et al. (2012) found that, based on which techniques they tend to use during therapy, CBT clinicians working with eating disorders fall into one of three groups, and only one of these groups reported high manual use. This indicates that clinicians might stick to their own style of therapy, regardless of whom they are treating, and this style might not even resemble the therapy that they say they are conducting. For example, Meyer et al. (2014) found that therapists are more likely to exclude anxious clients from exposure therapy if they themselves are anxious, despite the clear evidence base for the therapy (e.g., Lohr, Lilenfeld, & Rosen, 2012).

When clinicians are reluctant to adhere to manualised protocols, they often report that they value their clinical experience and that strict guidelines do not adequately reflect such experience (Stewart, Stirman, & Chambless, 2012). However, evidence for therapist experience leading to superior outcomes is mixed. Huppert et al. (2001) showed that overall experience conducting psychotherapy is related to positive outcomes, but experience relating to the specific therapy in the study (CBT) is not. More often, research indicates that level of experience or training actually has no impact on treatment outcome (Franklin, Abramowitz, Furr, Kalsy, & Riggs, 2003; Okiishi et al., 2006), unless patient characteristics are again taken into account. When working with clients with severe anxiety, rather than mild or moderate anxiety, qualified therapists outperform trainees (Mason et al., 2016). In addition, experience can be beneficial when working with a patient who is clinically and demographically similar to a recently treated patient (Leon, Martinovich, Lutz, & Lyons, 2005).

In an attempt to eliminate therapist effects, research that compares outcomes of different psychotherapies often requires the same therapist to deliver all treatments. However, this method does not eliminate allegiance effects (Falkenström, Markowitz, Jonker, Philips, & Holmqvist, 2013). Often therapists will have an allegiance to a specific therapy, believing it to be superior to others (McLeod, 2009). Therefore, they might be more competent and adhere more to the protocol when delivering that specific therapy. In turn, this adherence can lead to superior patient outcomes for the preferred therapy (Shaw, 1999).

Using the same therapist to deliver all treatments also does not eliminate the impact of therapist responsiveness on patient outcome. Therapist responsiveness refers to the way in which a therapist’s behaviour is affected by emerging context, including client behaviours (Stiles, 2009). For example, Hardy, Stiles, Barkham, and Startup (1998) found that CBT therapists used more affective and relationship-oriented interventions with overinvolved than underinvolved patients. In contrast, with underinvolved patients, psychodynamic-interpersonal therapists used more cognitive treatment methods than with overinvolved patients.

***1.4.6 Summary***

This review has briefly covered factors that can influence patient outcomes in psychotherapy. These include (but are not limited to) therapy format, therapeutic alliance, patient factors, and therapist factors. The influence of these factors is complex. They not only directly impact outcome, but can also interact with each other (e.g., Brauhardt et al., 2014). The effect of some of these factors upon outcome is reduced in RCTs when compared to clinical settings (Crits-Christoph & Mintz, 1991; Seligman, 1995). Some of these factors (e.g., therapist adherence) might be reduced in RCTs due to stricter monitoring and supervision in such settings (Gibbons et al., 2013).

Unfortunately, there is very little empirical evidence for the impact of clinical supervision. Although there is a widely held assumption that supervision has a positive influence on therapy via therapist behaviour (Lambert & Ogles, 1997; Milne & James, 2000; Wampold & Holloway, 1997), this assumption might not necessarily be true. Therefore, the role of supervision will be considered now, before moving on to a full review of the literature on this element of psychological therapies – considering both models of supervision and the effectiveness of supervision.

**1.5 The importance of supervision of therapists**

Clinical supervision can be described as a forum for supervisees to review and reflect on their clinical practice with the intention of improvement (Carroll, 2007). Proctor (1988) suggests that supervision has three main functions – ‘formative’, ‘restorative’, and ‘normative’. The ‘formative’ nature of supervision refers to the development of skills or the educational aspect, the ‘restorative’ provides the supportive element of supervision, and the ‘normative’ refers to managerial roles and case management. Kadushin (1976) refers to the same aspects of supervision as ‘educational’, ‘supportive’, and ‘managerial’.

Supervision is used widely in both clinical and research settings (Roth, Pilling, & Turner, 2010). Although supervision in RCT settings has not been directly compared to supervision in clinical settings, RCT supervision seems to differ from supervision in clinical practice. RCT clinicians receive closer, more structured supervision (Gibbons et al., 2013; Roth et al., 2010; Tracey, Bludworth, & Glidden-Tracey, 2012). Roth et al. (2010) found that the majority of clinical trials required a minimum of weekly supervision, whereas professional bodies in clinical settings require a minimum of monthly supervision (e.g., British Association for Behavioural and Cognitive Psychotherapies [BABCP, 2012]; British Association for Counselling and Psychotherapy [BACP, 2016]). Therefore, it is possible that the quantity or quality of supervision contributes to differences in patient outcomes between RCTs and clinical settings.

There is a widely held assumption that supervision ensures positive patient outcomes (Lambert & Ogles, 1997; Milne & James, 2000; Wampold & Holloway, 1997). Within research protocols, supervision is often described as necessary to ensure therapist adherence, and many therapy organisations consider regular supervision to be a requirement for therapist accreditation (e.g., BABCP, 2012; BACP, 2016). Unfortunately, while there are many models describing the optimum way in which to conduct supervision to benefit both therapists and patients (e.g., Bernard & Goodyear, 2004; Hawkins & Shohet, 1989; Mead, 1990; Stoltenberg & Delworth, 1987), they are usually based on anecdotal evidence. There is actually very little empirical evidence to support or distinguish them (Watkins, 1998). Given this failure to use the evidence base, there is a need for a clear summary of the evidence as to the role of supervision in impacting on therapy delivery and outcomes.

**1.6 Thesis overview**

In this thesis, I will be discussing the use of clinical supervision for therapists using cognitive behaviour therapy (CBT) to treat depression. More specifically, I will be exploring supervision models, evidence for the impact of supervision on both therapists and patients, and factors that can impact the content of supervision (the characteristics of patients, therapists, and the supervisors themselves). The following is a brief overview of the coming chapters.

***1.6.1 Chapter 2 – How do we know what makes for ‘best practice’ in clinical supervision for psychological therapists? A content analysis of supervisory models and approaches***

Chapter 2 presents a content analysis, which explored the recommendations of published supervision models. As the majority of supervision models are not disorder- or paradigm-specific, all forms of supervision model were included. The review identified which aspects of supervision are consistent across models and which are not. Models were found to focus more on formative aspects of supervision, rather than normative or restorative. Few models focused on the patient in therapy and instead directed their attention to the supervisee and supervisor. Finally, none of the models were clearly or adequately empirically based.

***1.6.2 Chapter 3 – Does clinical supervision contribute to therapist and patient outcomes? A meta-analysis***

In order to examine the empirical evidence for clinical supervision, two meta-analyses are presented in Chapter 3. The aim of these meta-analyses was to investigate the effect of supervision on both supervisees and patients. Due to the lack of empirical research in the area, studies of all disorders and therapeutic paradigms were included. Supervision was found to have a moderate, positive effect on supervisees, but a non-significant effect on patients. Moderator analyses were limited due to the small number of studies. There was some evidence that controlled studies investigating supervisee effects had larger effect sizes than non-controlled studies. Whether supervisees were qualified and supervision frequency were also potential moderators of effect size.

***1.6.3 Chapter 4 – Supervisor practice when guiding therapists working with depression: The impact of supervisor and patient characteristics***

Chapter 4 presents an empirical study exploring how supervisors’ own characteristics and those of patients can influence the focus of supervision sessions. Participants were clinical supervisors who supervised CBT therapists working with patients with depression. Supervisors were asked to indicate their supervision focus for three different patient cases, which varied in clinical complexity. Participants’ intolerance of uncertainty and their self-esteem were also assessed. Supervisors tended to focus their supervisees on the use of evidence-based therapeutic techniques for both straightforward and complex cases. However, their approach was less evidence-based for diffuse cases. Three supervisory types emerged, and which group the supervisor fell into was related to their personal characteristics. Findings indicate that supervisors are influenced by factors outside of supervision.

***1.6.4 Chapter 5 – Supervision for depression: An experimental study of the role of therapist gender and anxiety***

Chapter 5 reports a second empirical study. This study explored how supervisee and supervisor characteristics impacted the focus of supervision sessions. Similar to the study reported in Chapter 4, supervisors indicated their supervision focus for three supervision cases. While the patient complexity remained the same, supervisee anxiety and gender varied across vignettes. Supervisors focused calm female supervisees more on therapeutic techniques than state anxious female supervisees. Males were supervised in the same way, regardless of their anxiety. Both male and female supervisors had this pattern of focus. Findings indicate that supervision is influenced by supervisors' own biases towards their supervisees. The anxiety of the supervisors themselves also impacted their recommendations for supervision.

***1.6.5 Chapter 6*** – The role of supervision for depression: Dealing with non-adherence from patients and therapists

Chapter 6 presents three mini-studies investigating the effect of non-adherence to behavioural activation on the focus of supervision sessions. All three studies used the same paradigm as in the previous two chapters. Study 3a explored the impact of a lack of supervisee adherence on supervisor recommendations. The supervisees in the vignettes varied in anxiety and gender. All male supervisees were treated in the same way, regardless of their anxiety. There appeared to be a specific effect relating to trait anxious females. Supervisors were less likely to encourage a return to behavioural activation for this group.

The vignettes in Study 3b again described a supervisee who was not adhering to behavioural activation. This time the supervisee varied in experience level and the patient varied in complexity. In this study, the supervisors’ recommendations did not vary with the characteristics of the supervisee or patient.

Study 3c had vignettes varying in supervisee gender and anxiety (as in Study 3a) however; this study investigated the impact of patient non-adherence. All male supervisees were given the same guidance, but calm female supervisees were guided towards behavioural activation more than trait anxious female supervisees were.

Across the three mini-studies, supervisors tended to focus more on alliance and case management work than on technique work. However, the majority of supervisors lacked much focus in supervision. Most supervisors fell into natural groupings with very low focus on any aspect of supervision.

### 1.6.6 Chapter 7 – General discussion

In Chapter 7, findings from across the thesis are synthesised. These findings are discussed within the context of the empirical supervision literature, the supervision models literature, and wider psychology theory. Recommendations are made for clinical and service improvement, including increased monitoring of supervision, and training and protocols highlighting potential supervisor biases. A number of research implications are outlined and ideas for future research are proposed. Suggestions for future research include, similar investigations for other therapies and disorders, and the use of observational and actual clinical data in future research paradigms.

# – How do we know what makes for ‘best practice’ in clinical supervision for psychological therapists? A content analysis of supervisory models and approaches

This chapter is adapted from Simpson-Southward, C., Waller, G., & Hardy, G. E. (2017). How do we know what makes for “best practice” in clinical supervision for psychological therapists? A content analysis of supervisory models and approaches. *Clinical Psychology and Psychotherapy, 24,* 1228–1245.

**Abstract.** Clinical supervision for psychotherapies is widely used in clinical and research contexts. Supervision is often assumed to ensure therapy adherence and positive client outcomes, but there is little empirical research to support this contention. Regardless, there are numerous supervision models, but it is not known how consistent their recommendations are. This review aimed to identify which aspects of supervision are consistent across models, and which are not. A content analysis of 52 models revealed 71 supervisory elements. Models focus more on supervisee learning and/or development (88.46%), but less on emotional aspects of work (61.54%) or managerial/ethical responsibilities (57.69%). Most models focused on the supervisee (94.23%) and supervisor (80.77%), rather than the client (48.08%) or monitoring client outcomes (13.46%). Finally, none of the models were clearly or adequately empirically based. While we might expect clinical supervision to contribute to positive client outcomes, the existing models have limited client focus and are inconsistent. Therefore, it is not currently recommended that one should assume that the use of such models will ensure consistent clinician practice or positive therapeutic outcomes.

**2.1 Background and aims**

The majority of the literature on clinical supervision of psychological therapists is in the form of theoretical models or approaches to supervision. Often these models are diverse and suggest many different ways to conduct supervision. In order to create a coherent picture of the supervision model literature, the current chapter presents a content analysis of the literature. Although this thesis is focused on treatments for depression, most psychotherapy supervision models are not disorder or paradigm specific. Therefore, this review considered all forms of supervision model in psychotherapy, as they all have potential to be used within depression treatments.

Supervision is conducted in a number of different settings and takes a variety of different forms (Kilminster & Jolly, 2000), but it usually involves a relationship between senior and junior members of a profession, which is intended to enhance personal functioning and has aspects of evaluation and monitoring (Bernard & Goodyear, 2004). Three core functions of supervision appear repeatedly throughout the literature. Proctor (1988) describes them as ‘normative’ (managerial and ethical responsibilities), ‘formative’ (education and development of the supervisee), and ‘restorative’ (emotional aspects of work) functions. Kadushin (1976) labels the same functions as ‘managerial,’ ‘educational,’ and ‘supportive’.

Supervision is widely used in both clinical and research settings (O’Donovan, Halford, & Walters, 2011; Roth et al., 2010). Many professional bodies require therapists to have supervision both during training and after (Lambert & Ogles, 1997; Roth & Pilling, 2007), and receiving therapist accreditation is often reliant on regular supervision (Milne, 1998; O’Donovan et al., 2011). There has been a concomitant rise in training and accreditation for supervision itself (Peake, Nussbaum, & Tindell, 2002). Reasons for the recommendation of supervision are multiple, including the belief that supervision will ensure therapist adherence and promote high-quality healthcare, resulting in positive patient outcomes (Ellis & Ladany, 1997; Milne & James, 2000).

While such assumptions are widely held, they largely remain assumptions at present. There is limited research into the impact of clinical supervision (O’Donovan et al., 2011), particularly on patient outcomes (Watkins, 2011). Where there is research, results are inconsistent. Supervision can increase therapist adherence (Schoenwald, Sheidow, & Chapman, 2009) and perceived therapeutic effectiveness (Livni, Crowe, & Gonsalvez, 2012), but how these findings translate to patient outcome data is less clear. Callahan, Almstrom, Swift, Borja, & Heath (2009) demonstrate that supervisors might account for around 16% of the variance in patient outcome, while other researchers looking at patient outcomes have found that supervision can increase therapeutic alliance, reduce symptoms, and increase retention rates (Bambling, King, Raue, Schweitzer, & Lambert, 2006; Bradshaw, Butterworth, & Mairs, 2007). However, some research indicates no impact on patient outcome (White & Winstanley, 2010).

Although there is some indication that supervision can have a positive effect (Bambling et al., 2006; Bradshaw et al., 2007), universal guidelines on best practices in supervision are lacking (Roth & Pilling, 2007). This lack of clear guidance might be responsible for some of the inconsistent results in supervision research, as outlined above. Some training and governing bodies identify their own guidelines for supervision (e.g., The National Board for Certified Councelors, the American Association of State Counselor Boards; Borders, 2014), but there is no ‘gold standard’ supervision manual, as there are for individual therapies. Instead, there are a number of models or approaches to clinical supervision. While these models are widely discussed (Carroll, 1996; Hawkins & Shohet, 1993; Scaife, 2001), the full content of models has not been assessed or compared. Therefore, it is not clear whether a consistent message is being communicated about how we should be conducting supervision.

Consequently, there is a need for a systematic analysis of the supervision model literature, to determine the consistencies and differences across models. This review is the first to examine the content of the many supervision models that exist for psychotherapies, to determine whether supervisors are receiving consistent messages regarding how best to deliver supervision. In short, if the content is not reliable across models, then the validity of supervisory models (or some of them) has to be questionable, and it is not clear which should be treated as suitable for enhancing clinical practice.

It is likely that there will be some variability across models for understandable reasons. For example, over time, models might increase in amount of content, reflecting growth in research findings in the area (Ellis & Ladany, 1997). However, it can be hypothesised that some broad content should remain consistent across models. For example, given that the core functions of supervision (normative, formative, and restorative – Proctor, 1988) are widely accepted (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001) aspects of each of these should be found in all models. There is also general agreement that supervision is a tool for the improvement of supervisees (Bernard & Goodyear, 2004; Carroll, 2007). Therefore, it is anticipated that models will recommend some form of evaluation process. Although supervision events usually only require the presence of a supervisor and supervisee, supervision is actually triadic in nature as it also involves patients (Tracey et al., 2012). Accordingly, one might expect that models should discuss all three parties involved in the process – the supervisor, supervisee, and patient. Finally, evidence-based practice is essential for ensuring safety and progress in the clinical profession (Watkins, 2011), so models might be expected to be based on empirical evidence.

This review aims to investigate similarities and differences across models of clinical supervision, and therefore determine whether they have core features, indicating reliability. Content analysis will be used, as it is an appropriate method to extract patterns of similarity and difference from such data. The hypotheses of the study are as follows. First, the broad content of models will be similar, including: discussion of the three core factors in supervision; the three parties in supervision; and the use of evaluation to ensure progress. Second, the amount of content in newer models is predicted to differ from older models. Newer models might have more (and more diverse) content than older models. Alternatively, as models are refined, content might decrease. Finally, it is hypothesised that the content of these models will be based on empirical evidence.

**2.2 Method**

***2.2.1 Selection of supervision models for analysis***

Texts were included if they met the following selection criteria:

* They were models or approaches to supervision describing what happens within the context of clinical supervision
* The main focus of the model/approach was one-to-one supervision (rather than group supervision or self-supervision)
* The supervision described was of therapists working with any model of psychotherapy
* The text was in the English language.

Texts were excluded if:

* They described training or education of therapists, rather than supervision itself
* The model/approach was for working with supervisees who did not have real patients, only simulated therapy
* They focused on one particular method that is used in supervision, rather than the process of supervision as a whole.

To ensure consistency, the earliest version available of each model was used. Where the original version was not available, a later version by the same author was used (this is highlighted in Table 2.1).

***2.2.2 Search strategy***

The majority of models or approaches to clinical supervision are published in books, rather than journals. Therefore, to avoid missing key models/approaches, the literature was searched using a three-stage approach:

* The search started with an existing library of clinical supervision texts that are used in training on a course for clinical supervision, aimed at qualified clinical psychologists. If earlier editions were available, they were obtained and used rather than the later versions. This start point identified 29 models.
* Models were also found through database searches in PubMed, Web of Science, and PsychINFO using the terms ‘supervision,’ ‘psychotherapy,’ and ‘outcome’. This identified three models.
* Finally, all of the texts identified to this point were scrutinised for any further models. This stage yielded a further 20 models.

The decision to stop at 52 models was based on saturation of the data, and is explained below. All models used are listed below.

A second search was conducted to investigate whether the models had been tested after they were developed. Models (where available) were located on the Web of Science database. Using the ‘times cited’ tab, all literature that cited each model was scrutinised for an empirical test of the model.

***2.2.3 Procedure***

A content analysis was carried out for each model identified, using the approach outlined in Neuendorf (2002). Models were tabulated along with their content variables. Definitions and examples of all content variables are outlined in Appendix 2A. While the great majority of elements were derived from the content analysis itself, a small set of the variables were identified prior to reading the supervision models, in keeping with the hypotheses above. These were: whether the model was based on an empirical study; whether they cited empirical evidence; and three core aspects of supervision. These core aspects have been highlighted in previous literature – supervisee learning and/or development; emotional effects of work; and managerial and/or ethical responsibilities (formative, restorative, and normative - Proctor, 1988; or educational, supportive, and managerial - Kadushin, 1976). The remaining elements emerged from the content analysis. Each time a new supervision element came up in a model, the variable was added to the table.

The search for new models stopped when it was clear saturation was achieved. The number of new variables in each new model declined quickly - 80.30% of the total number of elements had been identified by model 10 and 95.45% by model 36. The last new variable was identified in model number 43. It was not clear that saturation had been reached until around model 49 as previously up to six models in a row had been analysed without the appearance of any new variables. At this point, a decision was made to include any models that had already been identified, but not to include any new models that only appeared in these final few texts. This lead to a final nine models being analysed after model 43, none of which produced new variables.

Finally, a search for empirical testing of the identified models was conducted using the search strategy described above.

***2.2.4 Inter-rater agreement on coding for content analysis***

A subsample of the data were analysed by a second rater, to determine agreement with the original rater’s conclusions. The second rater (CH) was a Psychology PhD student at the University of Sheffield. Subsamples of between 10% and 20% are commonly recommended for reliability checks in content analysis research (Neuendorf, 2002). Due to the small overall sample of models in our analysis, 20% was used to maximise validity of the coding. Therefore, ten models were randomly selected for the subsample. Overall percentage agreement was high (87.3%), giving a Cohen’s kappa of 0.695, which indicates ‘substantial’ agreement between coders. In addition, Krippendorff’s alpha was 0.695, which is above the ‘acceptable’ level.

***2.2.5 Data analysis strategy***

Initially, the content analysis was conducted. This included consideration of whether models addressed: the three core factors of supervision (supervisee learning and/ or development; emotional effects of work; and managerial and/or ethical responsibilities); focus on the three key people in supervision (supervisor, supervisee, and client); and the more general content elements of what models recommend should form the basis and substance of supervision. Correlational analysis was used to determine temporal patterns in the development of models (i.e., do models get more or less detailed over time; are there temporal trends in models’ foci). Finally, two-step cluster analysis was carried out in SPSS to determine whether the content of models formed distinct clusters or ‘types’ of model. The interaction of those clusters was examined using chi-squared analysis.

**2.3 Results**

The first section of the Results considers the broad content and elements of the identified supervision models, and whether this content was similar across models (Hypothesis 1). Differences in models over time are then evaluated (Hypothesis 2) and evidence for each model outlined (Hypothesis 3). Finally, possible clustering of the elements and models are investigated.

***2.3.1 Content of models***

A brief description of each of the 52 models is outlined in Table 2.1, along with the number of elements identified in each model and coverage of the three main factors of supervision. The number of elements (not including the higher-level factors – the main three and those relating to the evidence base) identified in each model ranges from six to 34 (*M* = 17.81, *SD* = 6.80). Sixty-six separate elements were identified in total (rising to 71 when including higher-level factors). Considering the three core elements of therapy, as outlined above, most models focus on supervisee learning and/or development (88.46%). However, there is a lesser focus on the emotional effects of work (61.54%) or on managerial and ethical responsibilities (57.69%). Only 38.41% of models focused on all three core elements.

Table 2.1. Basic information about models including coverage of core factors and number of identified elements (\* indicates models that were not the original text).

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | | **Managerial and/ or ethical responsib-ilities** | **Emotional effects of work** |  |
|  |  |  |  | 46  (88.46%) | | 30 (57.69%) | 32 (61.54%) | **No. of** **models**  **with**  **factor**  **No.**  **of**  **elements**  **in model** |
| 1964 | Issues and approaches in supervision (Hogan, 1964) | - | Developmental model consisting of four stages. | ✓ | |  | ✓ | 9 |
| 1972\* | The teaching and learning of psychotherapy (Ekstein & Wallerstein, 1972) | - | Highlights the four parties within the supervisory process (administrator, supervisor, therapist, and patient) and the relationships between them. | ✓ | | ✓ |  | 20 |
| 1972 | Coping with conflict: Supervising counselors and psychotherapists (Mueller & Kell, 1972) | - | Highlights conflicts that can arise in the therapeutic and supervisory processes and how they can be coped with. |  |  | | ✓ | 23 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 1972 | A behavioural model for the practicum supervision of counselor candidates (Delaney, 1972) | - | Identifies five stages of supervision: initial session; development of a facilitative relationship; goal identification and determination of supervisory strategies; use of supervisory techniques and procedures; and termination and follow-up. | ✓ | ✓ | ✓ | 15 |
| 1973 | Providing clinical supervision for marriage counselors: A model for supervisor and supervisee (Ard, 1973) | - | Outlines the ‘who, what, when, where, and why’ of supervision. | ✓ | ✓ |  | 19 |
| 1979 | Supervisor training: A discrimination model (Bernard, 1979) | The Discrimination Model | Highlights three functions (process skills, conceptualisation skills, and personalisation skills), and three supervisory roles (teacher, counsellor, and consultant). | ✓ |  | ✓ | 14 |
| 1979 | A developmental framework for counseling supervision (Littrell, Lee-Borden, & Lorenz, 1979) | - | Incorporates four models of supervision (counselling/therapeutic, teaching, consulting, and self-supervising). | ✓ | ✓ | ✓ | 16 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 1980 | Supervision and the bipersonal field (Langs, 1980) | - | An adaptational-interactional model of supervision of psychoanalytic psychotherapy. | ✓ |  |  | 14 |
| 1980 | A client-centered approach to the supervision of psychotherapy (Rice, 1980) | - | An approach to supervision based on client-centred theory. | ✓ |  |  | 12 |
| 1980 | Supervision of behavior therapy (Linehan, 1980) | Three-Dimensional Model of Behavioral Supervision | An approach to supervision of behaviour therapy based on three dimensions (goals of supervision; methods and procedures used to achieve the goals; and the universes). | ✓ | ✓ |  | 19 |
| 1980 | Supervision in communications analytic therapy (Beier & Young, 1980) | - | An approach to supervision based on communications analytic theory. | ✓ |  |  | 11 |
| 1981 | Approaching supervision from a developmental perspective: The counselor complexity model (Stoltenberg, 1981) | The Counselor Complexity Model | Describes the expected counsellor characteristics and optimal environments for four levels of supervisee development. | ✓ |  | ✓ | 17 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 1982 | Supervision: A conceptual model (Loganbill, Hardy, & Delworth, 1982) | - | Describes three stages of supervisee development (stagnation, confusion, and integration). | ✓ | ✓ | ✓ | 23 |
| 1982 | An eclectic model of supervision: A developmental sequence for beginning psychotherapy students (Yogev, 1982) | - | Outlines three stages of supervisee development (role definition; skill acquisition; and solidification and evaluation of practice). | ✓ |  |  | 18 |
| 1983 | Toward a cognitive developmental approach to counselling supervision (Blocher, 1983) | Cognitive Developmental Model of Supervision | Focuses on the development of more complex and comprehensive schemas for understanding human interaction. | ✓ |  | ✓ | 13 |
| 1983 | A working alliance based model of supervision (Bordin, 1983) | A Working Alliance Based Model of Supervision | Highlights the importance of the working alliance in supervision. | ✓ |  | ✓ | 16 |
| 1983 | A social learning approach to counselor supervision (Hosford & Barmann, 1983) | A Social Learning Approach to Counselor Supervision | An approach to clinical supervision based on social learning theory. | ✓ |  | ✓ | 23 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 1983 | A client-centered approach to supervision (Patterson, 1983) | A Client-Centered Approach to Supervision | Description of supervision for supervisees using a client-centred therapeutic approach. | ✓ | ✓ |  | 14 |
| 1983 | Supervision in counseling: Rational-emotive therapy (Wessler & Ellis, 1983) | - | Approach to supervision of supervisees using rational-emotive therapy. | ✓ | ✓ |  | 21 |
| 1984 | An approach to supervision of symbolic-experiential psychotherapy (Connell, 1984) | - | Highlights four stages of experiential supervision (supervisory structure; supervisory initiative; trial of labour; and supervisory termination). | ✓ | ✓ | ✓ | 16 |
| 1985 | Stages in psychotherapy supervision: From therapy skills to skilled therapist (Grater, 1985) | - | Provides a four-stage model based on the belief that psychotherapy progress is determined by interaction between clients' presenting problems, their personalities, techniques used by therapists, and interpersonal interactions of therapists. | ✓ | ✓ | ✓ | 19 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 1986 | The development of professional identity in psychotherapists: Six stages in the supervision process (Friedman & Kaslow, 1986) | - | Outlines six stages in early learning and supervisory processes (Excitement and anticipatory anxiety; dependency and identification; activity and continued dependency; exuberance and taking charge; identity and independence; calm and collegiality). | ✓ | ✓ | ✓ | 22 |
| 1986 | Growth in supervision: Stages of supervisee and supervisor development (Hess, 1986) | - | Describes a three-stage model of supervisor development (beginning; exploration; and confirmation of supervisor identity). |  | ✓ |  | 11 |
| 1987 | Supervising counsellors and therapists: A developmental approach (Stoltenberg & Delworth, 1987) | Integrated Developmental Model of Supervision (IDM) | Four level developmental model. Supervisees develop in self & other awareness, motivation, and autonomy over the four levels. | ✓ | ✓ | ✓ | 32 |
| 1988 | Teaching an integrated model of family therapy: women as students, women as supervisors (Ault-Riché, 1988) | The Apprenticeship Model | Proposes a 'continuum of emphasis' on gender issues as a trainee moves from an observer to a live supervised member of a therapy team. | ✓ | ✓ |  | 14 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 1990 | Development of the psychotherapy supervisor (Watkins, 1990) | Supervisor Complexity Model | Highlights four stages of supervisor development: role shock, role recovery/transition, role consolidation, and role mastery. |  |  |  | 6 |
| 1990 | Solution -focused supervision (Wetchler, 1990) | Solution-Focused Supervision Model | Focuses on supervisee strengths and solutions, rather than problems and mistakes. | ✓ | ✓ |  | 16 |
| 1990 | Effective supervision: A task oriented model for the mental health professions (Mead, 1990) | A Task-Oriented Model of Supervision | Focuses on three hierarchically connected systems that can be seen in terms of levels and meta-levels (level 1 = client, level 2 = therapist, level 3 = supervisor). | ✓ | ✓ |  | 32 |
| 1993\* | Supervision in the helping professions (Hawkins & Shohet, 1993) | The Seven-Eyed Model of Supervision | Highlights the seven aspects of the supervision process: supervisor, supervisee, client, strategies and interventions used by the supervisee, the therapeutic relationship, the supervisory relationship, and the wider context in which the work happens. |  | ✓ | ✓ | 17 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 1994 | Toward a multidimensional model for psychotherapy supervision based on developmental stages (Rodenhauser, 1994) | A Dynamic Multidimensional Developmental Model | Outlines the supervisor, supervisee, and patient developmental stages, and how they interact. | ✓ |  |  | 17 |
| 1994 | Solution-oriented supervision: The coaxing of expertise (Thomas, 1994) | Solution -Orientated Supervision | Proposes that supervisees are not complete but are competent. Focuses on solutions, not problems. | ✓ |  |  | 7 |
| 1994 | A cognitive-developmental model for marital and family therapy supervision (Rigazio-DiGilio & Anderson, 1994) | A Cognitive-Developmental Model of Supervision | Assumes supervisee development is maximised when the supervisory environment is tailored to the supervisees' learning style. | ✓ |  |  | 16 |
| 1995 | Clinical Supervision: A systems approach (Holloway, 1995) | A Systems Approach Model | Highlights seven dimensions of supervision. The supervision relationship is the core dimension, surrounded by the functions of supervision, the tasks of supervision, and four contextual factors (institution, supervisor, supervisee, and client). | ✓ | ✓ | ✓ | 25 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 1995 | The partnership model: A feminist supervision/consultation perspective (Hipp & Munson, 1995) | The Partnership Model | Focuses on equality between men and women in supervision, based on the Partnership Model from Eisler (1987) | ✓ | ✓ | ✓ | 14 |
| 1996 | Counselling Supervision: Theory, skills and practice (Carroll, 1996) | The Seven Tasks of Supervision Model | Focuses on seven generic tasks of supervision: creating the learning relationship, teaching, counselling, monitoring professional/ethical issues, evaluating, consulting, and administrating. | ✓ | ✓ | ✓ | 16 |
| 1996 | Counselling Supervision: Theory, skills and practice (Carroll, 1996) | - | Focuses on how to manage the supervision process. Five stages of supervision are highlighted: assessing; contracting; engaging in supervision; evaluating; and terminating. | ✓ | ✓ | ✓ | 21 |
| 1996 | Dimensions of psychotherapy supervision: Maps and means (Haber, 1996) | - | Considers the internal processes of the supervisee combined with the external therapeutic context. | ✓ | ✓ | ✓ | 30 |
| 1997 | Cognitive therapy supervision (Liese & Beck, 1997) | Cognitive Therapy Supervision | An approach to clinical supervision based on cognitive therapy. | ✓ | ✓ | ✓ | 11 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 1998 | Counseling supervision: A reflective model (Ward & House, 1998) | - | Integrates reflective learning theory with concurrent development of supervisees and the supervisory relationship. | ✓ |  | ✓ | 10 |
| 1999 | Narrative approaches to supervision and case formulation (Bob, 1999) | - | Highlights use of meaning and narrative in interpersonal discourse within supervision. |  |  |  | 12 |
| 1999 | School counselors and supervisors: An integrated approach for supervising school counseling interns (Nelson & Johnson, 1999) | - | Combines models of Bernard (1979) and Littrell et al. (1979) to create an integrated model specifically for school counsellors. Four stages are outlined (orientation, working, transition, and integration). | ✓ | ✓ | ✓ | 14 |
| 1999 | Strength-based supervision: Frameworks, current practice, and future directions (Edwards & Chen, 1999) | A Strength Based ‘Wu-wei’ Method | Highlights supervisees' strengths rather than weaknesses. | ✓ |  | ✓ | 8 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 2000 | Encouraging the cognitive development of supervisees: Using Bloom's Taxonomy in supervision (Granello, 2000) | - | Uses Bloom's Taxonomy (Bloom, Engelhard, Furst, Hill, & Krathwohl, 1956) to assess the cognitive level of the supervisee. Six levels are outlined: knowledge, comprehension, application, analysis, synthesis, and evaluation. | ✓ |  |  | 13 |
| 2000 | Psychotherapy supervision: An integrative relational approach to psychotherapy supervision (Gilbert & Evans, 2000) | An Integrative Relational Model of Supervision | Highlights the interpersonal nature of supervision and the co-creation of a 'new' narrative by the supervisor and supervisee that informs work with the client. | ✓ | ✓ | ✓ | 34 |
| 2001\* | Supervision in mental health professions: A practitioner's guide (Scaife, 2001) | General Supervision Framework | Lays out supervisor role (inform-assess; enquire; listen-reflect), supervisor focus (actions, events and responses; knowledge, thinking and planning; feelings and personal qualities) and medium providing data for supervision. | ✓ |  | ✓ | 16 |
| 2001 | The Supervisory Relationship: A contemporary psychodynamic approach (Frawley-O’Dea & Sarnat, 2001) | A Relational Model of Supervision | Highlights the importance of relationships and the embeddedness of supervision in a work context. The model has three dimensions: the nature of the supervisor's authority; the supervisory focus; and the supervisor's primary mode of participation. |  |  | ✓ | 18 |

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| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 2004 | The integrative family therapy supervisor (Lee & Everett, 2004) | - | Highlights the importance of integration of aspects of different approaches to supervision. | ✓ | ✓ | ✓ | 30 |
| 2005 | Critical events in psychotherapy supervision: An interpersonal approach (Ladany, Friedlander, & Nelson, 2005) | An Events-Based Model of Supervision | Identifies critical events in supervision. 'Markers' can be identified within the supervisory working alliance then worked through in the 'task environment' to resolution. | ✓ | ✓ | ✓ | 31 |
| 2006 | Conceptualising and formulating cognitive therapy supervision (Armstrong & Freeston, 2006) | Newcastle Supervision Framework | Identifies four interactive levels of supervision: learning process, dynamic focus, parameters, and primary inputs. | ✓ |  |  | 17 |
| 2007 | Toward a common-factors approach to supervision (Morgan & Sprenkle, 2007) | - | Combines common factors of supervision models. Three dimensions of supervision are highlighted: emphasis (clinical competence to professional competence), specificity (idiosyncratic need of each supervisee to mandates of the field at large), and the supervisory relationship (collaborative to directive). | ✓ | ✓ | ✓ | 15 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Reference** | **Name of model (where provided)** | **Brief Description** | **Supervisee learning and/ or development** | **Managerial and/ or ethical responsib-**  **ilities** | **Emotional effects of work** | **No. of**  **elements**  **in model** |
| 2009\* | The art, craft and tasks of supervision: Making the most of supervision (Inskipp & Proctor, 2009) | - | Addresses the three main functions of supervision: formative, normative, and restorative. | ✓ | ✓ | ✓ | 27 |
| 2015\* | Supervising the counsellor and psychotherapist (Page & Wosket, 2015) | Cyclical Model of Supervision | Addresses the structure of supervision sessions. The model has five stages: contract, focus, space, bridge, and review. | ✓ | ✓ | ✓ | 30 |

#### 2.3.1.1 People in supervision

Considering the three parties in the supervision process, the content of most models includes a focus on the supervisee (94.23%) and on the supervisor (80.77%). In contrast, only half include a focus on the client (48.08%). Thus, many more aspects of the supervisee and supervisor are discussed in the models than aspects of the client, as summarised in Table 2.2. See Appendices 2B to 2E for more details.

Table 2.2. Focus on the aspects of individuals involved in the supervision process.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Supervisor elements** | **No. of models** | **%** | **Supervisee elements** | **No. of models** | **%** | **Client elements** | **No. of models** | **%** |
| Focus on supervisor | 42 | 80.77 | Focus on supervisee | 49 | 94.23 | Focus on client | 25 | 48.08 |
| Supervisor’s personal characteristics | 18 | 34.62 | Supervisee’s personal characteristics | 38 | 65.38 | Client’s personal characteristics | 4 | 7.69 |
| Development of supervisor | 5 | 9.62 | Development of supervisee | 29 | 55.77 | Development of client | 1 | 1.92 |
| Supervisor gender | 9 | 17.31 | Supervisee gender | 18 | 34.62 | Client’s gender | 2 | 3.85 |
| Supervisor ethnicity/ culture | 7 | 13.46 | Supervisee ethnicity/ culture | 13 | 25 | Client’s ethnicity/ culture | 3 | 5.77 |
| Supervisor anxiety | 3 | 5.77 | Supervisee anxiety | 23 | 44.23 | - | - | - |
| Supervisor can take on a variety of roles | 11 | 21.15 | Supervisee can take on a variety of roles | 6 | 11.54 | - | - | - |
| Supervisor as an authority figure/expert | 19 | 36.54 | - | - | - | - | - | - |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Supervisor elements** | **No. of models** | **%** | **Supervisee elements** | **No. of models** | **%** | **Client elements** | **No. of models** | **%** |
| Supervisor has the ability to assign clients | 4 | 7.69 | - | - | - | - | - | - |
| Supervisors have their own individual supervisory styles | 2 | 3.84 | - | - | - | - | - | - |
| - | - | - | Supervisee motivation | 10 | 19.23 | - | - | - |
| - | - | - | Supervisee autonomy vs dependency | 12 | 23.08 | - | - | - |
| - | - | - | Supervisee awareness of self and/or others | 15 | 28.85 | - | - | - |
| - | - | - | Supervisee individual learning styles | 12 | 23.08 | - | - | - |
| - | - | - | - | - | - | Client’s expectations | 1 | 1.92 |

#### 2.3.1.2 Overt content of supervision

Guidance for the content of supervision sessions varies across models (see Table 2.3 and Appendix 2F). Most, but not all, models explicitly recommend reporting on therapy sessions (78.85%). Some models require that supervisors should observe the therapy sessions, whether through recordings (65.38%) or live supervision (38.46%). However, fewer than half of the models suggest discussion of theory or direction to literature (46.15%).

Table 2.3. Number of models focusing on each ‘content of supervision sessions’ element.

|  |  |  |
| --- | --- | --- |
| **Content of supervision element** | **No. of models** | **%** |
| Reporting on therapy sessions | 41 | 78.85 |
| Recorded therapy sessions | 34 | 65.38 |
| Interactive discussion between supervisor and supervisee to further understanding/ decide on focus | 24 | 46.15 |
| Enactment of therapy sessions/role-play | 24 | 46.15 |
| Discussion of theories and reading of literature | 24 | 46.15 |
| Live supervision/observation | 20 | 38.46 |
| Shared experience from the supervisor | 15 | 28.85 |
| Supervisor using enquiry as learning technique | 6 | 11.54 |
| Supervisee takes charge of what is shared in supervision | 3 | 5.77 |

#### 2.3.1.3 Evaluation in supervision

Over half of the models suggest the use of assessment or evaluation of supervisees (59.62%), and the use of feedback from the supervisor and/or supervisee (57.69%). However, these are not always the same models (see Appendix 2G). In contrast, very few (13.46%) models suggest that evaluation should take the form of client outcome monitoring, and only two models suggest the use of client feedback (3.85%).

#### 2.3.1.4 Management of supervision

There was relatively little focus on how supervision might be planned. Only 23.08% of models suggest the use of supervision contracts, though two of these models (3.85%) go one step further, suggesting re-contracting regularly. Only 17.31% of models discuss the termination process. Finally, only five models (9.62%) discuss some form of supervision of supervision (see Appendix 2H for further details).

#### 2.3.1.5 Relationships in supervision

Most models discuss the supervisor and supervisee relationship (82.69%), but only around half discuss the supervisee and client relationship (51.92%). In even greater contrast, only three models (5.77%) discuss the relationship between the supervisor and client (see Appendix 2I).

#### 2.3.1.6 Idiosyncratic methods in supervision models

Six further elements (which have not already been covered) were found in the content analysis, each of which was present in only one or two of the models (as detailed in Appendices 2J-2L). They were: the use of phone/email/teleconferencing for supervision sessions (two models); the use of imagery or metaphor in supervision (two models); setting of homework in supervision (two models); acceptance of therapist regression during supervision (two models); the role of an administrator in the supervision process (two models); and the suggestion that clients should be invited into supervision sessions (one model).

#### 2.3.1.7 Evidence

While 73.08% of models cite empirical evidence in the model, none of the models themselves are based on an empirical study (see Appendix 2M). Seven models (13.46%) were empirically tested after their development (Table 2.4). The majority of empirical tests investigate model construct validity or developmental structure rather than the impact of the model on the supervisee. None of the empirical investigations test the model’s impact on the patient.

Table 2.4. Empirical testing of models after their development.

|  |  |  |
| --- | --- | --- |
| **Model** | **Test of construct validity and/ or developmental structure** | **Test of impact on supervisee** |
| *Hogan (1964)* | Reising & Daniels (1983) | - |
| *Bernard (1979)* | Stenack & Dye (1982)  Ellis & Dell (1986)  Ellis, Dell, & Good (1988) | - |
| *Littrell, Lee-Borden, & Lorenz (1979)* | Ellis & Dell (1986)  Ellis et al. (1988) | - |
| *Stoltenberg (1981)* | Friedlander & Snyder (1983)  Miars et al. (1983)  McNeill, Stoltenberg, & Pierce (1985)  Stoltenberg, Solomon, & Ogden (1986)  Wiley & Ray (1986)  Stoltenberg, Pierce, & McNeill (1987)  Krause & Allen (1988)  Chagnon & Russell (1995) | Krause & Allen (1988) |
| *Loganbill, Hardy, & Delworth (1982)* | Heppner & Roehlke (1984)  Ellis (1991)  Hutter, Oldenhof-Veldman, & Oudejans (2015) | - |
| *Bordin (1983)* | - | Ladany, Ellis, & Friedlander (1999) |
| *Stoltenberg & Delworth (1987)* | McNeill, Stoltenberg, & Romans (1992)  Bear & Kivlighan (1994) | Bear & Kivlighan (1994) |

***2.3.2 Temporal Patterns***

Figure 2.1 shows that the number of models published per decade rose over time, peaking in the 1980s and 90s, and then declined. Although this search for models was conducted only halfway through the current decade (2010s), the very low number of models in that decade demonstrates that the trend is still one of decline.

Figure 2.1. Number of new models from each decade.

It was hypothesised that newer models would differ in content to older models. New models would either build on previous ones, so that the number of elements in each model would increase over the time period when the models were published, or models would become more refined, so the number of elements in each model would decrease. However, contrary to this hypothesis, the number of individual elements in a model was not significantly correlated with the year the model was published (*r* = .135, *p* = .341).

To determine any changes in model focus over time, models were split into quartiles by year (Q1 = 1964-1981 [12 models]; Q2 = 1982-1988 [13 models]; Q3 = 1990-1998 [14 models]; Q4 = 1999-2015 [13 models]). Model focus over time on the main three factors and three core people of supervision is outlined in Table 2.5.

Focus on *‘supervisee learning and/or development’* aspects stays consistently high across time. *‘Managerial and/or ethical responsibilities’* focus increases between quartiles one (1964-1981) and two (1982-1988), then decreases again between quartiles three (1990-1998) and four (1999-2015). Focus on the managerial and ethical aspect varies from around half of the models to around two thirds. Finally, the focus on *‘emotional effects of work’* increases from half the early models to around three quarters of the later models. Focus on the three people in supervision remains relatively consistent over time. Overall, the greatest amount of focus is on the supervisee, then the supervisor. Finally, only around half of the models focus on the client, with no increase over time in this element.

Table 2.5. Change over time in focus on main three factors and people involved in supervision.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Main three factors** | | | **People in supervision** | | |
| **Year** | **Supervisee learning and/or development (%)** | **Managerial and/or ethical responsibilities (%)** | **Emotional effects of work (%)** | **Focus on supervisor (%)** | **Focus on supervisee (%)** | **Focus on client (%)** |
| 1964 - 1981 | 83.33 | 41.67 | 50 | 75 | 100 | 41.67 |
| 1982 - 1988 | 92.31 | 69.23 | 61.54 | 76.92 | 92.31 | 53.85 |
| 1990 - 1998 | 85.71 | 64.29 | 57.14 | 85.71 | 92.86 | 50 |
| 1999 - 2015 | 84.62 | 53.85 | 76.92 | 84.62 | 92.31 | 46.15 |

***2.3.3 Content of supervision sessions: What is recommended?***

A two-step cluster analysis was carried out using the nine elements of the models that related to the content of supervision sessions (interactive discussion between supervisor and supervisee to further understanding/decide on focus; supervisee takes charge of what is shared in supervision; discussion of theories and reading of literature; shared experience from the supervisor; reporting on therapy sessions; live supervision/observation; recorded therapy sessions; enactment of therapy sessions/role-play; and the supervisor using enquiry as a learning technique). A three-cluster solution had the highest silhouette coefficient (0.3; ‘fair’) when grouping the models based on what they recommended for the content of sessions. This solution provides the smallest within-cluster differences with the largest between-cluster differences.

The first cluster (30.8% of the sample) included a group of models with little focus on any of the content elements of supervision, apart from reporting on therapy sessions (56.2% of models in the cluster), and are referred to as *Unfocused* models. The second cluster (36.5% of the sample) included models that all indicated a focus on reporting and recording of therapy sessions. Around half of these models also indicated a focus on live supervision (56.2%). These models are referred to as *Fidelity* models. The final cluster (32.7% of the sample) included models that, again, focused on reporting (76.5%) and recording of therapy sessions (88.2%), but also focused on theory discussion (100%), the use of live supervision (58.8%), and the use of role play (88.2%). Models in this cluster are referred to as *Enhanced Fidelity* models.

Full details of the clusters can be found in Appendix 2N.

#### *2.3.3.1 Validation of the Content Clusters*

To determine whether they had external validity, the three clusters were compared on model characteristics. There was no difference between groups in mean year of publication of the relevant models (*F*(2, 51) = 0.475, *ns*). Nor was there any difference between groups on whether they cited evidence (*χ 2* (*df* = 2) = 0.742*, ns*). However, the groups differed in the mean number of elements in the models (*F*(2, 51) = 6.834, *p* = .002). *Fidelity* models (*M* = 18.63, *SD* = 5.98) and *Enhanced Fidelity* models (*M* = 20.76, *SD* = 7.40) had more elements in them (*p* < .05) than *Unfocused* models (*M* = 13.13, *SD* = 4.56).

***2.3.4 Supervisor elements***

A two-step cluster analysis was carried out using the eight elements of the models that emerged as aspects of the supervisor (supervisor gender; supervisor ethnicity/culture; supervisor anxiety; development of supervisor; the supervisor has ability to assign clients; supervisor can take on a variety of roles; supervisor as authority figure/expert; and supervisors have their own supervisory styles). A four-cluster solution was found to have the highest silhouette coefficient (0.6). This is a ‘good’ solution, indicating that the within-cluster differences are small and the between-cluster differences are large.

The first cluster (50% of the sample) included a group of models with little focus on any of the supervisor elements, and this cluster is referred to as *Unfocused* models. The second cluster (21.2% of the sample) contained models, which, on the whole, described the supervisor as an authority figure (90.9% of the models in the cluster). This cluster is referred to as *Supervisor as an authority figure* models. The third cluster (17.3% of the sample) contains models, which all indicated a focus on the supervisor taking on a variety of roles. This cluster is referred to as *Supervisor as a multitasker* models. The final cluster (11.5% of the sample) consisted of models that focus mainly on the supervisor as an authority figure (83.3% of the models in the cluster), supervisor’s culture (100%), and supervisor’s gender (100%). This cluster is referred to as *Supervisor as an individual* models.

Full details of the clusters can be found in Appendix 2N.

#### 2.3.4.1 Validation of the supervisor clusters

The four clusters were compared to other characteristics of the models. No difference was found between groups in mean year of publication of the relevant models (*F*(3, 51) = 2.174, *ns*). Nor was there any difference between groups on whether they cited evidence (*χ**2*(*df* = 3) = 2.90, *ns*). However, there was a significant difference between the groups on the mean number of elements in the models (*F*(3, 51) = 12.636, *p* < .001). *Supervisor as an individual* models had significantly more elements in them (*M* = 28.83, *SD* = 4.07) than all other groups (*Unfocused* (*M* = 14.58, *SD* = 5.10); *Supervisor as an authority figure* (*M* = 19.36, *SD* = 6.70); and *Supervisor as a multitasker* (*M* = 16.89, *SD* = 3.98)).

***2.3.5 Supervisee elements***

A two-step cluster analysis was carried out using the nine elements of the models that were considered to be aspects of the supervisee (supervisee gender; supervisee ethnicity/culture; supervisee anxiety; supervisee motivation; supervisee autonomy vs dependency; supervisee awareness of self and/or others; development of supervisee; supervisee individual learning styles; and supervisee can take on a variety of roles). A three cluster solution had the highest silhouette coefficient (0.4; ‘fair’), indicating the highest between-group differences with the lowest within-group differences.

The first cluster (38.5% of the sample) contained models with little focus on any of the supervisee elements, and is referred to as *Unfocused* models. The second cluster (38.5% of the sample) contained models that all focused on supervisee development. Many of the models in this cluster also focused on supervisee anxiety (55%) and supervisee autonomy vs. dependency (45%). This cluster is referred to as *Supervisee as an individual* models. The final cluster (23.1% of the sample) contained models that all focused on supervisee culture and supervisee gender. Other areas of focus for models in this cluster were supervisee development (75%), supervisee awareness of self and/ or others (58.3%), supervisee anxiety (50%), and supervisees having their own learning styles (41.7%). This cluster is referred to as *Supervisee as an individual in context* models.

Full details of the clusters can be found in Appendix 2N.

#### 2.3.5.1 Validation of the supervisee clusters

The three clusters were compared on model characteristics. There was a significant difference between groups in mean year of model publication (*F*(2, 51) = 4.34, *p* = .018). The models of *Supervisee as an individual* were published earlier (*M* = 1985, *SD* = 10.88) than the *Supervisee as an individual in context* models (*M* = 1996, *SD* = 10.22). There was also a significant difference between the groups in the mean number of elements in the models (*F*(2, 51) = 42.24, *p* < .001). *Supervisee as an individual in context* models had significantly more elements in them (*M* = 27.25, *SD* = 4.97) than both other groups (*Unfocused* (*M* = 13.75, *SD* = 3.43) and *Supervisee as an individual* (*M* = 15.75, *SD* = 4.37). However, there was no difference between groups on whether they cited evidence (*χ**2*(*df* = 2) = 2.32, *p* = .313).

***2.3.6 Client elements***

It was planned to conduct a comparable cluster analysis that grouped models according to their focus on client elements. However, the very small number of such elements (see Table 2.2) meant that this analysis was not viable.

***2.3.7 Associations between the content, supervisor, and supervisee clusters***

Table 2.6 shows which of the supervisor and supervisee clusters of models were associated with each other. The two sets of clusters were significantly associated overall (*χ* 2 (*df* = 6) = 27.03, *p* < .001). 53.85% of models in the *Unfocused* supervisor cluster also fall into the *Unfocused* supervisee cluster, indicating that if a model lacked specific guidance on the role and behaviours of the supervisor, it also tended to lack specific guidance on the supervisee’s role. 63.63% of models in the *Supervisor as an authority figure* cluster were associated with the *Supervisee as an individual* cluster. Finally, 100% of models in the *Supervisor as an individual* cluster corresponded to the *Supervisee as an individual in context* cluster.

Neither the supervisor clusters nor the supervisee clusters were associated with the content clusters (*χ*2 (*df* = 6) = 7.50, *p* = .277; and *χ2* (*df* = 4) = 8.68, *p* = .07 respectively). Therefore, it cannot be concluded that the models link the content of supervision to the characteristics of either the supervisor of supervisee.

Table 2.6. Association between the supervisor aspects clusters and supervisee aspects clusters. Percentages indicate the proportion of models in a supervisor aspects cluster that correspond to those in the supervisee aspects cluster.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Supervisor clusters**  **Supervisee clusters** | *Unfocused* | *Supervisor as an authority figure* | *Supervisor as an individual* | *Supervisor as a multitasker* | **Total** |
| *Unfocused* | 14 (53.84%) | 2 (18.18%) | 0 (0%) | 4 (44.44%) | 20 |
| *Supervisee as an individual* | 9 (34.62%) | 7 (63.63%) | 0 (0%) | 4 (44.44%) | 20 |
| *Supervisee as an individual in context* | 3 (11.54%) | 2 (18.18%) | 6 (100%) | 1 (11.11%) | 12 |
| **Total** | 26 | 11 | 6 | 9 | 52 |

**2.4 Discussion**

The aim of this review was to investigate similarities and differences across models of clinical supervision within psychotherapy, and therefore determine whether there is a reliable pattern of recommendations across models. A content analysis was used to analyse 52 models of clinical supervision (further models were not sought after a saturation point was reached). Seventy-one elements were identified in total, including both higher and lower level constructs, and the categorisation of model content was well validated by a second rater.

***2.4.1 Summary of findings***

First, it was hypothesised that the broad content of different models would be similar. However, in general, the models lacked consistency. It was expected that all models would discuss the three core factors in supervision identified in the literature (Kadushin, 1976; Proctor, 1988), but they were not focused on equally. Although most models focused on supervisee learning and development, there was less of a focus on the emotional effects of work and on managerial and ethical responsibilities. Within this hypothesis, it was also suggested that all models would focus on the three people in the supervision process. However, these were also not focused on equally – most models focused on the supervisee and supervisor, but only half focused on the client. The final element of this hypothesis was that the use of evaluation would be present in all supervisory models. However, not all models recommended this. Only a small number suggested using client outcomes as a form of evaluation.

The second hypothesis predicted some variation across models - specifically that the amount of content in models would change over time. However, there was no significant correlation between the model publication year and number of elements in the model.

Finally, it was hypothesised that supervision models would be based on empirical evidence. Unfortunately, although most models cited empirical research, none were directly based on an empirical study. Nor had any been tested fully, making it difficult to know whether we have a model that works or to agree on what models to promote or reject.

To summarise, none of the hypotheses were supported in this review. Overall, the models lack consistency, and therefore lack reliability. Consequently, one cannot assume that any of the models are valid unless there is empirical evidence to support them.

***2.4.2 Relationship to reasonable assumptions about supervision***

It is surprising that nothing one might reasonably expect to be true about supervision models seems to be validated by the data. Within the area of clinical supervision, there appear to be many widely held assumptions that may or may not be supported (Ellis & Ladany, 1997; Milne & James, 2000). One might assume that clinical supervision ensures therapist adherence and results in positive patient outcomes, but there is little empirical evidence to support this (O’Donovan et al., 2011; Watkins, 2011). Where there *is* empirical evidence, results are often inconsistent (Bambling et al., 2006; Bradshaw et al., 2007; Callahan et al., 2009; Livni et al., 2012; Schoenwald et al., 2009; White & Winstanley, 2010). This review highlights some incorrect assumptions that we might hold about supervision models specifically – that they are empirically tested, that they provide a consistent view of the supervisory process, or that newer models will either build on or refine past models. The assumption-based nature of clinical supervision models is in contrast to models of therapy or treatment manuals, which rely heavily on empirical research and provide clear and consistent direction on how therapy should be conducted (Wilson, 1996).

Of course, it is reasonable to assume that clinical supervision will have one key goal – the maintenance and improvement of care for patients. Therefore, one of the starkest findings of this review is the lack of focus on the patient in supervision, challenging the widely held assumption that supervision ensures positive patient outcomes (Ellis & Ladany, 1997; Milne & James, 2000). A large number of models do not specifically discuss the patient, lacking any focus on individual patient differences, patient expectations, and patient development. The great majority of models do not consider the use of feedback from the patient or recommend patient outcome monitoring as a form of evaluation. Some models do not even consider the possibility that supervision might include the discussion of therapy sessions. In contrast, almost all models place a heavy focus on the supervisee, including their personal characteristics, development, motivation and learning styles. Given their content, the purpose of supervision models could be interpreted to be to ensure that the therapist feels better, rather than to ensure that they do better. There are disagreements between researchers as to whether supervision should be judged through the learning of supervisees or the outcomes of patients (Milne, Pilkington, Gracie, & James, 2003). A problem with the main focus being on the therapist, rather than the patient, is that we know that supervisors can have biases and overestimate the abilities of their supervisees (Dennhag, Gibbons, Barber, Gallop, & Crits-Christoph, 2012; Gonsalvez & Freestone, 2007). Without objectively measurable outcomes of supervision, we do not know whether it is effective.

***2.4.3 Implications for supervisory practice***

As there is a lack of consistency in supervision models, then how do we know what to do in supervision? Clinical supervision is costly in both time and money (Lyth, 2000). At a time when promises of investment for mental health services are not being seen by providers (NHS Providers, 2016), perhaps services need to assess how to conduct supervision most effectively. Assuming that clinical supervision is helpful is not enough to justify the use of models, given that none are based on an empirical study and few have been tested in any way.

***2.4.4 Future development***

It is highly possible that supervision is effective and therefore worth our investment, but there needs to be further development of supervision models to demonstrate such effectiveness. It is possible that authors of models fail to include key aspects because they assume that the reader will already know how supervision is carried out. Unfortunately, by not directly laying out important aspects of supervision (and perhaps assuming prior knowledge), it appears that authors of models have created a disorganised and complicated picture of supervision in the literature. In particular, it could be recommended that authors should always aim explicitly to address patient perspectives and outcomes when outlining supervision processes. Clearly, it is also essential that models be empirically tested to investigate their impact on both supervisees and patients.

There needs to be further investigation into the use of supervision and which aspects of supervision are the most effective. The impact of supervision on therapists can be explored in a number of ways, including therapist competence, job satisfaction and burn-out. It is important to get a realistic view of supervisee abilities and outcomes (Dennhag et al., 2012). Most importantly, the patient should not be lost from the supervisory literature. To fully establish supervisory effectiveness and the strengths and weaknesses of different, potentially competing supervisory models, future research into supervision must be conducted with patient outcome as the primary outcome variable. Factors relating to the therapist, while valuable, are secondary outcomes. Aspects of supervision that are found to be effective through empirical testing can then be pulled together to create an explicit model of supervision.

Finally, the effectiveness of supervision needs to be established through a review of the empirical literature on supervision. Given the costs associated with supervision, is the spending justified in the form of positive patient outcomes? Or is supervision mainly a tool to support therapists (as has been found in many supervision models), making very little impact on the patients themselves?

# – Does clinical supervision contribute to supervisee and patient outcomes? A meta-analysis

As outlined in Chapter 2, although supervision is used widely in both clinical and research practice (Roth & Fonagy, 2005; Wheeler & Richards, 2007), it can be argued that the supervision model literature does not provide a coherent message for practitioners to follow. Perhaps most concerning about the supervision model literature is the lack of empirical evidence for the majority of the models (Simpson-Southward et al., 2017). The present chapter turns specifically to the empirical literature exploring whether supervision is effective for supervisees or for patients. The chapter presents a meta-analysis of the outcomes of clinical supervision delivered to mental health professionals. Due to the limited amount of empirical research in this area, studies investigating the use of supervision in all mental health contexts were included in the review.

## 3.1 Background

The use of clinical supervision is standard practice within many clinical settings, particularly in the UK (BABCP, 2012; BACP, 2016; Wheeler & Richards, 2007). An important consideration is the cost-effectiveness of clinical supervision, as this element of clinical practice has the potential to be costly in terms of both time and money (Lyth, 2000). However, cost-effectiveness cannot be appraised without first addressing the question of how effective that supervision is. It is commonly assumed that clinical supervision aids therapist adherence, competence, and well-being (Lambert & Ogles, 1997). In turn, it is assumed that these effects will contribute to positive patient outcomes (Ellis & Ladany, 1997; Milne & James, 2000). However, those assumptions need to be verified, making it essential to establish the clinical effectiveness of supervision.

Previous reviews have found that empirical evidence for the effectiveness of clinical supervision is scarce (Alfonsson, Parling, Spännargård, Andersson, & Lundgren, 2017), and much of the research is methodologically flawed (Ellis, Ladany, Schult, & Krengel, 1996; Watkins, 2011; Wheeler & Richards, 2007). It is also noteworthy that most of this research relates to outcomes for the supervisee, rather than the patient (Freitas, 2002). For example, Simpson-Southward et al. (2017) have shown that very few clinical supervision models even mention the assessment of patient outcomes, focusing more on effects for the supervisee. Of course, while a relationship with clinical outcomes might be assumed, there is a need to test any such assumption. Does any effect of supervision on the supervisee’s practice and well-being translate into positive effects for the patient?

### 3.1.1 Aims and hypotheses

The current review aimed to investigate the impact of clinical supervision on both supervisees and patients, demonstrating the effect sizes associated with outcomes for each. To do this in a robust and replicable way, a systematic review and meta-analysis will be conducted. The outcomes of studies investigating supervisory impact on supervisees will be compared to those looking at the impact on patients. Based on an analysis of the supervisory model literature in Chapter 2, which found that models tend to focus on the supervisee (rather than patients), two hypotheses are proposed. First, there will be fewer studies investigating supervisory impact on patients than studies investigating the impact on supervisees. Second, the effect of supervision on patients will be less pronounced than that of supervision on supervisees.

A further aim of this review is to investigate the role of moderators on the effect sizes. Of particular interest is the role that study design plays in moderating the effect of supervision. Given findings from previous research assessing the relationship between study quality and effect size (e.g., Cuijpers et al., 2010), it is expected that higher quality studies will have lower effect sizes. Other dimensional and categorical moderators were also considered.

## 3.2 Method

### 3.2.1 Search strategy

The search strategy was designed to identify studies in which the outcomes of clinical supervision were investigated. Originally, this review was intended to focus solely on the use of supervision in treatment for depression. However, the limited amount of research available meant that the review was expanded to cover all disorders and therapies in order to drawn meaningful conclusions. A literature search was conducted in June 2014 and updated in July 2017. Web of Science (1900-present), PubMed (1809-present), and PsycINFO (1806-present) were systematically searched using the terms ‘supervision’ OR ‘consultation’ AND ‘psychotherapy’ AND ‘outcome’. Searches were limited to articles in the English language. A manual search of all full texts read was conducted, in order to identify additional texts.

### 3.2.2 Selection of studies

To meet the inclusion criteria for review, a study needed to: be written in the English language; investigate the outcomes of supervision; and investigate supervision in the mental health professions. Studies were excluded for the following reasons: the study was qualitative (*N* = 5); pre-post effect sizes could not be calculated from the data provided (18); the study only investigated the effect of supervisor characteristics on supervision outcome (9); the study only investigated the effect of supervisee characteristics on supervision outcome (1); the study only investigated the effect of specific supervision events on supervision outcome (8); or the study only investigated the impact of satisfaction with supervision on supervision outcome (1).

#### 3.2.2.1 Quality analysis

Articles were subject to quality assessment using the Quality Index (QI; Downs & Black, 1998). This measure consists of 27 questions, which can be grouped into five subscales (reporting, external validity, internal validity – bias, internal validity – confounding, and power). A copy of the checklist is in Appendix 3A. Due to the lack of data necessary to score question 27, this question was adapted to assess whether or not the article outlined a power analysis prior to the results section. A study scored 1 for including a power analysis and 0 for not including a power analysis. This adaptation was based on previous research (e.g., Mehin, Burnett & Brasher, 2010). All questions can be scored a maximum of 1, apart from question 5 (*Are the distributions of principal confounders in each group of subjects to be compared clearly described?*) which is scored out of 2. Therefore, overall scores can range from 0 – 28. Where studies investigated supervision outcomes for both supervisees and patients, two separate QI scores were calculated. To assess scoring reliability, a second rater scored 20% of the articles. The second rater (CH) was a Psychology PhD student at the University of Sheffield. Overall percentage agreement was high (83.7%), giving a Cohen’s kappa of .552 (‘moderate’ agreement between raters). Disagreements were re-assessed and consensus reached.

### 3.2.3 Data analysis

#### *3.2.3.1 Primary outcome measure*

Primary outcome measures were identified for each study. The primary outcome measure was the measure that directly related to supervisee or patient outcome. Where a study had more than one measure relating to outcome, the primary outcome measure was the one that the paper gave the greatest focus. Regarding patient outcomes, such measures were symptom improvement or working alliance enhancement. Supervisee outcome measures were more varied – measures of skill acquisition, reflection, self-awareness, self-efficacy, competence, and adherence were all used. Due to the limited number of studies, they could not be successfully grouped by outcome measure. Therefore, general patient and supervisee outcomes were the focus of the meta-analyses.

#### *3.2.3.2 Effect size calculations*

Paired effect sizes were calculated using the scores for pre- and post- intervention using Hedges’ *g* and its 95% confidence interval. Hedges’ *g* was used because it takes into account bias from small sample sizes. Effect size magnitudes were reported according to Cohen’s (1969) guidelines (0.2 = small effect size; 0.5 = medium; 0.8 = large).

To calculate the pre-post effect sizes for each study, a pre-post correlation was required. An average correlationvalue was calculated from the studies that provided this information, and this value was used for the studies that did not provide one. A sensitivity analysis was carried out to ensure that varying the pre-post correlation value did not substantially change the effect size (Borenstein, Hedges, Higgins & Rothstein, 2009; The Cochrane Collaboration, 2011).

For studies that investigated supervision outcomes for both supervisees and patients, two separate effect sizes were calculated. Where studies investigated more than one type of supervision, multiple effect sizes were calculated along with a mean for the study. Where studies had a control condition, the difference between the control and experimental group effect sizes was calculated for the overall effect size of the study.

As few studies were identified in the literature search, in order to use as much of the available data as possible and to get the most comprehensive picture of supervision outcomes, uncontrolled studies were included in the meta-analysis along with controlled studies. Methodology outlined by Hunter, Jensen and Rodgers (2014) was followed when combining the two study designs in the meta-analysis. Data from those studies without a control group were adapted in two ways. First, the number of participants was doubled to account for a control condition. Second, the mean effect size of all the control groups from those studies with controls was calculated. This number was then deducted from the effect size calculated for each study without a control group. This methodology from Hunter et al. (2014) has been used previously, both within the field of psychology (e.g., Salekin, 2002) and elsewhere (e.g., Addy et al., 2016).

#### *3.2.3.3 Quantitative data syntheses and statistical calculations*

Meta-essentials workbooks were used to carry out statistical calculations and generate plots (Suurmond, van Rhee & Hak, 2017).Effect size calculations for each study were checked by hand using formulae and guidance from Borenstein et al. (2009), and Morris and DeShon (2002).

Due to the high heterogeneity between studies, random effects models were used for all analyses. Heterogeneity between the studies was calculated using Cochrane’s *Q* and *I2* statistics. To examine whether effect sizes varied as a function of study characteristics, moderator analyses were carried out. For categorical variables (study design, country in which the study was conducted, supervisee population, and patient population), separate effect sizes were calculated for each group in a subgroup analysis. For continuous variables (year of publication, QI score, supervision frequency, and study length), regression analyses were carried out. If a study did not clearly state a specific study characteristic, it was omitted from that particular analysis.

#### 3.2.3.1 Publication bias

Where the data were appropriate, publication analyses were examined. These were calculated using funnel plots with trim-and-fill procedure (Duval & Tweedie, 2000) and Egger regressions.

## 3.3 Results

The first section of the Results provides an overview of the studies that were assessed in this review, including whether the focus of these studies was more on the outcomes of supervisees or those of patients. The impact of supervision on both supervisees and patients is then assessed through meta-analyses. Finally, potential moderators are examined and publication bias is investigated.

### 3.3.1 Overview of studies considered

Across the three database searches, 3137 records were identified (excluding duplicates). Screening for eligibility resulted in 15 articles being identified as appropriate for this review (see PRISMA diagram in Figure 3.1). Key study characteristics are outlined in Tables 3.1 and 3.2. Addressing hypothesis one, four of the 15 articles investigated the effect of supervision on patient outcomes, seven investigated the effect of supervision on supervisee outcomes, and four investigated the effect of supervision on both patient and supervisee outcomes. Thus, as hypothesised, there was a greater emphasis on supervision’s impact on supervisee outcomes (11 papers) than on patient outcomes (eight papers).

Full text articles excluded (*n* = 125)

* Did not investigate supervision outcomes (*n* = 83)
* Qualitative data (*n* = 5)
* Investigated the effect of supervisor characteristics on supervision outcome (*n* = 9)
* Investigated the effect of supervisee characteristics on supervision outcome (*n* = 1)
* Investigated the effect of specific supervision events on supervision outcome (*n* = 8)
* Investigated the perception of supervision on supervision outcome (*n* = 1)
* Pre-post effect sizes could not be calculated (*n* = 18)

Records identified

(*n* = 4118)

PubMed

(*n* = 3470)

PsycINFO

(*n* = 346)

Web of Science

(*n* = 302)

Duplicates removed

(*n* = 981)

Removed based on abstract

(*n* = 3029)

Full text articles assessed

(*n* = 140)

Abstract screened

(*n* = 3137)

Articles found in other texts

(*n* = 32)

Articles used in meta-analysis

(*n* = 15)

Figure 3.1. PRISMA flow diagram for article selection.

Table 3.1. Studies investigating the impact of supervision on patient outcomes.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Bambling, King, Raue, Schweitzer and Lambert (2006)* | Graduates with two years supervisor experience, *n =* 40 | Qualified (therapists, *n* = 127) | Clinical (primary diagnosis of major depression, *n* = 103) | Australia | Problem-solving treatment | Alliance process-focused supervision  Alliance skill-focused supervision | ns | Control (no supervision) | Patients in both supervision conditions reported higher working alliance scores and a greater BDI reduction than in the control condition. There was no difference between the two supervision groups on these measures. The control condition had a significantly higher rate of patient dropout than the supervised conditions. | Patient outcome (Beck Depression Inventory; BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) | 20 |
| *Bradshaw, Butterworth and Mairs (2007)* | Graduates, *n =* ns | Qualified (mental health nurses, *n =* 23) | Clinical (schizophr-enia diagnosis, *n =* 93) | UK | Psychosocial intervention | Workplace supervision | Every two weeks | Control (received clinical supervision on the education programme but not additional workplace supervision) | Patients treated by supervised nurses had greater reductions in positive symptoms and total symptoms than those treated by unsupervised nurses. There were no differences in social functioning between the two patient groups. | Patient outcome (Krawiecka, Goldberg & Vaughan symptom scale]; Krawiecka, Goldberg, & Vaughan, 1977, modified by Lancashire [unpublish-ed]) | 11 |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Burlingame et al. (2007)* | Advanced Practice Registered Nurse, *n =* 1 | Qualified (nurses, *n =* 11) | Clinical (hospital inpatients, *n =* 38) | US | Psycho-educational group | ns | Weekly | Control (received workshop training only) | There was no difference in patient outcome between the supervision condition and workshop condition. | Patient symptoms (Moller-Murphy Symptom Managem-ent Assessme-nt Tool II; MM-SMAT II revised; original from Murphy & Moller, 1998) | 15 |
| *Crutchfield and Borders (1997)* | ns | Qualified (school counsellors, *n = 2*8) | Non-clinical(*n =* 156) | US | ns | Structured Peer Consultation Model for School Counsellors (SPCM-SC; Benshoff & Paisley, 1996)  Systematic Peer Group Supervision (SPCM-SC; Borders, 1991) | Weekly | Control (no supervision -this group were asked to focus individually on their plans for professional develop-ment) | No difference in patient change between two peer-group supervision models and a control group without supervision. | Patient change (Teacher Report Form; TRF; Achenbach, 1991) | 11 |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Grossl, Reese, Norsworthy and Hopkins (2014)* | Licensed psychologi-sts or marriage and family therapists with doctoral degrees, *n =* 18 | Trainee (graduate level, *n =* 44) | Clinical (typical of those attending community mental health or university counselling centres, *n =* 195) | US | Various | Supervision using patient feedback (including outcome data)  Supervision without patient feedback | Weekly | No control | Patient improvement was the same in both the supervisory feedback condition and supervision as usual. | Patient outcome (Outcome Rating Scale; ORS; Miller & Duncan, 2000) | 13 |
| *Kivlighan, Angelone and Swafford (1991)* | Doctoral-level counselling psychologi-st, *n =* 1. Advanced doctoral-level counselling psychology students, *n =* 16 | Trainee (master's-level counselling students, *n =* 48) | Non-clinical (undergraduate students, *n =* 48) | US | Interpersonal therapy | Live supervision  Videotaped supervision | Weekly | No control | Patients in the videotaped supervision condition reported a slightly greater working alliance improvement over the course of therapy than those in the live supervision condition. Live supervision was rated as ‘rougher’ than videotaped supervision but there was no difference in session depth between the two conditions. | Working alliance (Working Alliance Inventory; WAI; Horvath & Greenberg, 1989) | 16 |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Reese et al., (2009)* | Full-time or adjunct faculty staff *n =* 9 | Trainee (second year of a master's-level marriage and family program or a clinical-counselling psychology program, *n =* 28) | Clinical (typical of those attending community mental health or university counselling centres, *n =* 95) | US | Various | Supervision using patient feedback (including outcome data)  Supervision without patient feedback | Twice weekly | No control | Patients showed significant improvement in both groups, but those in the feedback condition had better outcomes than those in the no feedback condition. | Patient outcome (Outcome Rating Scale; ORS; Miller & Duncan, 2000) | 13 |
| *Tanner, Gray and Haaga (2012)* | Licensed psychologists and tenured faculty members in the department of psychology, *n =* 3 | Trainee (third -year students in an American Psychologi-cal Association-accredited clinical psychology PhD program, *n =* 79) | Clinical (most had primary diagnosis of anxiety or mood disorders, *n =* 176) | US | Cognitive behavioural therapy | Co-therapy supervision | ns | Control (unsupervi-sed) | No difference in client retention and symptom improvement between patients in co-therapy (with a supervisor) and those treated by a solo therapist. | Patient outcome (Outcome Questionna-ire; OQ-45; Lambert et al., 1996) | 13 |
| ns = not specified | | | | | | | | | | | |

Table 3.2. Studies investigating the impact of supervision on supervisee outcomes.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Study length (weeks)** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Berg and Stone (1980)* | Doctoral students *n =* 2 | Trainee (female psychology students, *n =* 60) | None | ns | None | High structure supervision  Low structure supervision | Weekly | Control (received dyadic training only) | 1 | Supervision increased empathic communication and refection of feeling in therapists compared to control group. There was no difference in these measures between high and low structure supervision conditions. | Therapist reflection of feeling responses | 14 |
| *Borders (1991)* | Faculty members, *n =* 3 | Trainee (students from a master's counselling program, *n =* 44) | ns | US | Various | Group and individual supervision (live observation and/or videotape review) | Weekly | No control | 16 | Supervisees increased in self-awareness, dependency/autonomy, and theory/skills acquisition between the 2nd and 16th weeks of the semester. | Supervis-ee develop-mental level (Supervis-ee Levels Question-naire; SLQ; McNeill, Stoltenbe-rg, & Pierce, 1985) | 13 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Study length (weeks)** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Bradshaw et al. (2007)* | Graduates, *n =* ns | Qualified (mental health nurses, *n =* 23) | Clinical (schizophre-nia diagnosis, *n =* 93) | UK | Psychosoci-al intervention | Workplace supervision | Every two weeks | Control (received clinical supervisi-on on the education program-me but not additional workplace supervise-on) | 52 | Those receiving supervision experienced a greater increase in knowledge of psychological interventions than those not receiving supervision. | Therapist knowledge (multiple choice question papers) | 18 |
| *Burlinga-me et al. (2007)* | Advanced Practice Registered Nurse, *n =* 1 | Qualified (nurses, *n =* 10) | Clinical (hospital inpatients, *n =* 38) | US | Psycho-educational group | ns | Weekly | Control (received workshop training only) | ns | No difference in nurse knowledge and skills between the workshop and supervision conditions. | Basic knowledge and skills (Psycho-Educatio-nal Group Question-naire for Nurses; PEGQ-N) | 16 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Study length (weeks)** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Crutchfield and Borders (1997)* | ns | Qualified (school counsellors, *n = 2*9) | Non-clinical(*n =* 156) | US | ns | Structured Peer Consultation Model for School Counsellors (SPCM-SC; Benshoff & Paisley, 1996)  Systematic Peer Group Supervision (SPCM-SC; Borders, 1991) | Weekly | Control (no supervis-ion -this group were asked to focus individual-ly on their plans for professio-nal develop-ment) | ns | No difference in therapist self-efficacy, job satisfaction or counselling effectiveness change between two peer group supervision models. Also no difference to control group without supervision. | Therapist self-efficacy (Counsell-ing Self-Estimate Inventory; COSE; Larson et al., 1992) | 15 |
| *Fenell, Hovestadt and Harvey (1986)* | ns | Trainee (doctoral students, *n =* 13) | na | US | Marriage and Family Therapy | Delayed feedback supervision  Live supervision | na | No control | 32 | There was no significant difference in therapist skill between delayed feedback and live supervision groups. | Therapist skill (Family Therapist Rating Scale; Piercy, Laird, & Mohamm-ed, 1983) | 12 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Study length (weeks)** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Ladany, Ellis and Friedland-er (1999)* | ns | Trainee (counsellor trainees, *n =* 107) | ns | US | ns | ns | ns | No control | ns | Trainee self-efficacy increased between 3rd - 5th weeks of supervision and 11th - 16th weeks of supervision. Supervisory working alliance did not increase, nor did trainee satisfaction with supervision. Changes over time in supervisory working alliance were not related to changes in trainees' self-efficacy ratings but were positively related to changes in trainees' satisfaction ratings of supervision. | Therapist self-efficacy (Self-Efficacy Inventory; SEI; Friedland-er & Snyder, 1983) | 15 |
| *Reese et al., (2009)* | Full-time or adjunct faculty staff *n =* 9 | Trainee (2nd year of a master's-level marriage and family or clinical-counselling psychology program, *n =* 28) | Clinical (typical of those attending community mental health or university counselling centres, *n =* 95) | US | Various | Supervision using patient feedback (including outcome data)  Supervision without patient feedback | Twice weekly | No control | 52 | Therapist self-efficacy improved in both conditions, but there was no difference in self-efficacy improvement between conditions. | Therapist self-efficacy (Counsell-ing Self-Estimate Inventory; COSE; Larson et al., 1992) | 14 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Study length (weeks)** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Sholoms-kas et al. (2005)* | *n =* 3 | Qualified (clinicians predominat-ely treating a substance using population, *n =* 42) | Clinical (substance using population , *n =* ns) | US | Cognitive Behavioural Therapy | ns | Once every 4-12 weeks | Control (manual only) | 12 | There was a greater increase in adherence and skill of therapists in the manual + seminar + supervision condition compared to the manual only condition. Performance of therapists in the manual + web condition fell in between the other two conditions | Therapist adherence and skill (Yale Adherence Compete-nce Scale; YACS; Carroll et al., 2000) | 18 |
| *Singo (1991)* | Doctoral students, *n =* 7 | Trainee (counsellors from a master's program in counsellor education and rehabilitation, *n =* 19) | ns | US | ns | Individual supervision  Peer supervision | Weekly | No control | 5 | Therapists increased in competence in both supervision conditions. There was no significant difference between the two conditions in competency, anxiety, or self-efficacy change. | Therapist basic skill compete-ncy (Basic Skill Observati-on; Ellington, unpublish-ed) | 22 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Supervisor population** | **Supervisee population** | **Patient population** | **Location of study** | **Clinical intervention** | **Type(s) of supervision** | **Supervision frequency** | **Study design** | **Study length (weeks)** | **Main findings** | **Primary outcome variable** | **QI score** |
| *Weck et al. (2016)* | Licenced clinical psychologis-ts and supervisors, *n =* 9 | Qualified(therapists with a master's degree in clinical psychology, *n =* 23) | Clinical (outpatients from the Department of Clinical Psychology and Psychother-apy at the University of Frankfurt, *n =* 42) | Germany | Cognitive Behavioural Therapy | Bug in the eye supervision (BITE)  Delayed video based supervision (DVB) | ns | No control | ns | When controlling for therapeutic alliance and competence at the beginning of the study, no differences were found between BITE and DVB supervision in either of these measures. For both supervision conditions, the therapeutic alliance had positive growth from session 1 to 21, whereas therapist competence had a negative growth pattern. | Therapist compete-ncy (Cognitive Therapy Scale; CTS - German version; Weck, Hautzinger, Heidenr-eich, & Stangier, 2010) | 22 |
| ns = not specified, na = not applicable | | | | | | | | | | | | |

### 3.3.2 Quality analysis

Overall scores in the quality analysis ranged from 11 – 22 out of 28 (*M* = 15.32, *SD* = 3.33). Detailed scores for each study are in Appendix 3B. Scores on the subscales were as follows: *Reporting* 5 – 10 (*M* = 7.79, *SD* = 1.58), *External Validity* 0 – 3 (*M* = 0.95, *SD* = 0.78), *Internal Validity – Bias* 3 – 7 (*M* = 4.37, *SD* = 1.16), and *Internal Validity – Confounding* 0 – 5 (*M* = 2.21, *SD* = 1.62). All studies scored 0 on the *Power* item.

Studies investigating supervision impact on both therapist and patients were treated as two separate samples. Therefore, 19 QI scores were calculated for a total of 15 studies.

#### *3.3.2.1 Strengths of the samples*

The majority of samples provided clear descriptions of their hypotheses, aims, and objectives (*N* = 18, 94.74%), the main outcomes to be measured (*N* = 19, 100%), and the interventions (*N* = 17, 89.47%). Samples used appropriate statistical tests (*N* = 19, 100%), accurate outcome measures (*N* = 19, 100%), clearly described the main findings (*N* = 19, 100%), and did not base results on “data dredging” (*N* = 18, 94.74%).

#### 3.3.2.2 Weaknesses of the samples

None of the samples reported having conducted a power analysis prior to conducting the study. Only eight of the samples (42.12%) clearly described distributions of confounders in each group of participants. Only four samples (21.05%) made clear that their participants were representative of the entire population from which they were recruited, and only two samples (10.53%) showed that those prepared to participate were representative. Few samples checked compliance with the interventions (*N* = 6, 31.58%), and none of the samples reported potential adverse consequences of the interventions. Two samples randomised subjects to intervention groups (10.53%), and there was no concealment of randomisation until recruitment was complete in any sample. Participants were blind to the intervention they received in four of the samples (21.05%), and researchers measuring the main outcomes were blind in five of the samples (26.32%).

#### *3.3.2.3 Differences between patient outcome and supervisee outcome studies.*

There was no difference between the overall QI scores for patient outcome studies (*M* = 14.0, *SD* = 2.98) and for supervisee outcome studies (*M* = 16.27, *SD* = 3.38; *t*(17) = 1.52, *p* = .147). Nor were there differences between the two sets of studies in any of the QI subscale scores (all *p* > .05).

### 3.3.3 Impact of supervision on patient outcomes

The random effects model meta-analysis (Figure 3.2) indicated that the overall effect of clinical supervision on patient outcomes (symptom and working alliance improvement) was small and non-significant; Hedges’ *g* = 0.22 (95% CI [-0.11, 0.55], *z* = 1.60, *p* = .110). Tests of heterogeneity indicated a high level of between-study variability (*I*2 = 85.82%, *Q* = 49.36, *p* < .01). Therefore, subgroup and moderator analyses were conducted.

Figure 3.2. Forest plot for patient effect sizes.

#### 3.3.3.1 Subgroup and moderator analyses

A number of subgroup analyses were carried out (see Table 3.3). Effect sizes were moderated by Quality Index (QI) score (*B* = 0.07, *z* = 1.99, *p* = .047), such that studies with greater effect sizes had a higher quality rating (see Figure 3.3a). Six of the eight studies provided information regarding the frequency of supervision and these were used in a moderator analysis. The number of supervision sessions per week was found to moderate effect sizes (*B* = -0.42, *z* = -3.12, *p* = .002). Smaller effect sizes were found in studies with a higher number of supervision sessions per week (see Figure 3.3b). Effect sizes were not moderated by publication year (*B* = 0.00, *z* = -0.23, *p* = .817). Both the subgroup and moderator analyses should be interpreted with caution, due to the small number of studies.

**(b)**

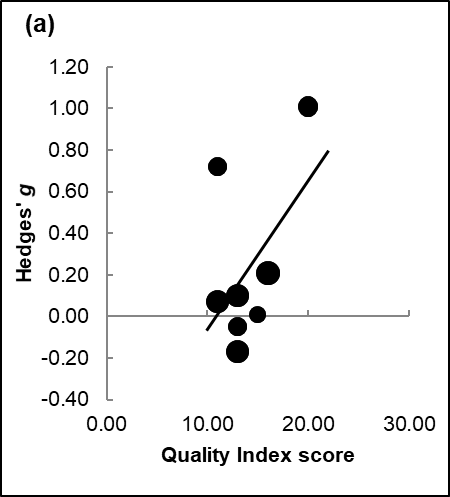
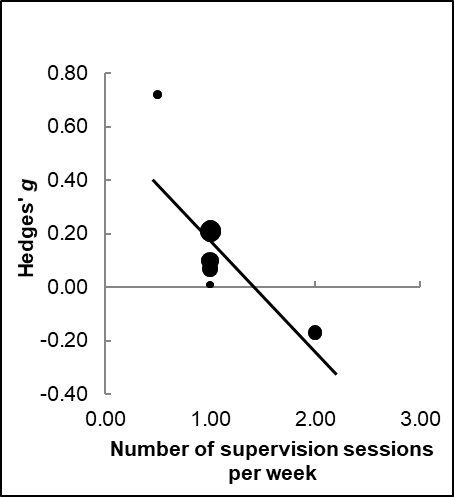


Figure 3.3. Study effect sizes moderated by (a) Quality Index score and (b) the number of supervision sessions per week.

Table 3.3. Subgroup analyses for studies investigating patient effects.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subgroup | *n* | Hedges’ *g* [95% CI] | Q | *PQ* | *I2* |
| *Study design* |  |  |  |  |  |
| Controlled | 5 | 0.36 [-0.24, 0.96] | 33.39 | < .001 | 88.70% |
| *Active control* | *2* | *0.38 [-4.12, 4.89]* | *5.18* | *.023* | *80.68%* |
| *Passive control* | *3* | *0.34 [-1.09, 1.78]* | *28.64* | *< .001* | *93.02%* |
| Non-controlled | 3 | 0.07 [-0.40, 0.54] | 10.15 | <.001 | 80.29% |
| *Country* |  |  |  |  |  |
| US | 6 | 0.06 [-0.08, 0.21] | 11.55 | .042 | 56.70% |
| Non-US | 2 | 0.88 [-0.94, 2.71] | 1.34 | .247 | 25.52% |
| *Supervisee population* |  |  |  |  |  |
| Trainees | 4 | 0.05 [-0.22, 0.33] | 11.04 | .012 | 72.82% |
| Qualified | 4 | 0.46 [-0.33, 1.24] | 31.92 | < .001 | 90.60% |
| *Patient population* |  |  |  |  |  |
| Clinical sample | 6 | 0.27 [-0.24, 0.77] | 47.49 | < .001 | 89.47% |
| Non-clinical sample | 2 | 0.16 [-0.69, 1.01] | 1.85 | .174 | 45.92% |

#### 3.3.3.2 Publication bias

Publication bias analysis was not carried out, due to the heterogeneity of the sample.

### 3.3.4 Impact of supervision on supervisee outcomes

The random effects model meta-analysis (Figure 3.4) indicated that clinical supervision had a moderate positive impact on supervisee outcomes; Hedges’ *g* = 0.56 (95% CI [0.12, 0.99], *z* = 2.87, *p* = .001). Tests of heterogeneity indicated a high level of between-study variability (*I*2 = 88.90%, *Q* = 90.07, *p* < .01). The studies could not successfully be divided by outcome measures. Therefore, ‘supervisee outcomes’ refers to measures of skill acquisition, reflection, self-awareness, self-efficacy, competence, and adherence. Other subgroup and moderator analyses were explored.

Figure 3.4. Forest plot for supervisee effect sizes.

#### 3.3.4.1 Subgroup analyses

A number of subgroup analyses were carried out, the results of which can be found in Table 3.4. When studies did not provide the information needed for the analysis, they were excluded. All subgroup analyses should be interpreted with caution due to the small number of studies.

#### 3.3.4.2 Moderator analyses

No variables were found to moderate effect size (publication year, *B* = -0.02, *z* = -1.09, *p* = .275; QI score, *B* = -0.07, *z* = -1.06, *p* = .287; supervision frequency, *B* = 0.38, *z* = 1.01, *p* = .314; study length *B* = -0.01, *z* = -0.53, *p* = .597).

Table 3.4. Subgroup analyses for studies investigating supervisee effects.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subgroup | *n* | Hedges’ *g* [95% CI] | Q | *PQ* | *I2* |
| *Study design* |  |  |  |  |  |
| Controlled | 5 | 0.59 [0.28, 0.90] | 3.26 | .516 | 0% |
| *Active control* | *2* | *0.51 [-2.37, 3.40]* | *0.63* | *.426* | *0%* |
| *Passive control* | *3* | *0.59 [-0.07, 1.25]* | *2.54* | *.281* | *21.26%* |
| Non controlled | 6 | 0.56 [-0.35, 1.47] | 79.34 | < .001 | 93.70% |
| *Country* |  |  |  |  |  |
| US | 8 | 0.70 [0.19, 1.21] | 70.48 | < .001 | 90.07% |
| Non-US | 2 | -0.14 [-5.95, 5.66] | 4.63 | .031 | 78.39% |
| *Supervisee population* |  |  |  |  |  |
| Trainees | 6 | 0.79 [0.09, 1.20] | 75.12 | < .001 | 93.34% |
| Qualified | 5 | 0.24 [-0.42, 0.89] | 13.57 | .009 | 70.53% |
| *Patient population* |  |  |  |  |  |
| Clinical sample | 5 | 0.43 [-0.39, 1.25] | 22.52 | < .001 | 82.24% |
| Non-clinical sample | 2 | 0.21 [-1.21, 1.63] | 0.34 | .558 | 0% |

As the subgroup analyses indicated that studies with a control are a homogenous subgroup (see Table 3.4), the moderator analyses were re-run on only the studies without a control (a heterogeneous sample). Again, none of the variables were significant moderators of effect size (publication year, *B* = -0.03, *z* = -0.90, *p* = .367; QI score, *B* = -0.07, *z* = -0.78, *p* = .433; supervision frequency, *B* = -0.28, *z* = -0.39, *p* = .695; study length, *B* = -0.01, *z* = -0.33, *p* = .740).

A further set of moderator analyses were run on the subgroup of studies with clients from a clinical population (those with clients from a non-clinical population were a homogeneous subgroup, see Table 3.4). One variable was found to moderate effect size: QI score (*B* = -0.22, *z* = -4.67, *p* < .001). Studies with higher QI scores had smaller effect sizes (see Figure 3.5). Supervision frequency (*B* = 0.35, *z* = 1.66, *p* = .098), publication year (*B* = -0.11, *z* = -1.82, *p* = .069), and study length (*B* = 0.01, *z* = 0.32, *p* = .747) did not moderate effect size.

As with the subgroup analyses, the moderator analyses should be interpreted with caution due to the small number of studies.

Figure 3.5. Study effect sizes in the subgroup with a clinical population moderated by Quality Index score.

#### 3.3.4.3 Publication bias

The overall sample of studies has high heterogeneity. Therefore, publication bias analysis was only carried out on the homogenous subgroup of studies with control groups. As the other homogenous subgroup (studies using non-clinical samples) only contained two studies, it was too small to establish any meaningful publication bias.

A funnel plot and trim-and-fill procedure did not indicate any publication bias (see Figure 3.6). The effect size adjusted for publication bias was identical to the non-adjusted effect size (*g* = 0.59 [0.28, 0.90]). Egger regression also indicated no bias (*p* = 0.692). However, caution is required when interpreting these results, as there are such a small number of studies in this analysis.

Figure 3.6. Funnel plot indicating no publication bias for supervisee effect studies.

## 3.4 Discussion

This meta-analysis aimed to investigate the impact of clinical supervision on both supervisees and patients. A total of 15 studies were identified in the literature. The first hypothesis proposed that supervisory impact on supervisees would be more strongly represented than supervisory impact on patients. This hypothesis was confirmed, as the majority of papers did indeed focus on supervisees, rather than on patients. The second hypothesis – that supervision would have a greater effect on supervisees than on patients – was also confirmed. The impact of supervision on patient outcomes was non-significant, whereas supervision had a moderate, positive effect on supervisee outcomes. As there were not sufficient studies to divide the data into subgroups based on outcome measures, these effects refer to all patient and supervisee outcomes. Patient outcomes include symptom or working alliance change, and supervisee outcomes include skill acquisition, reflection, self-awareness, self-efficacy, competence, and adherence change.

Moderators of effect size were also investigated. It was expected that more rigorously controlled studies would produce smaller effect sizes. Study design (whether the study had a control group) moderated effect sizes for supervisee outcome studies. Contrary to the hypothesis, there was a moderate positive effect for controlled supervisee studies, and a non-significant effect for studies without a control. Supervisee population (trainee or qualified) and frequency of supervision were also found to be moderators of effect size.

This meta-analysis provides strong support for the use of supervision in clinical practice to enhance supervisee outcomes. However, it cannot be concluded that supervision also enhances patient outcomes. The main focus of the supervision model literature is on the supervisees, rather than the patients (Chapter 2). It is possible that this focus leads to supervision sessions being directed towards the supervisee’s needs, rather than patient outcomes. This pattern does not support the view that underpins many supervision models – that focusing on the development of the supervisee will benefit the patient (e.g., Blocher, 1983; Stoltenberg, 1981; Wetchler, 1990).

However, it should be noted that very few empirical studies of supervision employ established generic supervision models of the sort that Simpson-Southward et al. (2017) considered. Instead, the majority of studies in this review used their own supervision protocols – usually disorder-specific. This disjunction between the empirical and models literatures raises important questions. If we are not using generic supervision models in research, when *are* we using them? And if they are being used in clinical practice, how much do the empirical research findings then reflect standard practice?

This lack of synthesis between the models literature and the empirical literature also means we need to look elsewhere for the reason why supervision has a greater effect on supervisees than on patients. Although empirical studies of supervision do not appear to be using established supervision models, it is difficult to know what the focus of supervision is in these studies, as they often lack detail regarding the content of supervision. To investigate this issue further, we need to find out what is actually happening in clinical supervision. What dictates the direction of the sessions? Is it the patient being treated or is it the needs of the supervisee that are the focus?

### 3.4.1 Moderating effects

Regarding the predication that less rigorously controlled, lower quality studies would yield greater effect sizes, results appear mixed. Supervisee outcome studies with higher Quality Index scores do seem to have lower effect sizes (although this moderator analysis was only carried out on a subset of the studies, see Section 3.3.4.2). This appears to be in line with previous research (e.g., Cuijpers et al., 2010).

However, supervisee outcome studies with a control group indicated a moderate positive effect of supervision. In contrast, the group without a control showed a non-significant effect. This would indicate that more rigorously controlled studies are producing higher effect sizes. In addition, the patient outcome studies with higher Quality Index scores also seem to produce higher effect sizes. These two findings contrast the previous literature indicating lower effect sizes in higher quality studies (e.g., Cuijpers et al., 2010).

A possible explanation for this is that although the previous literature indicates that studies of lower quality psychotherapy produce better patient effect sizes, this meta-analysis is not assessing the quality of the therapy per se, but the quality of the supervision. It is possible that good quality supervision (as reflected by good quality research) improves patient outcomes, regardless of the quality of the therapy itself. Perhaps supervision needs to be carried out in a highly controlled manner in order for it to positively impact patients. In contrast, it appears that supervision has a positive impact for supervisees regardless. Therefore, the expected pattern is found in supervisee outcome studies – studies with higher QI scores have lower effect sizes.

The current meta-analyses indicate that there is a greater positive effect of supervision on trainees than on qualified supervisees. There are a few possible explanations for this. First, the guidance given in supervision might only be beneficial to those early in their career who are lacking a well-rounded experience of therapy. Second, it is possible that supervision plays a lesser role for qualified supervisees, and that other factors contribute more to their outcomes (e.g., experience; Eells, Lombart, Kendjelic, Turner, & Lucas, 2005). Finally, as a number of supervision models suggest (e.g., Hogan, 1964; Stoltenberg & Delworth, 1987), supervisors might be treating their supervisees in different ways depending on the supervisee’s experience. Often models advocate more structured supervision for those supervisees at a lower level. It is possible that such structure would benefit all supervisees, regardless of qualification status.

There is a need for more studies to allow us to interpret these moderator and subgroup analyses robustly. Therefore, this discussion of moderating effects should be viewed as somewhat speculative, and its intention is to indicate possible directions for future research.

### 3.4.2 Limitations of the studies

Specific methodological issues with supervision research have been highlighted in previous reviews (e.g., Type I and Type II errors, unreliability or invalidity of independent and dependent measures, non-random samples; Ellis et al., 1996; Watkins, 2011). The current review found some additional issues, many of which can be described as a lack of clarity in methodological descriptions. For example, a lack of information describing the populations from which participants were recruited (e.g. Crutchfield & Borders, 1997; Fenell et al., 1986), or a failure to make randomisation and blinding procedures clear (e.g., Berg & Stone, 1980). In addition, a key element that all studies lacked is a power analysis.

### 3.4.3 Limitations of this review

When conducting the current review, some general issues surrounding the supervision literature became apparent that limited the scope of the review. The first is that there are relatively few studies investigating the effects of clinical supervision. Therefore, it is difficult to reach definitive conclusions about the area as a whole. The lack of studies becomes particularly problematic when investigating moderators and subgroups (Cochrane Collaboration, 2011). High heterogeneity and the small number of studies also makes drawing conclusions about publication bias challenging (Terrin, Schmid, Lau & Olkin, 2003).

Due to the lack of studies in this area, all were combined within a single meta-analysis (regardless of whether the study had a control group). This required the use of pre-post effect sizes and pre-post correction estimates. While standard procedures were used for these analyses (e.g., Borenstein et al., 2009; Hunter et al., 2014), the use of pre-post effect sizes has been criticised by Cuijpers, Weitz, Cristea and Twisk (2017). They argue that pre-post effect sizes are uncontrolled and are vulnerable to variables such as recruitment strategies and expectations. Such uncontrolled variables might be one reason for the high levels of heterogeneity in these two groups of studies.

Turning to the content of the studies themselves, much of the research into the impact of supervision does not address outcomes – particularly patient outcomes (Lichtenberg, 2007). A number of studies focus on specific events or people in supervision, but without first establishing the general impact of supervision, and therefore could not be included in this review (e.g., Dodenhoff, 1981; Lizzio, Wilson, & Que, 2009; Pierce & Schauble, 1970). Another group of studies that could not be included are those that did not provide enough data for an effect size to be calculated (e.g., Cashwell & Dooley, 2001; Rousmaniere, Swift, Babins-Wagner, Whipple, & Berzins, 2016).

### 3.4.4 Implications of this review

A number of implications for both research and clinical practice are highlighted by this review. Regarding future research, a key area to explore is how the positive effect of supervision on supervisees might be translated to patients. Possible indirect effects of supervision on patients need to be investigated. For example, supervision might benefit patients through a reduction in supervisee burnout or an increase in supervisee job satisfaction – both of which are associated with more positive patient outcomes (Delgadillo, Saxon & Barkham, 2018).

Given that there are potential outcome differences across various settings, future research specifically needs to investigate what happens in standard clinical settings (where the majority of patients are treated). We need to know how research outcomes translate to standard clinical practice. To do this we need to find out what is happening in clinical practice and how this might differ from research settings. Potential areas to explore are supervision model use, supervision focus, and the impact of supervisor and supervisee characteristics (e.g., experience level).

Finally, due to the limited number of studies investigating clinical supervision outcomes, this meta-analysis covered the full range of presenting psychological problems. However, it will be important to understand how supervision might work for specific disorders and therapies.

A few implications can be drawn regarding clinical practice. First, supervision is a worthwhile element of clinical practice for supervisees, though its links to clinical outcomes need to be considered more fully. Perhaps supervisors should be placing a greater focus on patient outcomes when conducting supervision, to determine whether supervision is progressing in a useful way. Second, although there are many clinical supervision models, very few have been tested in empirical research (Simpson-Southward et al., 2017). To ensure effective supervision, clinical practice might aim to follow research protocols for supervision, rather than untested models. Finally, we could look to focus supervision resources on trainee supervisees. Supervision potentially has a greater benefit with this population, and can be used to produce treatment effects that are on a par with those of qualified supervisees (Ost et al., 2012).

## 3.5 Conclusions

This review has investigated the impact of clinical supervision on both supervisees and patients. There is less research attention paid to patient outcomes (as reflected in the supervision manuals that exist – Simpson-Southward et al., 2017). Where patient outcomes (symptoms and working alliance) are considered, there is no evidence that supervision is effective. In contrast, supervision has a moderate, positive effect on supervisee outcomes (skill acquisition, reflection, self-awareness, self-efficacy, competence, and adherence). Therefore, clinical supervision can be supported on one level, but not when it comes to patient improvements. It is clear that there is a need for a much wider understanding of how to get this positive effect for supervisees to translate to patient benefit. Any such impact of supervision also needs to be explored across settings and disorders. Most importantly, supervisors and teams need to attend to whether supervision is demonstrably effective, rather than just assuming this to be the case. If it is not shown to be effective in this way, then alternative supervision models need to be considered, with more of a focus on patient outcomes.

# – Supervisor practice when guiding therapists working with depression: The impact of supervisor and patient characteristics

This chapter is adapted from Simpson-Southward, C., Waller, G., & Hardy, G. (2018). Supervisor practice when guiding therapists working with depression: The impact of supervisor and patient characteristics *The Cognitive Behaviour Therapist, 11,* E9.

**Abstract.** Currently recommended psychotherapies for depression are not always delivered in a consistent manner. There is an assumption that the use of clinical supervision will ensure reliable treatment and patient recovery. However, there is limited research supporting this assumption. This study explored the role of supervision in the treatment of depression. In particular, it examined how supervisors’ own characteristics and those of patients can influence the focus of supervision sessions. Clinical supervisors who worked with cognitive behavioural therapy (CBT) therapists treating depression cases were asked to indicate their supervision focus for three different patient vignettes. These vignettes varied in clinical complexity. Participants’ intolerance to uncertainty and their self-esteem were also assessed. Supervisors tended to focus their supervisees on the use of evidence-based therapeutic techniques for both straightforward and complex cases. However, their approach was less evidencebased for diffuse cases. Three supervisory types emerged: an ‘Alliance- and Technique-Focused’ group, a ‘Case Management-Focused’ group, and an ‘Unfocused’ group. Personal characteristics of the supervisors varied across the groups. The content of

supervision sessions is influenced by factors from outside the therapy process. These factors might cause supervisors to avoid focusing on evidence-based aspects of therapy, thus feeding therapist drift. Suggestions are made for new supervision protocols that consider the supervisor’s personal characteristics.

## 4.1 Overview of empirical chapters

The content analysis in Chapter 2 indicated that there is a lack of consistency across supervision models and it is unclear which (if any) outline effective supervision due to the lack of empirical evidence. The meta-analyses in Chapter 3 indicate that supervision has a positive impact on supervisees, but no impact on patients. It is possible that supervision has an indirect positive effect on patients through the effect on the supervisee. The value of supervision might lie in preventing therapist deterioration. If supervisors are to ensure therapists stay on track, it is key that supervisors do not drift in the same way as therapists.

The next three chapters will present empirical studies looking to explore what happens in supervision sessions, and whether supervisors drift in their practice for similar reasons to therapists. The current chapter outlines an empirical study investigating whether the complexity of the patient in therapy dictates supervisory recommendations or whether aspects of the supervisor themselves drive the content of the sessions. Chapter 5 explores whether aspects of the therapist affect the supervision content, and Chapter 6 explores non-adherence in therapy and how this, alongside patient and therapist characteristics, affect supervision content.

## 4.2 Background and aims

The availability of effective treatments for depression is essential. While such psychological treatments do exist, they are not universally effective. Nor are they always delivered effectively or consistently (e.g., Wang, Demler, & Kessler, 2002). There is an assumption that supervision of therapists will ensure adequate, accurate delivery of psychological therapies (Lambert & Ogles, 1997; Milne & James, 2000; Wampold & Holloway, 1997). The meta-analyses in the previous chapter indicated that supervision has a moderate, positive effect on supervisees but no effect on patients. In addition, few empirical studies detailed the content of the supervision provided, and the suggested content of supervision varies across theoretical models (Chapter 2). Therefore, it is difficult to know what happens in the successful delivery of supervision. This study will consider the role of supervision in ensuring that treatments for depression are delivered in a consistent manner. In particular, it will examine whether supervisors’ own characteristics and those of patients with depression combine to influence the content of supervision sessions and recommendations that supervisors give to their supervisees.

There are several proposed models of supervision, including: developmental models (Stoltenberg & Delworth, 1987; van Ooijen, 2000; Worthington, 1987); competency-based models (Bernard & Goodyear, 2004; Mead, 1990); and process models (Hawkins & Shohet, 1989; van Ooijen, 2000). Supervision is considered to have three core functions: ‘normative’ (managerial and ethical responsibilities), ‘formative’ (education and development of the supervisee), and ‘restorative’ (emotional aspects of work; Proctor, 1988). However, only 38.41% of models emphasise a focus on all three core elements. In addition, very few supervisory models focus on the patient in therapy, instead they focus on the supervisees or the supervisors (Simpson-Southward et al., 2017). Research has found that therapist effects on clinical outcomes are impacted by patient complexity (Saxon & Barkham, 2012). However, it is unclear how patient complexity might influence the therapeutic process and the advice given by supervisors.

The objectivity of clinical supervision is questionable, given evidence that supervisors of therapists substantially overestimate the ability of their supervisees (Dennhag et al., 2012). This overestimation makes it likely that supervisors will be less demanding than they should be in routine settings. Therefore, it is possible that supervisors’ own practices could permit supervisees to stray from effective practice. In other words, supervisor drift could permit or drive therapist drift. While the emotional, behavioural and cognitive factors that are associated with therapist drift are increasingly well understood (e.g., anxiety, safety behaviours, dismissal of manuals – Lilenfeld, Ritschel, Lynn, Cautin, & Latzman, 2013; Waller, 2009), little is known about the reasons why supervisors might or might not drift in this way.

Therefore, this study will explore, experimentally, a key element in what influences supervisors of CBT clinicians working with depression - the nature of the clinical case being presented - and how that element interacts with the supervisor’s own characteristics. The study focuses on supervision for CBT specifically, rather than other therapies. This is not only because it is the recommended treatment for depression (NICE, 2011), but also because it has a rigorous protocol (Beck et al., 1979). Therefore, departure from that protocol might, arguably, have a greater effect on this therapy than it would on others.

This study has two aims. First, it will investigate how the content of supervision sessions varies depending on the clinical case that is presented in the supervision. Second, it will determine whether those patterns of supervisor focus fall into natural groupings (e.g., do clinicians report focusing on therapeutic alliance or evidence-based techniques, but not both?), and whether those patterns are related to supervisors’ other characteristics. Specifically, this will consider those characteristics that have previously been linked to therapist drift e.g., tolerance of uncertainty (Turner, Tatham, Lant, Mountford, & Waller, 2014), age, and clinical experience (Waller et al., 2012).

## 4.3 Method

### 4.3.1 Design

This was a within-subject, survey-based, experimental design, with all participants undertaking all conditions. The independent variable was the variation in patient vignettes, and the dependent variable was supervisor reaction (guidance given to supervisees working with patients with depression).

### 4.3.2 Participants

The participants were a sample of 42 clinical supervisors, guiding clinicians in the delivery of CBT for depression. Although all worked as clinical supervisors, only 27 were accredited supervisors (64.3%). The mean age of the group was 50.2 years (*SD* = 10.6 years, range = 35-67 years), and 61.9% were female. The supervisors were members of organisations that were part of the European Association for Behavioural and Cognitive Therapies. They were from eight different countries across Europe, with the largest number working in the UK (47%) and the second largest in the Netherlands (16.7%). The mean amount of time they had been using cognitive behavioural therapy (CBT) was 15.9 years (*SD* = 8.90 years, range = 0-38 years). The background professions of the supervisors were: clinical psychologists (*N* = 20), nurses (*N* = 5), counselling psychologists (*N* = 3), social workers (*N* = 2), occupational therapists (*N* = 2), psychiatrists (*N* = 2), high intensity Improving Access to Psychological Therapies workers (IAPT; *N* = 2), psychotherapists (*N* = 2), a health clinical psychologist (*N* = 1), a psychotherapist and medical doctor (*N* = 1), and a mental health practitioner (*N* = 1). One supervisor gave no background profession.

#### *4.3.2.1 Sample size estimation*

A sample size analysis was performed using G\*Power (Faul, Erdfelder, Lang, & Buchner, 2007) to determine the number of participants needed. For a medium to large effect size (with an alpha of .05 and power of 0.80), the sample size required was between 17 and 40.

### 4.3.3 Ethics

This research was approved by the University of Sheffield's Department of Psychology Research Ethics Committee (see Appendix 4A for ethics approval).

### 4.3.4 Measures and Procedure

All participants were sent an email containing a link to an online questionnaire (adapted from Simpson-Southward, Waller, & Hardy, 2016), hosted by the website Qualtrics. A copy of the questionnaire can be found in Appendix 4B. Participants indicated consent and provided demographic information. Three case vignettes were then presented, each relating to individuals with depression with whom their supervisees would be working. The vignettes were based on the clinical experience of two of the authors (GH and GW), to ensure that it represented a realistic scenario that the supervisor would be likely to attend to and might respond to. These vignettes were based on case examples that supervisors would be used to seeing in supervision manuals. These were presented in random order. The vignettes varied in terms of patients’ clinical severity - one “straightforward case” of depression, one “diffuse case”, and one “complex case” (see Appendix 4B for full vignettes). The vignettes indicate the severity of each case through the symptoms and social factors outlined. For example, the “diffuse case” has social support and is lacking any clear symptoms of depression, other than feeling ‘down’. Whereas, the “complex case” is isolated with a number of biological symptoms as so appears more ‘risky’. Each was relatively brief, to ensure that the supervisor’s reaction to the nature of the case was not related to or obscured by superfluous information.

Following each vignette, the participant was asked what they would focus on in supervision for each case. Focus was measured using sliding scales, ranging from 0 (‘I would not focus on this’) to 100 (‘I would focus entirely on this’). The questions referred to three general areas of supervision focus: therapeutic technique, therapeutic alliance, and case management issues. These areas of focus were based on the three main functions of supervision often described in the literature. Proctor (1988) refers to these functions as ‘formative’ (education and development of the supervisee), ‘restorative’ (emotional aspects of work), and ‘normative’ (managerial and ethical responsibilities). The same functions are referred to as ‘educational’, ‘supportive’, and ‘managerial’ by Kadushin (1976). Further detail was requested to clarify which specific supervision methods the supervisors would focus on. Methods relating to the therapeutic alliance were: developing and maintaining the therapeutic bond with the patient; agreement on therapy tasks; and agreement on therapy goals. Those relating to the therapeutic techniques were: reviewing depression levels; CBT model education; agenda setting; Socratic questioning; linking cognitions, emotions, and behaviour; recording of negative automatic thoughts; clarifying dysfunctional assumptions; developing alternative hypotheses; behavioural activation; mindfulness; eye movement desensitisation and reprocessing; responding to patient feedback; discussion of thought records; reviewing homework tasks; behavioural experiments; cognitive rehearsal; assertiveness training; use of reattribution; and relapse prevention techniques. Case management issues covered: risk focus; focus on the patient’s capacity to use and benefit from treatment; focus on the patient’s week; and encouragement of the therapist to remain on track.

Participants were then asked to fill out two measures. These measures were presented after the vignettes to reduce demand characteristics. Participants’ reactions to uncertainty, ambiguous situations, and the future were measured using the 12-item version of the Intolerance of Uncertainty Scale (IUS; Carleton, Norton, & Asmundson, 2007). The IUS measures two aspects of intolerance of uncertainty – ‘prospective anxiety’ (fear and anxiety relating to future events), and ‘inhibitory anxiety’ (uncertainty that inhibits action). The IUS has high internal consistency (full scale α = .91, prospective anxiety α = .85, and inhibitory anxiety α =.85). The IUS is highly correlated with established anxiety scales (e.g., Beck Anxiety Inventory, Beck, Epstein, Brown & Steer, 1988; Generalised Anxiety Disorder Questionnaire, Newman et al., 2002; Carleton et al., 2007). The IUS-12 was chosen over other anxiety measures as clinicians are likely to be less familiar with the scale and so demand characteristics are reduced.

Finally, a self-esteem measure was used, because higher self-acceptance and self-efficacy of supervisors is associated with more positive trainee outcomes (Moldovan & David, 2012). Participants’ self-esteem was measured using the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965). The RSE measures both positive and negative views of the self, and has well-established psychometric properties (α ranging from .72 to .88; Gray-Little, Williams, & Hancock, 1997). Due to a technical error, scores were collected for only nine of the ten items, so the score was prorated.

### 4.3.5 Data analysis

To address the first aim, a repeated measures analysis of variance (ANOVA) was used to assess the reactions of the supervisors to each vignette. The within-subject factor was the different clinical condition (presentation type), and the dependent variables were the levels of focus on each supervision topic. To address the second aim, two-step cluster analysis was used to identify naturally-occurring supervisor ‘types’, and these were validated against other measures using one-way ANOVAs and chi-squared tests.

## 4.4 Results

### 4.4.1 ‘Supervision focus’ scale reliability

The Cronbach’s alphas of the three scales were (in the order ‘straightforward’, ‘diffuse’ and ‘complex’ each time): 0.701, 0.511, and 0.642 for therapeutic alliance; 0.893, 0.908, and 0.878 for therapeutic techniques; and 0.641, 0.583, 0.742 for case management. It is likely that the low alpha levels for some of the therapeutic alliance and case management scores are because the number of items in each is too low to allow for reliable calculation of Cronbach’s alpha. However, the alphas for the therapeutic techniques scale suggest that the items reflect a single construct rather than containing divergent techniques.

### 4.4.2 Supervision focus for different clinical conditions

Addressing the first aim, overall patterns of supervision focus (alliance, CBT techniques, and case management issues) are shown in Table 4.1 for each case presentation. The overall pattern was that the supervisors stated that they would focus their supervisees most on techniques and least on case management issues, with the level of focus on the alliance lying between those two. The ANOVAs showed that the type of case made no significant difference to the level of focus on the alliance or case management issues (all *p* > .05). However, there was a significant difference in the level of focus on evidence-based techniques, which the supervisors reported stressing least when the case presentation was relatively diffuse (*F*(2, 84) = 5.19, *p* = .008, partial *ɳ2* = .110).

Table 4.1. ANOVAs showing differences in overall supervision focus per case.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Patient Type** | | |  | **ANOVA** | |
|  | **Straightforward**  **(1)** | **Diffuse**  **(2)** | **Complex**  **(3)** | ***F*** | ***p*** | **Multiple Comparisons** |
| Alliance | 50.0 (25.9) | 46.4 (24.2) | 54.9 (27.1) | 2.92 | .071 | - |
| Techniques | 70.0 (22.0) | 58.6 (27.0) | 68.6 (24.7) | 5.19 | .008 | 1 = 3 > 2 |
| Case Management | 35.1 (24.6) | 44.6 (28.7) | 42.6 (23.7) | 2.71 | .073 | - |

### 4.4.3 Supervision styles when delivering CBT for depression

The second aim was to determine whether there are different natural patterns of supervisory practice. Using the supervisors’ overall scores on the degree to which they would focus on different therapy elements (alliance, techniques, case management), two-step cluster analysis provided a three-cluster solution. The first cluster (33.3% of the sample) were supervisors who indicated that they spend little time on any of the aspects of supervision. Therefore, they are referred to as *Unfocused*. The second cluster (23.8% of the sample) consisted of supervisors who mainly focused on topics of supervision other than alliance and technique. They are referred to as *Case Management-Focused*. The final, and largest, cluster (42.9% of the sample) consisted of supervisors who focused on both the therapeutic alliance and therapeutic techniques. They are therefore labelled *Alliance- and Technique-Focused*.

#### *4.4.3.1 Clinical validation of the clusters.*

Using one-way ANOVAs, the three clusters were compared on participant characteristics (Table 4.2). Relative to the *Unfocused* group, the individuals who were *Case Management-Focused* had been qualified (*F*(2, 39) = 6.11, *p* = .005), accredited (*F*(2, 32) = 5.72, *p* = .008) and using CBT (*F*(2, 39) = 3.50, *p* = .040) for longer. In contrast, compared to *the Alliance- and Technique-Focused* group, the *Case Management-Focused* group had higher levels of prospective anxiety (*F*(2, 38) = 5.83, *p* = .006) and worked less with depression (*F*(2, 39) = 3.33, *p* = .046).

Table 4.2. One-way ANOVAs comparing the three supervisor clusters on supervisor characteristics.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Supervisor Type** | | | **ANOVA** | | | |
|  | **Unfocused**  **(1)** | **Case Management- Focused**  **(2)** | **Alliance- and Technique- Focused**  **(3)** | ***N*** | ***F*** | ***p*** | **Multiple comparisons** |
| Age (years) | 48.0 (11.8) | 53.6 (9.62) | 49.9 (10.3) | 42 | .811 | .452 | - |
| No. of patients with a primary diagnosis of depression | 26.4 (20.1) | 16.5 (9.73) | 36.2 (23.0) | 42 | 3.33 | .046 | 3 > 2 |
| Time qualified (years) | 11.7 (7.00) | 24.7 (8.08) | 17.6 (10.6) | 41 | 6.11 | .005 | 2 > 1 |
| Time using CBT (years) | 12.0 (8.04) | 21.2 (9.22) | 15.9 (8.22) | 42 | 3.50 | .040 | 2 > 1 |
| Time accredited as therapist (years) | 8.69 (5.35) | 22.6 (11.5) | 13.0 (9.71) | 35 | 5.72 | .008 | 2 > 1 |
| Time accredited as supervisor (years) | 4.0 (1.41) | 15.5 (11.1) | 9.51 (9.36) | 27 | 2.36 | .116 | - |
| Intolerance of uncertainty – prospective | 2.30 (.680) | 2.73 (.367) | 1.99 (.463) | 41 | 5.83 | .006 | 2 > 3 |
| Intolerance of uncertainty – inhibitory | 1.37 (.414) | 1.84 (.467) | 1.42 (.837) | 41 | 1.68 | .199 | - |
| Rosenberg Self-Esteem Scale | 22.6 (4.37) | 22.2 (3.39) | 25.3 (2.87) | 42 | 3.36 | .045 | - |

The only categorical characteristic found to be associated with the clusters was supervisor accreditation (*χ 2*(*df* = 2) = 13.83, *p* = .001). In the *Unfocused* cluster, 28.6% were accredited, compared with 100% of the *Case Management-Focused* cluster and 72.2% of the *Alliance- and Technique-Focused* group. Categorical characteristics found not to be associated with the clusters were gender; country of training trained; current country of residence; background profession; use of treatment manuals and therapist accreditation.

## 4.5 Discussion

This study explored the focus of CBT supervision for depression cases, comparing patterns of guidance given to clinicians working with patients with different levels of clinical complexity. Overall, supervisors tended to focus on evidence-based techniques, especially for “straightforward” and “complex” depression cases. However, for relatively “diffuse” cases, supervisors reported taking a less evidence-based approach.

Three clear supervisory types emerged from the sample – an *Alliance- and Technique-Focused* group, a *Case Management-Focused* group, and an *Unfocused* group. An important point to note is that there was no distinction between supervisors who encouraged a focus on CBT techniques or the alliance – if the supervisor addressed one; they addressed both (albeit they stressed the use of techniques to a greater degree). Perhaps more surprising was the number of supervisors whose guidance for supervisees seemed to lack any of these foci, regardless of the nature of the case (at least within the domain of depression). These three patterns of clinical supervisory practice were related to the characteristics of the supervisors themselves. Those who focused their supervisees more on case management issues were more likely to have anxiety surrounding future events but to have also been practicing for longer than others. In contrast, those who focused on guiding both alliance and technique in supervision also tend to be those who had higher self-esteem.

The three supervisor types that have emerged from these data seem to be partially reflected in established supervision models. However, while most models tend to focus on one specific aspect of the supervision (Bernard & Goodyear, 2004; Hawkins & Shohet, 1989; Mead, 1990; van Ooijen, 2000), that was not the case here. The largest group of supervisors (Alliance- and Technique-Focused) combines features of competency-based models focusing on techniques (Bernard & Goodyear, 2004; Mead, 1990) and process models focusing on relationship dynamics (Hawkins & Shohet, 1989; van Ooijen, 2000). Thus, supervision models might need to be developed to allow for this dual focus in everyday practice, rather than being presented as alternatives. A new supervision model might take evidence-based aspects of other models and combine them for a more integrative model. Such a model should also take into account the characteristics of the supervisors themselves. Based on the current study, it is clear that supervisors need to evaluate their own characteristics, as well as those of their supervisees and patients.

The finding that supervisor characteristics are associated with their supervisory practice needs consideration. The fact that supervisors with higher levels of prospective anxiety are likely to encourage supervisees to focus on case management (e.g., monitoring risk; exploring the patient’s week) is compatible with the finding that more anxious therapists avoid the use of core CBT techniques in therapy (e.g., Meyer, et al., 2014; Waller et al., 2012). It is also possible that supervisors’ fear over future events leads them to focus on patient safety to the exclusion of more change-oriented methods. Similarly, the higher self-esteem of those who focus on the alliance and techniques is compatible with the finding that clinicians with higher self-esteem are more likely to use treatment manuals (Waller et al., 2013). This result might also be related to the finding that high supervisor self-acceptance and self-efficacy positively affects trainees’ outcomes (Moldovan & David, 2013). What is possibly more unexpected is the tendency for more experienced supervisors to focus their supervisees more on case management and less on alliance and techniques, though it could be argued that this is a simple example of supervisory drift with time.

Although supervision is usually thought to keep therapists on track (Bernard & Goodyear, 2004; Care Quality Commission, 2013; van Ooijen, 2000), the present findings indicate that this assumption is subject to doubt, as supervisors themselves are influenced by similar factors to therapists, causing them to drift off track. Given the reliance that many professions and therapies place on supervision, it is possible that supervisory drift accounts in part for therapist drift, and hence for differences in patient outcomes across settings (Gibbons et al., 2013). In particular, the demands placed on supervisors in RCT conditions are usually more regulated (Roth et al., 2010; Tracey et al., 2012). It might be argued that routine clinical practice would be augmented by the establishment of protocols for supervision of those clinicians. Those protocols might explicitly address the characteristics of supervisors and how those characteristics could result in therapist drift. Similarly, it can be suggested that supervisors’ worry around future events and their self-esteem levels might be addressed as part of training and continuing professional development, as has been recommended for clinicians delivering exposure-based therapy (e.g., Farrell, Deacon, Dixon, & Lickel, 2013).

For such training to be effective, supervisor tolerance of uncertainty and self-esteem should be explored further. A key issue is that this study has considered the potential role of prospective and inhibitory anxiety, and self-esteem within normal, non-clinical limits. Future research might focus on whether these patterns of supervisor behaviour are exacerbated when one focuses specifically on supervisors with levels of anxiety and self-esteem that are more representative of clinical groups. The findings of the current study might be picking up different forms of anxiety, such as state anxiety, as well as trait anxiety (due to the order in which the study materials were presented). Future research should look to tease out the types of anxiety that supervisors are experiencing.

The findings in this study relate to the supervision of clinicians working with depression. Further research will need to consider the impact of supervisor characteristics on how they guide treatment for other disorders. It will also be important that further research into supervisor practice in depression and other disorders considers the triadic relationship involved. This study has considered the impact and relationship of patient and supervisor characteristics. However, that does not allow for the intermediary role of the clinician being supervised. An important development of this research will be considering how supervisee and supervisor characteristics combine to influence the therapy being delivered. For example, is there an additive effect, such that having a supervisor and clinician who are both alliance- and technique-focused will have more positive results, while having a supervisor and clinician with contrasting approaches might lessen the impact of the therapy? And will having a supervisor and clinician who are both unable to tolerate uncertainty be even less beneficial for the patient, or is one of the two being more tolerant sufficient for the patient to benefit? Similarly, can a less experienced clinician retain focus on alliance and technique, even when a more experienced supervisor is directing therapy away from that focus? These are questions that can initially be addressed using vignette studies of this sort, but that would benefit from naturalistic, observational studies that relate real-life supervisory and clinical practice to patient outcomes and experiences.

The use of naturalistic studies will enhance this area of research, as there are some limitations to questionnaire research. Due to the need to keep questionnaires concise, there might not have been enough information given in this study to ensure that the supervisory content items did not confuse the participants. Although these items were outlined under specific categories (e.g., ‘therapeutic techniques’), any confusion might have caused some overlap between the categories. In addition, the imbalance of items between the categories could have caused some response bias towards selecting items from the ‘therapeutic techniques’ category. Observational studies would alleviate such problems.

The current study only provides a snapshot into supervisory intentions. Due to time restrictions and the need to prioritise certain patients in clinical settings, supervisors might only be provided with a small amount of detail about some patients, similar to the vignettes used in this study. However, this study has an analogue nature. In many real-life cases, the supervisor will have more information to work with – perhaps including video or audio recordings of the therapy sessions. Future research could benefit from the use of such recordings. These provide supervisors with a much richer source of information, thus allowing researchers to take a much deeper look into supervisory intentions.

# – Supervision for depression: An experimental study of the role of therapist gender and anxiety

This chapter is adapted from Simpson-Southward, C., Waller, G., & Hardy, G. E. (2016). Supervision for treatment of depression: An experimental study of the role of therapist gender and anxiety. *Behaviour Research and Therapy, 77*, 17-22.

**Abstract.** Psychological treatments for depression are not always delivered effectively or consistently. Clinical supervision of therapists is often assumed to keep therapy on track, ensuring positive patient outcomes. However, there is a lack of empirical evidence supporting this assumption. This experimental study explored the focus of supervision of depression cases, comparing guidance given to supervisees of different genders and anxiety levels. Participants were clinical supervisors who supervised therapists working with patients with depression. Supervisors indicated their supervision focus for three supervision case vignettes. Supervisee anxiety and gender was varied across vignettes. Supervisors focused calm female supervisees more on therapeutic techniques than state anxious female supervisees. Males were supervised in the same way, regardless of their anxiety. Both male and female supervisors had this pattern of focus. Findings indicate that supervision is influenced by supervisors' own biases towards their supervisees. These factors may cause supervisors to drift from prompting their supervisees to deliver best practice. Suggestions are made for ways to improve the effectiveness of clinical supervision and how these results may inform future research practice.

## 5.1 Background and aims

The previous chapter demonstrated that supervisors’ personal characteristics, such as anxiety and self-esteem, have an impact on the focus of supervision sessions (Simpson-Southward et al., 2018). Previous research also indicates that supervisors can be affected by their own biases (Dennhag et al., 2012). As parallel processes exist between supervision and therapy (Tracey et al., 2012), this variation in supervision might be expected to have an impact on patient outcome.

While therapist characteristics can impact the therapy process (Lilenfeld, et al., 2013; Waller et al., 2012), it is not known whether and how those clinician characteristics affect the focus of supervision sessions (and ultimately the content of therapy sessions). Two factors that have been identified in the literature on clinicians’ delivery of evidence-based treatments might be particularly pertinent to supervisory practice when working with depression – therapist anxiety and therapist gender.

It can be hypothesised that when faced with an anxious therapist who is seemingly avoiding evidence-based CBT techniques for depression, supervisors are reluctant to push the use of such techniques for fear of distressing the therapist. Such reluctance would parallel the reluctance of therapists themselves in delivering such techniques to anxious patients (e.g., Deacon et al., 2013). However, the impact of gender on supervision is a relative unknown. It has been shown that we have different expectations (either implicit or explicit) of the abilities of men and women (Heilman, 2012), and that men are often seen as more competent than women (Ridgeway & Correll, 2004). For example, supervisors treat male and female supervisees differently – assuming a more powerful role with female supervisees than with males, and failing to reinforce females if they attempt to take a more powerful role themselves (Nelson & Holloway, 1990). Therefore, it can be hypothesised that supervisors will focus supervision differently for male and female supervisees, potentially focusing men more on the techniques of therapy because they see male therapists as more expert and competent than females.

Therefore, the first aim of this study is to explore experimentally how supervisee anxiety and gender impact the advice that supervisors give in directing clinicians working with depression. It is hypothesised that supervisors who are working with a calm clinician will stress the need for their supervisee to focus on CBT techniques more than when the clinician is anxious. It is also hypothesised that supervisors will focus male supervisees more on CBT techniques than female supervisees. The second aim is to determine whether patterns of supervisor focus fall into natural groupings, and whether those patterns are related to supervisors’ own characteristics. It is expected that supervisors with high anxiety themselves will focus their supervisees less on CBT techniques.

## 5.2 Method

### 5.2.1 Participants

The participants were a sample of 89 clinical supervisors, supervising clinicians delivering CBT to patients with depression. Their names and email addresses were drawn from CBT clinician organisations from across Europe (members of the European Association for Behavioural and Cognitive Therapies). A snowball approach was used to recruit participants, and therefore the *N* approached is not known. The mean age of the group was 50.2 years (*SD* = 9.14 years, range = 27-68 years), and 55.1% were female. Participants were from eight different countries across Europe, the majority being from the UK (71.9%) and the second largest group being from the Netherlands (10.1%). The mean amount of time that the group had been using CBT was 13.8 years (*SD* = 7.43 years, range = 2-38 years). Participants came from a range of background professions, including clinical psychology (*N* = 27), nursing (*N* = 24), Improving Access to Psychological Therapies services (IAPT, *N* = 9), and counselling psychology (*N* = 6).

#### *5.2.1.1 Sample size estimation*

A sample size analysis was performed using G\*Power (Faul et al., 2007) to determine the number of participants needed. For a medium to large effect size (with an alpha of .05 and power of 0.80), the sample size required was between 26 and 64. As a medium to large effect size was found in the study in Chapter 4, the sample size of 89 was deemed adequate for the current study.

### 5.2.2 Ethics

This research was approved by the University of Sheffield's Department of Psychology Research Ethics Committee (see Appendix 5A for ethics approval).

### 5.2.3 Design

This was a survey-based, experimental design, using vignettes to present clinical material. The within-subject independent variable was the level of supervisee anxiety in the vignettes, and the between-subject independent variable was supervisee gender. The dependent variable was supervisor reaction (guidance given to supervisees).

### 5.2.4 Measures and Procedure

Participants were either sent an email containing a link to the online questionnaire, hosted by the website Qualtrics (*N* = 73), or given a paper copy of the questionnaire at a workshop (*N* = 16). A sample of a questionnaire is in Appendix 5B.Participants read through the instruction sheet and indicated consent before beginning the questionnaire. After collecting demographic information, three case vignettes were presented, relating to patients with depression that their supervisees were working with. Participants were randomly assigned to either a female or male supervisee condition. Within each condition, the vignettes varied in terms of the supervisee’s level of anxiety – one high trait anxiety, one high state anxiety and one calm (see Appendix 5B for full vignettes). Supervisee anxiety was highlighted in the vignette through stating the usual presentation of the supervisee and their current presentation. These were presented in random order. See Section 4.3.4 for more information on the vignette development.

After each vignette, the participant was asked: ‘To what extent would you focus on the following techniques when giving the clinician advice during supervision?’. The techniques were: ‘Focus on evidence-based therapeutic techniques’; ‘Focus on the development of the therapeutic alliance with the patient’; and ‘Focus on other issues in supervision’. Focus was measured using five-point Likert scales, ranging from 1 ‘I would not focus on this’ to 5 ‘I would focus entirely on this’. Further detail was requested if participants indicated that they would focus on other issues. ‘Other issues’ are henceforth referred to as ‘Case-Management issues’. These areas of focus (therapeutic techniques, alliance, and case-management) were based on the three main functions of supervision often described in the literature - formative, restorative, and normative (Proctor, 1988), or educational, supportive, and managerial (Kadushin, 1976).

Following the vignettes, participants’ anxiety was measured using the 12-item version of the Intolerance of Uncertainty Scale (IUS, Carleton et al., 2007). The IUS measures two elements of anxiety – ‘prospective anxiety’ (fear and anxiety relating to future events), and ‘inhibitory anxiety’ (uncertainty that inhibits action). It has good psychometric properties (Carleton et al., 2007). Finally, participants’ self-esteem was measured using the Rosenberg Self-Esteem Scale (RSE, Rosenberg, 1965). The RSE has 10 items, measures both positive and negative views of the self, and has well-established psychometric properties (Blascovich & Tomaka, 1991). See Section 4.3.4 for further details on these measures.

### 5.2.5 Data analysis

To address the first aim, a repeated measures analysis of variance (ANOVA) was used to assess the reactions of the supervisors to each vignette. The within-subject factor was supervisee anxiety (three levels), the between-subject factor was supervisee gender, and the dependent variables were the rated levels of focus on different topics in supervision. To address the second aim, two-step cluster analysis was used to identify naturally occurring supervisor ‘types’, and these were validated against other measures using one-way ANOVAs and chi-squared tests

## 5.3 Results

### 5.3.1 General supervision focus

Supervisors indicated a greater focus on technique (*M* = 3.73, *SD* = 0.77) than on alliance (*M* = 2.85, *SD* = 1.10; *t*(88) = 5.90, *p* < .001), or case management issues (*M* = 2.74, *SD* = 1.18; *t*(88) = 6.10, *p* < .001). There was no difference between case management and alliance focus (*t*(88) = 0.67, *p* = .504).

### 5.3.2 Supervision focus for different supervisees

Overall patterns of supervision focus (alliance, therapeutic technique and case management issues) for each vignette were assessed across genders, using repeated measure ANOVAs (Table 5.1).

Table 5.1. ANOVAs showing differences in overall supervision focus by supervisee gender and anxiety.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Clinician Vignettes** | | | | | | | | **3x2 ANOVA** | | | | | | | |
| **Supervisee anxiety** | **Trait**  **(1)** | | **State**  **(2)** | | | **Calm**  **(3)** | | | **Anxiety** | | | **Supervisee gender** | | **Anxiety x Supervisee gender** | |
| **Supervisee gender** | **Male** | **Female** | | **Male** | **Female** | | **Male** | **Female** | ***F*** | ***p*** | **MC** | ***F*** | ***p*** | ***F*** | ***p*** |
| **Focus of supervision** |  |  | |  |  | |  |  |  |  |  |  |  |  |  |
| Alliance | 2.79 (1.22) | 3.18 (1.11) | | 2.92 (1.26) | 3.47 (1.10) | | 2.44 (1.10) | 2.87 (1.10) | 13.0 | <.001 | 2>1>3 | 4.31 | .041 | 0.29 | *ns* |
| Technique | 3.71 (1.09) | 3.78 (0.92) | | 3.81 (1.02) | 3.52 (1.01) | | 3.60 (0.96) | 4.00 (0.76) | 0.81 | *ns* | - | .139 | *ns* | 5.45 | .005 |
| Case management | 3.03 (1.23) | 3.19 (1.38) | | 2.88 (1.22) | 2.81 (1.44) | | 2.90 (1.34) | 2.40 (1.33) | 4.81 | .009 | 1>3 | .326 | *ns* | 2.62 | *ns* |
| *ns* = not significant  MC = multiple comparisons | | | | | | | | | | | | | | | |

#### *5.3.2.1 Alliance focus*

There was an overall effect of supervisee anxiety (*F*(1.75,143.5) = 13.0, *p* < .001, partial *ɳ2* = 0.14) on alliance focus. Post-hoc multiple comparisons showed that supervisors focused on the alliance most when the supervisee was state anxious (*M* = 3.21, *SD* = 1.20), less when they were trait anxious (*M* = 3.00, *SD* = 1.17), and least for calm supervisees (*M* = 2.67, *SD* = 1.11), all differences *– p* < .05. There was an overall effect of supervisee gender (*F*(1,82) = 4.31, *p* = .041, partial *ɳ2* = 0.04) on alliance focus, indicating that supervisors focused more on the alliance when advising female (*M* = 3.17, *SD* = 0.99) than male clinicians (*M* = 2.72, *SD* = 1.00). There was no significant interaction of the two factors.

#### *5.3.2.2 Case management focus*

There was an overall effect of supervisee anxiety (*F*(2,162) = 4.81, *p* = .009, partial *ɳ*2 = 0.06). Post-hoc multiple comparisons indicated that supervisors focused more on case management issues with trait anxious supervisees (*M* = 3.11, *SD* = 1.31) than with calm supervisees (*M* = 2.64, *SD* = 1.35), *p* = .005, but there were no differences between these and the state anxious supervisees. There were no main or interaction effects involving supervisee gender.

#### *5.3.2.3 Technique focus*

There were no main effects of supervisee anxiety or gender on technique focus. However, there was an interaction effect of supervisee anxiety x gender (*F*(2,172) = 5.45, *p* = .005). Post hoc *t*-tests were used to investigate this effect. Supervisors focused more on technique for trait anxious than for state anxious female supervisees (*t*(45) = 2.21, *p* = .032, Cohen’s *d* = 0.33), and more on technique for calm female supervisees than state anxious females (*t*(45) = 3.23, *p* = .002, Cohen’s *d* = 0.26). The trait anxious female supervisees were not treated significantly differently to the calm female supervisees (*t*(45) = 1.75, *p* = .086), though the direction of differences is in keeping with the hypothesis that anxious supervisees are not directed towards therapeutic techniques when treating depression. There were no such differences in supervisor focus for male supervisees with different anxiety levels. In addition, focus on technique was higher for calm female supervisees than for calm males (*t*(87) = 2.01, *p* = .047, Cohen’s *d* = 0.46), but not under other supervisee anxiety conditions.

#### *5.3.2.4 Supplementary analyses*

To ensure that these findings were not a product of differences in participant characteristics, further ANOVAs were conducted with supervisor age as a covariate and supervisor gender as independent variable. With these variables factored in, the only significant result remaining was the supervisee anxiety by gender interaction effect for technique focus (*F*(2,164) = 5.40, *p* = .005, partial *ɳ2* = 0.06). This result suggests that this interaction is a robust one. The age and gender of supervisors did not affect how they proposed delivering supervision to different subsets of therapists.

To summarise, there was a robust pattern of reported supervisory practice, where supervisee anxiety and gender each played a part. Supervisors were less likely to focus state anxious females on the use of core CBT techniques, but the same did not apply to anxious male supervisees.

### 5.3.3 Supervision styles when directing supervisees delivering CBT for depression

Addressing the second aim, a two-step cluster analysis was carried out to identify natural patterns of supervisory practice. Using the supervisors’ scores for their degree of focus on different supervision aspects (alliance, techniques, case management), a two-cluster solution was found. The difference between the two clusters was in alliance focus. The first cluster (53.7% of the sample) was *high alliance-focused* and the second (46.3% of the sample) was *low alliance-focused*. Technique and case management focus were not different between the two clusters.

#### *5.3.3.1* Clinical validation of the supervisor clusters

Independent samples *t-*tests were used to compare the clusters on participant dimensional characteristics (age; time qualified; time using CBT; time as an accredited therapist; time as an accredited supervisor; number of supervisees; hours spent supervising; caseload; percentage of patients with a primary diagnosis of depression; percentage with a secondary diagnosis of depression; RSE total; IUS inhibitory and IUS prospective). No differences were found on any of these variables. A number of categorical variables were examined for their association with cluster membership, including: gender; current country of residence; country of training; background profession; therapist accreditation; supervisor accreditation; and the use of treatment manuals. Of these, only accreditation as a supervisor was associated with cluster membership (*χ2* (*df* = 1) = 4.37, *p* = .037). In the *high alliance-focused* cluster, 54.5% were accredited. In contrast, only 31.6% were accredited in the *low alliance-focused* cluster.

Although there were no dimensional relationships with supervisors’ IUS or RSE scores, it is possible that levels of anxiety and self-esteem among supervisors are more clinically valid as categorical variables. Therefore, the supervisors were divided into two groups on each variable (IUS prospective, IUS inhibitory, RSE), according to whether they scored above or below the median score on that scale. One-tailed chi-squared tests were used to determine associations between the two supervisor clusters and high/low scores on each scale. The only significant finding involved scores on the IUS prospective scale. Supervisors who were high scorers on the IUS prospective anxiety scale were more likely to be in the *high-alliance focused* cluster (*χ2* (*df* = 1) = 3.49, *p* = .031).

In addition, ANOVAs were carried out to test the difference in dimensional levels of supervisory focus for those high and low scoring groups on each on the IUS scales and the RSE. The only significant result indicated that high scorers on the IUS prospective scale focused more on the alliance than low scorers (*F*(1,81) = 5.14, *p* = .026), confirming the finding above. Therefore, it can be concluded that supervisors with higher prospective anxiety levels focus their supervisees more on the alliance than supervisors with low anxiety levels.

## 5.4 Discussion

This experimental study has explored the focus of clinical supervision for therapists treating cases of depression. The study aimed to explore how supervisee anxiety and gender impact the advice that supervisors give in supervision. It was hypothesised that supervisors would focus ‘calm’ supervisees more on CBT techniques than ‘anxious’ supervisees. This hypothesis was supported, but only when the supervisors were working with female supervisees who were state anxious. Male supervisees were supervised in the same way, regardless of their anxiety. These findings imply that, in the supervisors’ eyes, supervisee anxiety has an influence on guidance only if that supervisee is female. It was also hypothesised that supervisors would focus male supervisees more on CBT techniques than female supervisees. Overall, supervisors focused both male and female supervisees on CBT techniques to the same extent. However, supervisors focused female supervisees more on alliance work than males. To summarise, both supervisee anxiety and gender had an impact on supervisor focus in supervision.

The second aim was to investigate whether patterns of supervisor focus fall into natural groupings, and whether such groups are validated by the supervisors’ own characteristics. It was hypothesised that supervisors with high anxiety would focus their supervisees less on CBT techniques. There was no difference in reported practice of male and female supervisors. However, supervisors that are more anxious were likely to focus on the therapist developing a good alliance with the patient, rather than focusing them on delivering evidence-based techniques.

This finding supports the conclusion that supervisors have biases (whether implicit or explicit) in how they support the work of different clinicians treating depression. Dennhag et al. (2012) showed that bias came from the supervisor having a prior working relationship with the therapist, but here it is based purely on therapist characteristics. There are a number of possible explanations for this finding. Perhaps supervisors are aware that anxious therapists tend to focus on immediate patient comfort to the exclusion of more change-oriented methods (Deacon et al., 2013). Therefore, supervisors might be particularly reluctant to push anxious therapists towards more anxiety-evoking aspects of therapy (e.g., behavioural techniques). Alternatively, supervisors might feel that supervisee anxiety is preventing the establishment of a good therapeutic alliance with the patient (Hardy, Cahill, & Barkham, 2009). A third possible explanation is that supervisors might be reluctant to challenge their supervisee because they do not want to disrupt the supervisory relationship, as it has been suggested that poor supervisory relationships can be harmful to supervisee growth (Gray, Ladany, Walker, & Ancis, 2001).

However, none of these possibilities account for the fact that this pattern of focus exists only when supervisors are directing female supervisees in treating depression. Perhaps male and female supervisors assume that female therapists are likely to have a more anxious disposition, by virtue of their gender (e.g., Leahy et al., 2012). Therefore, any display of anxiety might lead supervisors to assume that female clinicians are more vulnerable than males. However, any such assumption would be ill-founded, as therapist gender has little consistent impact on therapy performance and patient outcome, with females sometimes performing better than males (Branson, & Shafran, 2015; Huppert at al., 2001). An alternative explanation is that supervisors might feel that females are more likely to pick up on cues that there are alliance problems, which might stall therapy progression. Supervisors might therefore take female supervisees’ anxiety more seriously than that of male supervisees and hold off focusing on CBT techniques accordingly. The finding that supervisors are more likely to focus females on alliance work than males would support this explanation.

It is worthy of note that supervisor gender was unrelated to this different treatment of male and female supervisees. Nelson and Holloway (1990) found a similar pattern in their study of power balance in supervision, where both male and female supervisors assumed more power in supervision with female supervisees than with male supervisees. There is similar evidence of gender relevance in other domains. For example, Steinpreis, Anders, and Ritzke (1999) discovered that regardless of their own gender, employers were more likely to offer positions and higher starting salaries to men than women with identical curricula vitae. Thus, it is understandable that both male and female supervisors treated female supervisees differently to males.

Not only does therapist anxiety have an impact on supervision sessions, but so does supervisor anxiety. Two distinct types of supervisor emerged from the sample – those with a low focus on the therapeutic alliance and those with a stronger focus on the alliance. Those supervisors in the latter group were distinguished by a greater level of prospective anxiety. One of the functions of the alliance is to offer a soothing bond (Greenberg, 2009). This soothing effect might mean that alliance building is a more relaxing aspect of therapy than other aspects (e.g., technique work). Alliance work might therefore be viewed as less anxiety-provoking for both supervisor and supervisee. This focus on less anxiety-provoking aspects of therapy by anxious supervisors seems to mirror that of anxious therapists. Anxious therapists avoid anxiety-provoking features of therapy, not wanting to distress the patient (Meyer et al., 2014; Waller et al., 2012). Such a pattern would be compatible with the proposal that parallel processes exist between supervision and therapy (Tracey et al., 2012).

It is important to understand how the findings of this research relate to the various models of supervisory practice that exist in the literature. Supervision models often have one main focus – typically either the alliance (Hawkins & Shohet, 1989) or technique (Carroll, 1996). In contrast, the naturally-occurring supervisor types in the current study were distinguished purely by a high or low level of focus on the alliance, with both having a concurrent focus on treatment techniques. Although supervision models go some way to describe how supervision is conducted, different supervisor types need be taken into account in these models. Some models, such as the Discrimination Model (Bernard, 1979), suggest that supervisors should take on different roles (teacher, counsellor, consultant) and areas of focus (intervention, conceptualisation, personalisation), depending on the case that their supervisee presents in supervision. However, results from this study indicate that supervisors can have their own patterns of supervisory focus that are related to their own characteristics, not the case presentation or supervisee. Such models should take account of our intrapersonal characteristics as factors that might bias how we deliver supervision (Dennhag et al., 2012; Simpson-Southward at al., 2018).

Although supervision is commonly represented as necessary to keep therapists on track (Bernard & Goodyear, 2004; Care Quality Commission, 2013; van Ooijen, 2000), the present study suggests that this assumption is not straightforward. Supervisors themselves are influenced by similar factors to therapists, causing them to drift away from encouraging their supervisees to deliver best practice. Indeed, supervisory drift might even contribute to or exacerbate therapist drift, influencing differences in patient outcome across settings (Gibbons et al., 2013).

These findings are informative to both clinical and research practice. With regards to clinical practice, greater regulation of supervision might make a difference to patient outcomes. Such regulation might take the form of more stringent protocols for supervision in clinical settings, similar to those used in many RCTs (Gibbons et al., 2013; Roth et al., 2010). In particular, protocols should address clinician characteristics and how they might influence supervision (and, ultimately, therapy outcome). The tendency to supervise anxious female clinicians differently to all others is a particular concern, and more gender-neutral supervisory practice might be a specific part of supervisor training. Furthermore, supervisors’ own anxieties could be addressed in training and ongoing professional development, as has been recommended for anxious therapists delivering exposure-based therapy (Farrell et al., 2013). This study can also inform future research. Within research protocols, supervision is often used to ensure therapist adherence. Results of this study indicate that supervision by itself might not be enough to ensure adherence, as supervisors themselves may drift. This supervisory drift should be acknowledged within future study designs, possibly requiring researchers to monitor adherence to expected supervisory practice as well as monitoring therapists’ adherence.

Further research is clearly needed to elaborate on these early findings. Such research will need to examine the effects of therapist characteristics on supervision focus for disorders other than depression, as well as within that domain. The therapy process is an active, triadic relationship between the supervisor, therapist and patient (Tracey et al., 2012), and that three-way interaction should be further analysed. Combining and manipulating both therapist and patient variables will paint a more realistic picture of the supervision process. How supervisors deal with therapy-interfering behaviours from therapists or patients will provide further insight into this complex relationship. For example, will supervisors accept non-adherence from anxious female but not calm male clinicians? Will they allow non-adherence from an inexperienced therapist, or a patient with a more complex condition? And will supervisors’ own anxieties affect how they deal with refusal from therapists and patients? These are questions that can be addressed using experimental studies, similar to the present one. As participant representativeness was unclear in our study due to the sampling method used, further research should improve on this. Finally, further investigation would benefit from naturalistic studies of real-life clinical and supervisory practice and its relation to patient outcome.

# – The role of supervision for depression: Dealing with non-adherence from patients and therapists

## Background and aims

Adherence is a key aspect of psychotherapy, and can refer to the actions of both therapists and patients. Therapist adherence refers to the extent to which interventions are delivered in line with the specific treatment model or manual (Waltz, Addis, Koerner, & Jacobson, 1993). In contrast, patient adherence refers to the extent to which the patient’s behaviours correspond to those mutually agreed upon with their therapist (World Health Organisation, 2003). A lack of adherence from patients is often seen as a therapy-interfering behaviour, whereas the same from therapists might be viewed as being ‘creative’ (Waller, 2009). This view is highlighted through the use of the term ‘non-compliance’ (rather than non-adherence) for patients (e.g., Helbig & Fehm, 2004; Kazantzis & Lampropoulos, 2002), but not for therapists. Although this term implies that such behaviours are more problematic from patients, both parties have the potential to be equally disruptive to the therapy process.

Both therapist and patient adherence are necessary to ensure effective treatments. Therapist adherence to concrete aspects of cognitive therapy (e.g., reviewing homework, labelling cognitive beliefs) predicts later symptom change in patients with depression (DeRubeis & Feeley, 1990). Adherence also interacts with other therapy variables. For example, adherence positively predicts therapeutic alliance (Brauhardt et al., 2014; Loeb et al., 2005). Patient adherence in CBT is often measured in terms of completed homework tasks. The use of homework allows patients to apply skills that they have learned in-session to situations outside of therapy, thereby generalising these skills to natural settings (Kazantzis & Lampropoulos, 2002). Alfonsson, Olsson and Hursti (2015) found that a greater number of homework exercises completed by patients predicts better patient outcomes, and a meta-analysis by Mausbach, Moore, Roesch, Cardenas and Patterson (2010) found a small to medium effect of homework compliance on patient outcome.

One of the roles of a supervisor is to ensure that therapists adhere to therapy protocols, with the aim of giving patients the best possible outcome (Milne & James, 2000). A number of studies have found that supervision does indeed increase therapist adherence (e.g., Beidas et al., 2012; Sholomskas et al., 2005). However, studies in Chapters 4 and 5 of this thesis demonstrate that supervisors treat therapists and patients differently, depending on their personal characteristics and the characteristics of the supervisors themselves (Simpson-Southward et al., 2016; 2018).

The need to ensure adherence is particularly important for behavioural aspects of CBT. Clinicians often fail to implement such aspects of therapy, despite evidence suggesting these are the more powerful elements of CBT (Dimidjian et al., 2006; Jacobson et al., 1996). As these aspects of therapy can be anxiety-provoking for the patient, this lack of adherence might be explained as a desire on the part of the clinician to protect the patient from short-term distress (e.g., Meehl, 1973). However, this clinician decision can come at the cost of patient recovery in the long-term (Waller & Turner, 2016). It is important to understand why it is that such decisions are made in order to assist supervisors in identifying situations where they might be at risk of delivering therapy sub-optimally.

Therefore, the aim of this set of three mini-studies is to investigate how the characteristics of patients, therapists, and supervisors interact in order to impact the way in which supervisors react to non-adherence. Specifically, the studies will consider non-adherence to a key behavioural aspect of CBT for depression – behavioural activation. It is expected that some supervisee characteristics (e.g., a lack of experience, anxiety), and patient characteristics (e.g., complexity of case) will lead supervisors to avoid encouraging a return to behavioural activation. It is also expected that there will be an interaction of both supervisee and patient characteristics in determining supervision focus. Finally, it is expected that supervisors will fall into natural groupings according to their stated supervisory focus and these groups will be related to the supervisors’ own characteristics (e.g., anxiety, self-esteem). Each mini-study will use a different set of six vignettes, the details of which are outlined below, along with specific aims and hypotheses for each study.

## 6.2 General method

### 6.2.1 Participants

The participants were a sample of 53 clinical supervisors, supervising clinicians delivering CBT to patients with depression. These supervisors took part in all three studies. The supervisors were recruited through email lists of members of CBT organisations across Europe (84.9% currently worked in the UK, 9.4% in Italy, 3.8% in Denmark, and 1.9% in Sweden). The mean age of the group was 49.2 years (*SD* = 9.25 years, range = 29-67 years) and 64.2% were female. Although all participants were working as clinical supervisors, only 35.8% were accredited supervisors. The mean amount of time the participants had been using CBT to treat depression was 12.9 years (*SD* = 6.90 years, range = 1.5-35 years). The participants had a range of background professions, including: clinical psychology (*N* = 13), nursing (*N* = 12), Improving Access to Psychological Therapies (IAPT) services (*N* = 8), and counselling psychology (*N* = 5).

#### *6.2.1.1 Sample size estimation*

A sample size analysis was performed using G\*Power (Faul et al., 2007) to determine the number of participants needed. For a medium to large effect size (with an alpha of .05 and power of 0.80), the sample size required was between 52 and 90. As both medium and large effect sizes were found in the studies in Chapters 4 and 5, the sample size of 53 was deemed adequate for the current study.

### 6.2.2 Measures and procedure

The three mini-studies were all delivered via one questionnaire pack. Participants completed the online questionnaire (hosted by the website Qualtrics) using a link sent in an email. A sample questionnaire is in Appendix 6B. Participants read an information sheet and gave consent before starting the study. After filling out demographic information, participants were presented with three case vignettes (one from each of the three studies outlined below). The vignettes were presented in a random order. See Section 4.3.4 for further details on the vignette development.

After each vignette, participants were asked what they would focus on in supervision, given each case. Focus was measured from 0 (‘I would not focus on this’) to 100 (‘I would focus entirely on this’). The questions referred to three general aspects of supervision (therapeutic techniques, therapeutic alliance, and case management issues). These aspects were based on three main functions of supervision often described in the literature. The functions are described by Proctor (1988) as ‘formative’ (education and development of the supervisee), ‘normative’ (managerial and ethical responsibilities), and ‘restorative’ (emotional aspects of work). Kadushin (1976) describes the same functions as ‘educational’, ‘managerial’, and ‘supportive’.

Following the vignettes, participants filled out two measures. The first was the 12-item version of the Intolerance of Uncertainty Scale (IUS; Carleton et al., 2007), and the second was the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965). For further details about these two measures, see Section 4.3.4.

### 6.2.3 Ethics

This research was approved by the University of Sheffield's Department of Psychology Research Ethics Committee (see Appendix 6A).

## 6.3 Study 3a – Patient non-adherence and the role of supervisee gender and anxiety

## 6.3.1 Background and aims

Supervisors have been found to treat their male and female supervisees differently, depending on the supervisee’s level of anxiety (see Chapter 5). Supervisors focus their calmer female supervisees more on therapeutic techniques, relative to state anxious female supervisees. In contrast, male supervisees are supervised in the same way regardless of their anxiety. In addition, supervisors’ own characteristics have been found to affect their recommendations in supervision. For example, supervisors who focus supervisees on case management issues are more likely to be anxious, whereas those who focus on both alliance and technique tend to have higher self-esteem (see Chapter 4).

The current study will investigate the recommendations that supervisors give to their supervisees when the patient is not adhering to the treatment methods for depression, as previously agreed upon by the supervisor and supervisee. It will consider whether such recommendations differ depending on the personal characteristics of the supervisee and supervisor.

The first aim is to explore how the gender and anxiety of supervisees impact on advice given by the supervisors. The following hypotheses are proposed:

1. supervisors will direct their female supervisees in different ways according to the supervisee’s anxiety. Calm female supervisees will be directed back to the originally suggested course of action (behavioural activation), whereas anxious female supervisees will not.
2. male supervisees will be given the same directions by the supervisors, regardless of their anxiety.

The second aim of this study is to investigate whether patterns of supervisor focus fall into natural groupings, and whether such groups are validated by the supervisors’ own characteristics. Two hypotheses are proposed:

1. anxious supervisors will not encourage the supervisee to return to the therapeutic techniques
2. supervisors with higher self-esteem will encourage supervisees to return to therapeutic techniques.

## 6.3.2 Method

Please refer back to Section 6.2 or further detail on participants, measures and procedures, and ethics.

### 6.3.2.1 Design

This was a between-subject, survey-based, experimental design. The independent variables were the level of supervisee anxiety (state anxious/trait anxious/calm) and the supervisee gender as outlined in the vignettes. Appendix 6C contains the full vignettes. The dependent variable was the supervisor reaction (the guidance that they would give to the supervisees).

### 6.3.2.2 Data analysis

To assess the overall pattern of focus in supervision, a repeated-measures ANOVA was carried out. Addressing the first aim, a two-way ANOVA was used to assess encouragement to return to behavioural activation, and a MANOVA was used to assess general supervision focus given to different supervisees. To address the second aim, a two-step cluster analysis was carried out to identify supervisor ‘types’. These clusters were then validated against other measures using chi-squared tests and one-way ANOVAs.

## 6.3.3 Results

### 6.3.3.1 Overall focus in supervision

Totals for focus on case management, alliance and technique were calculated by taking the overall mean of the aspects in each category. There was a significant difference in the supervisors’ overall focus on case management, alliance, and technique, regardless of the type of clinician (*F*(2,104) = 61.89, *p* < .001). Supervisors focused most on the alliance (*M* = 51.89, *SD* = 20.58), then case management (*M* = 43.43, *SD* = 20.56), and least on technique (*M* = 29.64, *SD* = 16.49).

Supervisors focused more on returning to behavioural activation (*M* = 46.98, *SD* = 28.26) than therapeutic techniques in general (*t*(52) = 4.90, *p* < .001). However, there was no difference between behavioural activation focus and either alliance focus (*t*(52) = 1.40, *p* = .169) or case management focus (*t*(52) = 1.18, *p* = .243).

### 6.3.3.2 Supervisor focus on returning to behavioural activation given different supervisees

There was no main effect of supervisee gender (*F*(1, 47) = 1.063, *p* = .308)or anxiety (*F*(2, 47) = 1.790, *p* = .178) on whether supervisors suggested returning to behavioural activation. However, further analysis revealed that supervisors focused more on the return to behavioural activation with state anxious females than with trait anxious females, *t*(12.88) = 2.62, *p* = .021 (see Table 6.1).

The interaction effect was not significant *F*(2,47) = 3.128, *p* = 0.053. However, further analysis revealed some gender-specific results regarding the focus on behavioural activation for trait anxious females. Supervisors focused less on the return to behavioural activation with trait anxious females than with trait anxious males, *t*(14) = 2.564, *p* = .022. Although it did not reach significance, there also appears to be a trend for supervisors to focus trait anxious females less on behavioural activation than state anxious males (*t*(16) = 2.115, *p* = .051), and calm males (*t*(16) = 2.108, *p* = .051). These differences are shown in Table 6.1.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Vignette type | | Male trait anxious | |  | Male calm | |  | Female state anxious | |  | Female trait anxious | |  | Female calm | |
|  | ***M* (*SD*)** | ***t*** | ***p*** |  | ***t*** | ***p*** |  | ***t*** | ***p*** |  | ***t*** | ***p*** |  | ***t*** | ***p*** |
| Male state anxious | 50.00 (26.46) | 0.532 | .603 |  | 0.302 | .767 |  | 0.929 | .367 |  | 2.115 | .051 |  | 0.804 | .432 |
| Male trait anxious | 57.14 (26.90) | - | |  | 0.896 | .386 |  | 0.426 | .676 |  | 2.564 | .022\* |  | 1.350 | .197 |
| Male calm | 46.67 (20.00) | - | |  | - | |  | 1.231 | .242 |  | 2.108 | .051 |  | 0.580 | .570 |
| Female state anxious | 64.44 (38.44) | - | |  | - | |  | - | |  | 2.622 | .021\* |  | 1.602 | .134 |
| Female trait anxious | 25.56 (22.42) | - | |  | - | |  | - | |  | - | |  | 1.502 | .151 |
| Female calm | 41.00 (22.34) | - | |  | - | |  | - | |  | - | |  | - | |
| \* significant at the .05 level | | | | | | | | | | | | | | | |

Table 6.1. *t*-tests showing difference in behavioural activation focus given different supervisees.

### 6.3.3.3 Supervisor focus on case management, alliance, and technique given different supervisees

There were no significant main effects of clinician gender or anxiety on case management, alliance, and technique focus. There was also no overall interaction effect (all *p* > .05). Further analyses indicated a greater case management focus for male state anxious cases (*M* = 57.78, *SD* = 18.34) than female trait anxious cases (*M* = 33.33, *SD* = 25.35; *t*(16) = 2.343, *p* = .032), and female calm cases (*M* = 36.20, *SD* = 14.25; *t*(17) = 2.88, *p* = .01). In addition, there was a greater technique focus for male state anxious cases (*M* = 44.05, *SD* = 20.04) than female calm cases (*M* = 24.07, *SD* = 7.10; *t*(9.80) = 2.835, *p* = .018).

### 6.3.3.4 Summary of results addressing Aim 1

Results have indicated that all male supervisees are given the same direction by their supervisor, regardless of their anxiety level. However, female supervisees are treated differently depending on their anxiety levels. In addition, results indicate that female supervisees are also treated differently to their male colleagues. Trait anxious females in particular, are unlikely to be directed back towards behavioural activation techniques.

### 6.3.3.5 Supervisor cluster analysis

Using the supervisors’ total scores for the degree to which they would focus on different therapy elements (alliance, techniques, case management), two-step cluster analysis provided a four-cluster solution. The first cluster (30.2% of the sample) had little focus on any aspect of supervision and is referred to as *Unfocused*. The second cluster (34.0% of the sample) had a moderate focus on all aspects of supervision, referred to as *Moderate Focus*. The third cluster (17.0% of the sample) had the greatest focus on all aspects of supervision, referred to as *High Focus*. The final cluster (18.9% of the sample) had a high focus on both alliance and case management but a low to moderate focus on technique, referred to as *Low Technique Focus*.

#### 6.3.3.5.1 Clinical validation of clusters

Using one-way ANOVAs, the four clusters were compared on participant characteristics. Those in the *High Focus* group had been qualified for longer (*M* = 24.56, *SD* = 12.21) than those in all of the other clusters (*Unfocused* *M* = 14.63, *SD* = 8.62, *Moderate Focus* *M* = 12.72, *SD* = 7.41*, Low Technique Focus* *M* = 9.25, *SD* = 7.55, *F*(3,49) = 5.40, *p* = .003). Those in the *High Focus* group (*M* = 18.22, *SD* = 7.87) had also been using CBT for depression for longer than those in the *Moderate Focus* group (*M* = 12.11, *SD* = 5.06) and those in the *Low Technique Focus* group (*M* = 8.45, *SD* = 4.36, *F*(3,49) = 3.821, *p* = .015). No categorical participant variables were found to be associated with the clusters.

### 6.3.3.6 Summary of results addressing Aim 2

Supervisors fell into four natural groups and these were differentiated by the amount of focus supervisors gave to the three core aspects of supervision. Only around two fifths of supervisors indicated a high focus on alliance and case management work and less than one fifth indicated a high focus on all three core aspects of supervision. These groups were not related to participant anxiety or self-esteem but were related to time since qualification and time using CBT for depression.

## 6.3.4 Discussion

This study investigated the reaction of supervisors guiding supervisees who were experiencing non-adherence to behavioural activation from their patients with depression. The first aim was to explore how the gender and anxiety of the supervisees impacted the advice given by supervisors. It was expected that female supervisees would be guided in different ways depending on their anxiety level - specifically that calm female supervisees would be directed back to behavioural activation more than anxious female supervisees. This hypothesis was not supported. However, state anxious females were directed back to behavioural activation more than trait anxious females. The second hypothesis, that male supervisees would be treated in the same way regardless of their anxiety, was supported. These findings indicate that both gender and anxiety can impact the way clinicians are guided, irrespective of the patient who they are treating.

The second aim of this study was to investigate whether patterns of supervisor focus fall into natural groupings, and whether such groups are validated by the supervisors’ own characteristics. Although supervisors low in anxiety or high in self-esteem did not direct supervisees more towards therapeutic techniques (as predicted), four supervisor ‘types’ emerged from the data, and these were related to characteristics of the supervisors.

These findings support previous work indicating that supervisors have biases in how to direct their supervisees (Dennhag et al., 2012; Simpson-Southward et al., 2016). In the current study, there appears to be a specific effect relating to trait anxious female supervisees. This group was encouraged to return to behavioural activation less than state anxious females. Perhaps supervisors are reluctant to push those with trait anxiety, believing them to lack the coping mechanisms required to handle the lack of adherence. In contrast, state anxious supervisees could be perceived as more robust and able to overcome anxieties surrounding their work.

However, this does not explain why trait anxious female therapists are treated differently to trait anxious males. One possible explanation is that supervisors might feel that female therapists are more likely to pick up on cues indicating problems in therapy. Therefore, supervisors might take concerns from female supervisees more seriously and might not push for behavioural activation. Alternatively, supervisors might assume females are more vulnerable to anxiety-related issues, by virtue of their gender (e.g., Leahy et al., 2012). For this reason, supervisors might be reluctant to ask female clinicians to push their clients, believing that these supervisees could lack the ability to cope with potential conflict. However, such concern over female performance would be unfounded, as previous research has shown therapist gender to have little consistent impact on therapy performance and patient outcome, with females sometimes performing better than males (Branson & Shafran, 2015; Huppert at al., 2001).

This lack of focus on behavioural activation for trait anxious females does not mean there is a lack of focus on therapeutic techniques in general. Supervisors indicated that they would give the same amount of focus to therapeutic techniques for trait anxious females as they would for any of the other supervisees. There are two possible explanations for this. First, there is something specific about encouraging behavioural activation that supervisors feel this group of supervisees will struggle with. In a similar way to exposure-based methods for anxiety disorders (Schumacher et al., 2014), behavioural activation might be viewed as more anxiety-provoking than other aspects of therapy as it requires the patient to be pushed out of their comfort zone. Anxious therapists often exclude such methods, but male and female therapists exclude exposure work to the same extent (Meyer et al., 2014). A second explanation is that supervisors are reluctant to enforce a technique that has not been adhered to, regardless of which technique it is. Supervisors might believe trait anxious females are unable to get therapy back on track without causing friction in the therapeutic relationship. However, as stated previously, gender has no consistent impact on therapeutic performance (Branson & Shafran, 2015; Huppert at al., 2001).

In addition to therapist characteristics, supervisor characteristics also impact the guidance given in supervision. Four types of supervisor emerged from the sample. The first three differed by the amount of focus given to all aspects of supervision; these groups are described as *Unfocused*, *Moderate Focus*, and *High Focus*. The *High Focus* group is the smallest of these three groups, representing less than one fifth of the sample of supervisors, whereas the *Unfocused* and *Moderate Focus* represent almost two thirds. This indicates that a majority of supervisors lack a clear focus in their supervision session, which is perhaps unsurprising given the unfocused and confusing nature of clinical supervision models (Simpson-Southward et al., 2017).

The final group of supervisors, *Low Technique Focus*, indicate a high focus on both alliance and case management issues but little focus on the therapeutic techniques. This pattern of focus is contrary to both the supervision models literature and CBT theory. The majority of supervision models indicate a focus on techniques, whereas less than two thirds focus on emotional aspects of work or managerial and ethical responsibilities (Simpson-Southward et al., 2017). Similarly, Beck et al. (1979) outline the alliance as necessary in therapy, but emphasise techniques as key to ensuring patient change. This lack of technique focus might be attributed to supervisors not wishing to upset or ‘break’ the presumably ‘fragile’ patient (Meehl, 1973) who is not adhering to therapeutic techniques.

Previous results exploring the relationship between therapist experience and therapy outcomes have been mixed. Some previous research has indicated that greater therapist experience has no impact on treatment outcome (Franklin, Abramowitz, Furr, Kalsy & Riggs, 2003; Okiishi et al., 2006), some suggests a positive impact (Eells, Lombart, Kendjelic, Turner & Lucas, 2005), and some suggests a negative impact (Shapiro & Shapiro, 1982). The current study found that those with greater experience tended to have a high focus on all aspects of supervision – a pattern of focus described as necessary for successful supervision (Kadushin, 1979; Proctor, 1988). Having more experience is perhaps beneficial specifically when working with non-adhering patients – a group who might be viewed as more difficult to treat. This explanation resonates with results from Mason et al. (2016), who found that qualified therapists only outperform trainees when working with patients with severe anxiety (rather than mild or moderate). The impact of experience upon supervision is explored further in Study 3b.

## 6.4 Study 3b – Patient non-adherence and the role of patient complexity and supervisee experience

## 6.4.1 Background and aims

As discussed in the previous section, the relationship between therapist experience and therapeutic outcome is somewhat unclear. For example, case formulation ratings of expert therapists have been found to be more comprehensive, elaborate, and complex than those of novice or of experienced clinicians (Eells et al., 2005). However, other studies have found that clinical experience is negatively associated with symptom change (Bjaastad et al., 2018; Goldberg et al., 2016). Witteman and van de Bercken (2007) found a third relationship between experience and outcome. Their results indicated an intermediate effect; intermediate level clinicians had a worse diagnostic classification performance than either novice or experienced clinicians. Looking specifically at the role of experience within the context of supervision, Ost, Karlstedt and Widen (2012) found that supervision by experienced therapists could be used to support inexperienced student therapists to achieve treatment effects that are on par with those of experienced therapists.

A number of supervision models highlight the development of supervisees as they gain experience as a therapist (e.g., Hess, 1986; Hogan, 1964; Rigazio-DiGilio & Anderson, 1994). These models recommend that supervisors should treat their supervisees of different experience levels in different ways, often suggesting a heavy focus on educational approaches for low-level supervisees but peer work for higher levels (e.g., Hogan, 1964; Stotenberg & Delworth, 1987). Some empirical research suggests that such variation in supervision does happen in practice (Stoltenberg, McNeill & Crethar, 1994). The meta-analysis in Chapter 3 found that supervision has a medium to large positive effect on trainee clinicians’ outcomes but a non-significant effect for qualified outcomes. That difference might be due to this differential treatment of trainees and those who are qualified in supervision.

When allocating new patients to therapists, there is sometimes an assumption that trainee or inexperienced therapists should be allocated patient cases that are mild in complexity (Mason et al., 2016). In addition, some supervision models suggest that the supervisor should choose patients for their supervisees depending on the experience level of the therapists (e.g., Grater, 1985). Such an approach appears to be supported by Mason et al. (2016), who found that trainee therapists achieve the greatest symptom change with moderate anxiety cases, whereas experienced therapists elicit the greatest symptom change with severe anxiety cases.

As highlighted in Chapter 4, supervisors make different recommendations to their supervisees, depending on the complexity of their patient case. Supervisors focused more on therapeutic techniques in supervision when the patient case was straightforward or complex than when the patient case was diffuse. It is possible that when making such recommendations in supervision, the supervisor also takes the experience of the therapist into account.

Therefore, this study investigated the recommendations that supervisors give to their supervisees when the patient is not adhering to the behavioural activation methods previously suggested by the supervisor and supervisee. The first aim is to determine whether such recommendations differ according to the case – specifically, whether supervision focus varies with the complexity of the patient case and the experience level of the supervisee. The following hypotheses are proposed:

* 1. supervisors will have a greater focus on techniques for inexperienced therapists, as they might require a more educative approach.
  2. behavioural activation, specifically, will be emphasised more with experienced therapists.
  3. supervisors will indicate a greater technique focus for straightforward and complex cases than for diffuse cases.
  4. supervisors will recommend returning to therapeutic techniques based on an interaction between therapist experience and patient complexity.

The second aim of this study is to determine whether supervisors fall into natural groupings given their supervision focus, and whether these groups are validated by the supervisors’ own characteristics. It is hypothesised that:

1. supervisors who experience high anxiety will suggest returning to therapeutic techniques less than supervisors with low anxiety will.
2. supervisors with high self-esteem will stress returning to therapeutic techniques more than those with low self-esteem will.

## 6.4.2 Method

Please refer back to Section 6.2 or further detail on participants, measures and procedures, and ethics.

### 6.4.2.1 Design

This was a between-subject, survey-based, experimental design. The independent variables were the level of supervisee experience (inexperienced/experienced) and the complexity of the patient’s case (straightforward/diffuse/complex) as outlined in the vignettes. Appendix 6D contains the full vignettes. The dependent variable was the supervisor reaction (guidance given to the supervisees).

### 6.4.2.2 Data analysis

To assess the overall pattern of focus in supervision, a repeated measures ANOVA was carried out. A two-way ANOVA was used to assess encouragement to return to behavioural activation and a MANOVA was used to assess general supervision focus given different supervisees. Finally, a two-step cluster analysis was conducted to identify supervisor ‘types’. These clusters were validated using one-way ANOVAs and chi-squared tests.

## 6.4.3 Results

### 6.4.3.1 Overall focus in supervision

Totals were calculated for focus on case management, alliance and technique, by taking the overall mean of the aspects in each category. There was a significant difference in the supervisors’ overall focus on case management, alliance, and technique, regardless of the type of clinician or patient (*F*(2,104) = 40.81, *p* < .001). Supervisors focused most on the alliance (*M* = 51.51, *SD* = 23.24), then case management (*M* = 42.75, *SD* = 17.91), and least on technique (*M* = 30.78, *SD* = 16.77).

Supervisors focused more on returning to behavioural activation (*M* = 47.63, *SD* = 29.95) than on therapeutic techniques in general (*t*(52) = 4.55, *p* < .001). However, there was no difference between behavioural activation focus and either alliance focus (*t*(52) = 1.07, *p* = .290) or case management focus (*t*(52) = 1.36, *p* = .180).

### 6.4.3.2 Supervisor focus on returning to behavioural activation given different supervisees and patients

There was no main effect of supervisee experience (*F*(1, 47) = 0.001, *p* = .975)or of patient complexity (*F*(2, 47) = .671, *p* = .516) on whether supervisors suggest returning to behavioural activation. The interaction of supervisee experience by patient complexity was also non-significant (*F*(2,47) = 1.527, *p* = .228).

### 6.4.3.3 Supervisor focus on case management, alliance, and technique given different supervisees

There were no significant main effects of clinician experience or patient complexity on case management, alliance, and technique focus. There was also no overall interaction effect (all *p* > .05).

### 6.4.3.4 Supervisor cluster analysis

Using the supervisors’ total scores for the degree to which they would focus on different therapy elements (alliance, techniques, case management), two-step cluster analysis provided a two-cluster solution. The first cluster (30.2% of the sample) had little focus on any aspect of supervision and are referred to as *Unfocused*. The second group (69.8% of the sample) have a moderate focus on all aspects of supervision and are therefore referred to as *Moderate Focus*.

#### 6.4.3.4.1 Clinical validation of clusters

None of the participant variables were found to be associated with cluster membership.

## 6.4.4 Discussion

This study explored supervision of therapists working with patients who were not adhering to the behavioural activation components of CBT. The first aim was to investigate how the experience of the therapist and the complexity of the patient case impact the guidance given in supervision sessions. None of the hypotheses relating to therapist experience or patient complexity were confirmed. Supervisors indicated that they would focus on therapeutic technique (and on behavioural activation more specifically) to the same extent regardless of whether the therapist was experienced or inexperienced and regardless of whether the patient case was straightforward, diffuse or complex. There was also no interaction between therapist and patient characteristics. Addressing the second aim of this study – investigating the natural groupings of supervisors – two supervisor ‘types’ emerged from the data. However, these were not validated by any supervisor characteristics.

The lack of impact of therapist experience and patient complexity might appear contrary to previous research on supervision (e.g., Simpson-Southward et al., 2018; Stoltenberg, McNeill & Crethar, 1994) and therapy outcomes (Bjaastad et al., 2018; Eells et al., 2005; Goldberg et al., 2016; Mason et al., 2016; Witteman & van de Bercken, 2007). However, in the current study it is possible that the added element of non-adherence played a key role. The supervisors are perhaps basing their recommendations purely on the lack of adherence to behavioural activation, rather than on the qualities of the patients and therapists. This would appear to be a logical approach to take, given that successful completion of such between-session tasks in cognitive therapy for depression has a positive impact on patient outcomes (Detweiler & Whisman, 2006).

The finding that supervisors focused on a return to behavioural activation more than general therapeutic techniques also supports the notion that the non-adherence is playing a key role in supervisory recommendations. Alliance and case management were focused on to the same extent as behavioural activation, perhaps indicating supervisors feel they are important when dealing with non-adherence. However, as none of these aspects were focused on to a great extent (as shown in the cluster analysis finding that participants either fall into either an *Unfocused* or *Moderate Focus* group), this outcome might also indicate a lack of clear focus in supervision. As with Study 3a, this pattern could be viewed as a reflection of the lack of clarity in the supervision models literature (Simpson-Southward et al., 2017).

## 6.5 Study 3c – Supervisee non-adherence and the role of supervisee gender and anxiety

## 6.5.1 Background and aims

The previous two mini-studies in this chapter focused on how supervisors react to patients not adhering to the behavioural activation aspects of therapy. Reluctance from patients might be unsurprising, given that such techniques push patients to engage in behaviours considered to be out of their comfort zone (Kanter, Busch & Rusch, 2009). Something that is perhaps more surprising is when therapists do not adhere to core aspects of therapy – a phenomenon known as therapist drift (Waller, 2009). Various research has indicated that therapist drift is a common occurrence (e.g. Becker, Zayfert & Anderson, 2004; Stobie et al., 2007; Waller et al., 2012). It is often assumed that clinical supervision will ensure therapist adherence (Lambert & Ogles, 1997), and thus contribute to positive patient outcomes (Ellis & Ladany, 1997; Milne & James, 2000). However, supervisors do not always treat their supervisees equally (Dennhag et al., 2012, Simpson-Southward et al., 2016), and sometimes their own anxieties can interfere with the supervision process (Simpson-Southward et al., 2018). This study will investigate how supervisors react to non-adherence from their supervisees and whether the characteristics of the supervisors or supervisees affect the advice given.

The first aim is to explore whether the recommendations given in supervision differ according to the characteristics of the supervisee. The following hypotheses are proposed:

1. supervisors will direct female supervisees in different ways according to the supervisee anxiety. Calm female supervisees will be directed back to the original course of action (behavioural activation), whereas, anxious female supervisees will not.
2. male supervisees will be given the same directions by the supervisors, regardless of their anxiety.

The second aim of this study is to investigate whether patterns of supervisor focus fall into natural groupings, and whether such groups are validated by the supervisors’ own characteristics. Two hypotheses are proposed:

1. anxious supervisors will not encourage the supervisee to return to the therapeutic techniques
2. supervisors with higher self-esteem will encourage supervisees to return to therapeutic techniques.

## 6.5.2 Method

Please refer back to Section 6.2 or further detail on participants, measures and procedures, and ethics.

### 6.5.2.1 Design

This was a between-subject, survey-based, experimental design. The independent variables were the level of supervisee anxiety (state anxious/trait anxious/calm) and the supervisee gender as outlined in the vignettes. Appendix 6E contains the full vignettes. The dependent variable was the supervisor reaction (guidance given to the supervisees).

### 6.5.2.2 Data analysis

To assess the overall pattern of focus in supervision, a repeated measures ANOVA was carried out. A two-way ANOVA was used to assess encouragement to return to behavioural activation, and a MANOVA was used to assess general supervision focus given different supervisees. A two-step cluster analysis was used to identify supervisor ‘types’, and these clusters were validated using one-way ANOVAs and chi-square tests.

## 6.5.3 Results

### 6.5.3.1 Overall focus in supervision

Totals for focus on case management, alliance, and technique were calculated by taking the overall mean of the aspects in each category. There was a significant difference in the supervisors’ overall focus on case management, alliance, and technique, regardless of the type of clinician (*F*(1.77, 92.16) = 70.36, *p* < .001). Supervisors focused most on the alliance (*M* = 53.46, *SD* = 21.37), then case management (*M* = 42.04, *SD* = 18.52), and least on technique (*M* = 29.89, *SD* = 16.54).

Supervisors focused more on returning to behavioural activation (*M* = 56.04, *SD* = 26.77) than therapeutic techniques in general (*t*(52) = 7.25, *p* < .001) or case management aspects (*t*(52) = 3.94, *p* < .001). However, alliance work was focused on to the same extent as behavioural activation (*t*(52) = .645, *p* = .522).

### 6.5.3.2 Supervisor focus on returning to behavioural activation for different supervisees

There was no main effect of supervisee gender (*F*(1, 47) = 1.896, *p* = .175)or supervisee anxiety (*F*(2, 47) = 1.205, *p* = .309) on whether supervisors suggest returning to behavioural activation. The interaction of supervisee gender by supervisee anxiety was non-significant (*F*(2,47) = 1.142, *p* = .328). However, further planned comparisons revealed that supervisors suggested a greater focus on behavioural activation for calm female clinicians (*M* = 63.0, *SD* = 30.20) than for trait anxious female clinicians (*M* = 35.0, *SD* = 10.0, *t*(11.92) = 2.60, *p* = .023).

### 6.5.3.3 Supervisor focus on case management, alliance, and technique given different supervisees

There were no significant main effects of clinician experience or patient complexity on case management, alliance, or technique focus. There was also no overall interaction effect (all *p* > .05).

### 6.4.3.4 Supervisor cluster analysis

Using the supervisors’ total scores for the degree to which they would focus on different therapy elements (alliance, techniques, case management), two-step cluster analysis provided a three-cluster solution. The first cluster (24.5% of the sample) had a low focus on all aspects of supervision, referred to as *Unfocused*. The second cluster (56.6% of the sample) had a moderate focus on all supervision aspects and is referred to as the *Moderate Focus* group. The final cluster (18.9% of the sample) had a high focus on all aspects of supervision, referred to as the *High Focus* group.

#### 6.4.3.4.1 Clinical validation of clusters

The only participant characteristic that was associated with cluster membership was the number of manuals that the supervisors used (*F*(2, 50) = 3.77, *p* = .03). Those in the *Moderate Focus* cluster (*M* = 0.90, *SD* = 1.13) indicated that they used more manuals than those in the *Unfocused* (*M* = 0.23, *SD* = 0.56) or *High Focus* cluster (*M* = 0.15, *SD* = 0.47).

## 6.5.4 Discussion

This study investigated the content of supervision sessions when therapists are not adhering to the behavioural activation components of CBT. The first aim focused on how the anxiety and gender of the supervisee affects the advice given in such sessions. It was expected that female supervisees would be treated differently according to their anxiety levels but that male supervisees would be treated in the same way regardless of their anxiety. These two hypotheses were supported. Supervisors focused calm female supervisees back on behavioural activation more than trait anxious female supervisees, whereas all male supervisees were given the same guidance.

The second aim of this study was to investigate whether patterns of supervisor guidance fall into natural groupings, and whether such groups are validated by the supervisors’ own characteristics. Although supervisors low in anxiety or high in self-esteem did not direct supervisees more towards therapeutic techniques (as was predicted), three supervisor ‘types’ emerged from the data. These were related to the number of manuals used by the supervisors.

Although trait anxious female supervisees were not directed back towards behavioural activation to the same extent as calm female supervisees, all supervisees (regardless of gender and anxiety level) were focused on general therapeutic techniques to the same extent. This is a similar pattern of results to those found in study 3a, and could be due either to the effect of non-adherence specifically to behavioural activation, or to the lack of adherence in general from the supervisee. Looking first at behavioural activation, perhaps it is seen as anxiety-provoking in a similar way to exposure-based methods in anxiety disorder therapies (Schumacher et al., 2014). However, this does not explain why male and female supervisees are treated differently, as both therapist genders avoid exposure work to a similar extent (Meyer et al., 2014).

Turning to the lack of adherence from supervisees, Bearman et al. (2013) found that discussion of evidence-based practice in supervision predicted adherence from male, but not from female supervisees. Therefore, discussion of such techniques with female supervisees might be viewed as unproductive, and supervisors are perhaps choosing to focus their attention on other aspects of supervision. In addition, supervisors might feel that female supervisees are more likely to pick up on alliance problems in therapy. Staczan et al. (2017) found that patients report higher alliance ratings with female (rather than male) therapists. This might lead to supervisors taking avoidance of and anxiety surrounding certain techniques by female therapists more seriously than those of their male colleagues. Therefore, encouragement back to such techniques is held off. However, it must be noted that although there is evidence of higher alliance ratings for female therapists, Staczan et al. (2017) found that this does not translate to better patient outcomes.

Regarding supervisor ‘types’, the majority of supervisors in this study appeared to lack a strong focus, falling into either the *Unfocused* group or the *Moderate focus* group. This pattern is similar to those found in the other two mini-studies in this chapter. This lack of clear focus could indicate that supervisors are unsure of the best course of action when dealing with non-adherence from their supervisees. However, as supervisors focused on the alliance over other aspects of supervision this might be showing that supervisors are using alliance work to deal with non-adherence. Indeed, alliance work is positively associated with aspects of therapist adherence (Patton & Kivlighan, 1997). Therefore, perhaps a better explanation for the general lack of focus from supervisors is that it is a reflection of the lack of focus in the supervision models literature (Simpson-Southward et al., 2017) and lack of clear protocols in the empirical literature (Chapter 3).

## 6.6 General Discussion

This chapter consisted of three mini-studies, investigating supervisor recommendations in supervision for CBT therapists working with depression. Vignettes were presented to supervisors in all three studies. These vignettes contained a scenario where either their supervisee or patient was not adhering to the behavioural activation techniques that were previously agreed upon. Characteristics of both the supervisees and the supervisors themselves had an impact on the content of supervision. However, patient characteristics did not affect supervisory focus.

### 6.6.1 Impact of supervisee characteristics

Along with previous research (Dennhag et al., 2012; Simpson-Southward et al., 2016), these results indicate that supervisors have biases towards their supervisees. Within this set of studies, trait-anxious female supervisees in particular were treated differently to other supervisees. This treatment might be due to reluctance from supervisors to push anxious supervisees towards behavioural activation, which is a potentially anxiety-provoking aspect of therapy. However, this ‘protective’ style does not explain why this happens to female supervisees in particular. Both male and female therapists avoid such aspects of therapy to the same extent (Meyer et al., 2014). In addition, any concern over female performance in general would be unfounded as previous research has shown therapist gender to have little consistent impact on therapy performance and patient outcome, with females sometimes performing better than males (Branson, & Shafran, 2015; Huppert at al., 2001).

The differential treatment of trait anxious female supervisees might be better explained through the presence of non-adherence, regardless of what that non-adherence is to. It is possible that supervisors view their female supervisees as more vulnerable to anxiety related issues. Therefore, they might believe that pushing such supervisees into potential conflict with a non-adhering patient might leave them unable to cope. Alternatively, supervisors might expect female supervisees to pick up on alliance issues in therapy, making the supervisors take female therapists’ anxiety and reticence around techniques more seriously (regardless of the lack of evidence-based justification). Furthermore, discussion of techniques in supervision only predicts adherence from male supervisees (Bearman et al., 2013). Therefore, discussion of such techniques with female supervisees could be viewed as unproductive by supervisors.

### 6.6.2 Supervisor types

Turning to the characteristics of the supervisors themselves, ‘types’ of supervisor were discovered in all three mini-studies. The most striking finding is that throughout all three studies, the majority of supervisors lacked a strong focus on any of the core aspects of supervision. This lack of focus could be due to the presence of non-adherence, leaving the supervisor unsure of how to proceed in order to achieve a successful outcome. If this is the case, then these results are concerning, given that a lack of adherence from both patients and therapists is far from an uncommon occurrence in therapy (Becker, Zayfert & Anderson, 2004; Mausbach et al., 2010; Stobie et al., 2007; Waller et al., 2012).

The general lack of focus from supervisors reflects the confused nature and lack of clarity in the supervision model literature (Simpson-Southward et al., 2017). The absence of supervision protocols from many of the empirical studies investigating supervision outcomes might also add confusion around the best way in which to conduct supervision (Chapter 3). Of particular note is that throughout all three mini-studies, the pattern of focus from supervisors is contradictory to the general focus of the supervision model literature. Supervisors in the current series of studies had a greater focus on alliance and case management aspects of therapy. In contrast, more supervision models emphasise the use of techniques than stress the use of alliance or case management aspects (Simpson-Southward et al., 2017). This low technique focus from the supervisors is also contradictory to therapy manuals, which emphasise techniques as key to patient change (Beck et al., 1979).

The avoidance of technique-focused work from supervisors is perhaps explained by the presence of non-adherence. Supervisors might be worried about upsetting or ‘breaking’ the ‘fragile’ patient or therapist (Meehl, 1973) who is not adhering to therapeutic techniques. Therefore, supervisors are turning to more comfortable aspects of supervision (alliance and case management work). Indeed, Meehl (1973) points out that many clinicians anticipate that their patients will be stressed by active therapy demands, and therefore avoid making such demands in the first place. It is possible that supervisors will do the same, and fail to make demands of their supervisees, particularly if they are female and relatively anxious.

In avoiding making their supervisees uncomfortable, supervisors might be hoping to ensure a positive supervisory alliance, which can lead to a positive therapeutic alliance (Patton & Kivlighan, 1997). A strong supervisory alliance can be beneficial in a number of ways. It is associated with lower levels of supervisee anxiety (Mehr, Ladany & Caskie, 2015), and a higher degree of supervisee self-disclosure (Ladany, Hill, Corbett, & Nutt, 1996). Greater self-disclosure about clinical mistakes occurs when the supervisory alliance appears to be strong (Walsh, Gillespie, Greer & Eanes, 2003). This is likely to have a positive impact on the patient as patient risk could be increased if supervisees are uncomfortable and unwilling to share information in supervision. Creating a comfortable atmosphere in supervision with increased self-disclosure is also beneficial for the supervisors, as they could be held responsible for any unethical behaviour of their supervisees (Bernard & Goodyear, 2009).

Alternatively, supervisors might be making decisions based on maintaining a good therapeutic alliance. They might perceive that there is a potential rupture in the therapeutic alliance and that this must be repaired before persisting with further technique work (Safran, Muran, Samstag & Stevens, 2001). When there are problems with the therapeutic alliance, an increased adherence to techniques can exacerbate the problem and lead to a less positive outcome for patients (Castonguay, Goldfried, Wiser, Raue & Hayes, 1996).

### 6.6.3 Clinical implications

A number of implications for clinical practice can be drawn from this series of studies, relating to the treatment of depression and potentially of other disorders. As many of the supervisors within these studies lacked a clear supervision focus, it would appear that clearer protocols are needed for clinical supervision in practice. Such protocols should address how to handle non-adherence from both supervisees and patients. In addition, there is a need to highlight how certain supervisee characteristics might affect the supervision process, and therefore clinical outcomes. Focusing on gender-neutral supervisory practice could be particularly beneficial. Practice should emphasis the use of technique work (which is key to patient change - Beck et al., 1979), regardless of therapist gender. Practice focusing on technique work is therefore more likely to look like the treatment of the male supervisees in the current set of studies, rather than the treatment of the female supervisees.

### 6.6.4 Research implications

When conducting research, there is perhaps a need to avoid an over-reliance on supervision to ensure adherence. The current series of studies indicates that supervisors might drift from appropriate techniques, just as therapists do. Therefore, it might not be appropriate to depend upon supervision in isolation to ensure therapist adherence to research protocols. Acknowledging such drift in study designs through the use of additional monitoring of supervision might help to ensure optimal research conditions. Study designs should also take into account how different types of therapists and supervisors can impact supervision and, ultimately, therapy outcomes. In addition to these design adaptations, when reporting studies, researchers should be clearly outlining how supervision was conducted within the study. Doing so would lead to a greater awareness of what to focus on in supervision in order to achieve positive outcomes.

### 6.6.5 Limitations and future research

Future research can expand on this series of studies in a number of ways: first, through investigation of supervision for other therapies and disorders and second, through further investigation of the aspect of non-adherence. For example, this study has focused on behavioural activation. Does non-adherence to other aspects of therapy produce similar reactions from supervisors? Third, future research could further investigate of the impact of supervisor gender in the therapeutic process. Although, supervisor gender did not impact supervisee treatment in a previous study (Chapter 5), it could not be investigated in this series of studies due to participant numbers. Fourth, it would be useful to consider more naturalistic and in vivo studies. Studies using recordings of therapy sessions could provide supervisors with a richer data source, indicating how they might conduct supervision in a specific case. Finally, this research area would be enhanced by clinical data allowing for the investigation of how supervisory focus might impact therapy outcomes.

# – General Discussion

This chapter begins with a brief discussion of the aims and hypotheses for this thesis and whether they were supported. Following this, key findings from across the thesis are synthesised with the aim of creating a bigger picture of what these data tell us about clinical supervision. These findings are then addressed in relation to wider psychology theory. Following this, implications for both clinical and research practice are discussed. Finally, this chapter ends by addressing the limitations of this thesis, outlining how future research can combat these, and suggesting ways in which research in this area might be expanded.

## 7.1 Aims of this thesis

This thesis explored the use of clinical supervision for therapists treating patients with depression. The first aim of this thesis was to gather the empirical and theoretical research into clinical supervision for the treatment of depression in order to generate a clear understanding of what constitutes supervision, and whether it has an impact on therapists and patients. Supervision is widely used as part of depression treatments in both clinical and research practice. However, the empirical research in this area is limited and the supervision model literature rarely focuses in on specific disorders. Therefore, to generate a comprehensive picture of the use and impact of clinical supervision, the general clinical supervision literature was assessed (rather than that specific to depression treatment). Following this, three empirical studies were outlined that investigated supervision specifically within depression treatment. Each study investigated factors that might affect what happens in supervision (and therefore, patient outcomes). These factors were the characteristics of the patients, the therapists, and the supervisors themselves.

In order to gain an insight into clinical supervision guidance that is available to supervisors, a review of supervision models was carried out (Chapter 2). This review aimed to identify which aspects of supervision are consistent across models, and which are not, and therefore determine whether they have reliability. A content analysis was used to assess 52 models. As supervision models are not disorder or paradigm specific, the review considered all forms of supervision model because they all have potential to be used within depression treatments. Three hypotheses were proposed. First, it was hypothesised that the broad content of models would be similar, specifically, discussion of the three core factors in supervision, the three parties in supervision, and the use of evaluation to ensure progress. Second, the amount of content in newer models was predicted to differ from older models. Finally, it was hypothesised that the content of the models would be based on empirical evidence.

These hypotheses were based on what one might reasonably expect to be true about supervision models; however, none of the hypotheses were supported. Models focused more on supervisee learning and/or development, but less on emotional aspects of work, or managerial or ethical responsibilities. Most models focused on the supervisee and supervisor, rather than the client, and only a small number suggested using client outcomes as a form of evaluation. There was no significant correlation between the model publication year and number of elements in the model. Finally, none of the models were based on an empirical study. Overall, the models lacked consistency, and therefore lacked reliability. Consequently, one cannot assume that any of the models are valid unless there is empirical evidence to support them.

In order to assess the empirical evidence for clinical supervision, two meta-analyses were carried out and these were presented in Chapter 3. The aim of these analyses was to investigate the impact of clinical supervision on supervisees and on patients. Two hypotheses were confirmed. First, the majority of studies focused on supervisees, rather than patients. Second, supervision has a greater effect on supervisees than on patients. Supervision has a moderate, positive effect on supervisees but a non-significant effect on patients. A further aim was to investigate the role of moderators on effect sizes. It was expected that studies with higher quality analysis scores and those featuring control groups would have smaller effect sizes. This was partially supported as high quality supervisee outcome studies produced lower effect sizes. However, controlled supervisee studies had a larger positive effect than those without a control and high quality patient outcome studies produced higher effect sizes. Whether the supervisee was a trainee or qualified, and the frequency of supervision were also found to moderate effect size. Unfortunately, as the overall number of studies was small, moderator analyses were limited. For this reason, studies investigating all therapies, forms of supervision, disorders, and outcome measures were analysed together.

The first of three empirical studies was outlined in Chapter 4. All participants in this study were clinical supervisors of CBT therapists treating patients with depression. These supervisors were asked to indicate how they would conduct supervision when given vignettes of patients with depression of varying complexities. The study had two aims. First, to investigate how the content of supervision sessions varies depending on the clinical case that is presented in the supervision. Second, to determine whether supervisors fall into natural groupings, and whether those patterns are related to the supervisors’ own characteristics.

Results indicated that supervisors tended to focus their supervisees on the use of evidence-based therapeutic techniques for both straightforward and complex cases. However, their approach was less evidence-based for diffuse cases. In addition, the supervisors fell into three natural groups: an *Alliance- and Technique-Focused* group, a *Case Management-Focused* group, and an *Unfocused* group. Personal characteristics of the supervisors varied across the groups. Those who focused their supervisees on case management issues were more likely to have anxiety surrounding future events and to have been practising longer. In contrast, those who focused on both alliance and technique in supervision also tended to be those who had higher self-esteem. Findings from this study indicate that the content of supervision sessions is influenced by factors from outside the therapy process. These factors might cause supervisors to avoid focusing on evidence-based aspects of therapy, thus feeding therapist drift.

A second empirical study was presented in Chapter 5. This study used the same methodology as Chapter 4; however, the vignettes varied in clinician characteristics, while patient complexity remained constant. There were two aims for this study. First, to explore how supervisee anxiety and gender impact the advice that supervisors give in supervision. It was hypothesised that supervisors working with calm supervisees would stress the need to focus on CBT techniques more than with anxious supervisees. This was supported, but only for female supervisees who were state anxious. Male supervisees were treated in the same way regardless of their anxiety level. It was also hypothesised that supervisors would focus male supervisees more on CBT techniques than female supervisees. Supervisors focused both male and female supervisees on CBT techniques to the same extent. However, supervisors indicated a greater alliance focus for female supervisees.

The second aim of this study was to determine whether patterns of supervisor focus fall into natural groupings, and whether those patterns are related to the supervisors’ own characteristics. It was hypothesised that supervisors with high anxiety themselves would focus their supervisees less on CBT techniques. The supervisors fell into two clusters; however, cluster membership was dictated by whether the supervisor indicated a high or low alliance focus, rather than technique focus. Supervisors with higher anxiety were likely to focus on the therapist developing a good alliance with the patient. Overall, the findings from this study indicate that supervision is influenced both by supervisors' biases towards their supervisees and by their own characteristics. These factors may cause supervisors to drift from prompting their supervisees to deliver best practice.

Three mini-studies were presented in Chapter 6. The aim of these studies was to investigate clinical supervisors’ recommendations in supervision when there was an element of non-adherence to treatment. Specifically, when a supervisee or patient was not adhering to previously agreed upon behavioural activation techniques. All three mini-studies used the same vignette paradigm as in Studies 1 and 2. Study 3a explored how the gender and anxiety of a non-adhering supervisee impacts supervision content. The first hypothesis that calm female supervisees would be directed back to behavioural activation more than anxious female supervisees was not supported. However, as predicted, all male supervisees were treated in the same way, regardless of their anxiety. In addition, there appeared to be a specific effect relating to trait anxious females. Supervisors appeared to be particularly reluctant to encourage a return to behavioural activation for this group.

Study 3b investigated the impact of supervisee experience and patient complexity upon supervisors’ recommendations in supervision when presented with non-adherence from their supervisee. None of the hypotheses relating to supervisee experience or patient complexity were supported. Supervisors indicated that they would have the same focus in supervision, regardless of the characteristics of the therapist or patient.

The final mini-study in Chapter 6 (Study 3c) investigated the impact of patient non-adherence to behavioural activation. As with study 3a, vignettes varied by supervisee characteristics of gender and anxiety. As predicted, calm female supervisees were focused back on behavioural activation more than trait anxious female supervisees were. Whereas, all male supervisees were given the same guidance by supervisors.

The supervisors’ general focus for supervision sessions in all three mini-studies appears to be contradictory to the focus presented in the supervision literature. Supervisors in this series of studies placed the greatest focus on alliance and case management work, rather than on technique work. Results from all three mini-studies also indicated that supervisors fall into natural groupings and these grouping are dictated by how they choose to conduct supervision. Only a small minority of supervisors had a high focus on all core aspects of supervision and large numbers of supervisors appear to lack a clear focus in supervision.

## 7.2 Synthesising key findings

In the following section, I will discuss some key findings from across this thesis. First, I will discuss what the function and value of supervision appears to be, based on the literature. Then, I will discuss the disconnect between the empirical and theoretical supervision literature. Following this, there is a discussion of the three core aspects of supervision and which ones supervisors choose to focus on. Finally, there is a discussion of the supervisor, supervisee, and patient characteristics that can influence supervisors’ recommendations in supervision.

### 7.2.1 The function and value of supervision

Clinical supervision usually describes a relationship between two people (supervisor and supervisee) with the aims of education, support, and management. However, the most fundamental aim of supervision is to guide effective therapy for a patient (Milne & James, 2000). Therefore, the supervision process actually involves three parties - the supervisor, the supervisee, and the patient - that is not present in both the theoretical and empirical literature. The content analysis of supervision models in Chapter 2 indicated that fewer than half of the supervision models analysed focus on the patient, and fewer still discuss individual patient differences, patient expectations, or patient development in any detail. Although the disparity between supervisees and patients is slightly less pronounced in the empirical literature, most studies focus on supervisee outcomes, rather than patient outcomes. The meta-analyses in Chapter 3 found 11 papers investigating supervisee outcomes, compared to eight investigating patient outcomes.

In addition to this lack of focus on the patient, the meta-analyses also found that there is a moderate, positive effect of supervision on supervisee outcomes, but a non-significant effect on patients. As supervision does not appear to benefit patients, this raises the question of whether clinical supervision is a cost-effective exercise. This element of clinical practice is costly in terms of both time and money (Lyth, 2000) and therefore it should have a clear value in clinical practice. Perhaps this value does not lie with direct benefit to patients, but instead the value of supervision might be in its potential to stop therapists from deteriorating and therefore aid patients in the long term.

It is possible that the lack of direct supervision impact on patients is a consequence of a lack of patient focus. Although the focus on supervision models is generally directed towards supervisee improvement, it is difficult to know whether this is the focus of supervision in practice. Empirical studies into supervision do not often outline the details of the supervision received. If such studies are following model protocols and focusing on the supervisee, this might explain the positive effect on the supervisee, but not on the patient.

### 7.2.2 Comparing the theoretical and empirical literature

When looking at the models literature alongside the empirical, a key finding in this thesis becomes apparent. That is, within the clinical supervision literature there is evidence of validity but without reliability. The content analysis of supervision models in Chapter 2 shows an inconsistent picture of what constitutes supervision. Models emphasise different aspects of supervision without building on previous models or empirically testing these aspects, and not all models focus on the three core functions of supervision. Therefore, the models literature is unreliable. Turning to the meta-analysis of the empirical literature (Chapter 3), although, the meta-analysis indicated that supervision had no effect on patient outcomes, it does have a positive effect on supervisee outcomes. Therefore, supervision does have value.

There appears to be a great disconnect between supervision theory (models) and empirical research into supervision. Very few models have been empirically tested or based on empirical research. Therefore, it is impossible to know which model, if any, should be used when conducting supervision. Alongside this, studies investigating the impact of clinical supervision often fail to outline details of the supervision or indicate whether they have used any specific supervision models. This means that clinical supervisors cannot learn procedure from the research and might struggle to replicate these results in clinical practice.

To summarise, although we know that supervision is beneficial to supervisees, we do not know what is happening in clinical supervision and whether this is related to the content of supervision models. It is possible that the models literature as a whole feels very unclear because the models of supervision are too generic. Perhaps supervision needs to be more specialised to specific disorders and treatments. In order to investigate how supervision looks specifically within CBT for depression three empirical studies were carried out. The studies explored what happens in supervision for depression treatment, and how various factors might impact the supervision content.

### 7.2.3 The three core aspects of supervision

Both the theoretical and empirical literature suggest that clinical supervision has three core functions. Proctor (1988) describes these functions as ‘formative’, ‘restorative’, and ‘normative’. The ‘formative’ aspect of supervision referring to education or the development of skills, the ‘restorative’ to the supportive element of supervision, and the ‘normative’ to case management and managerial roles. Kadushin (1976) describes the same aspects of supervision as ‘educational’, ‘supportive’, and ‘managerial’. The use of these elements of supervision was investigated in this thesis through analysis both of the recommendations of supervision models and of the recommendations of clinical supervisors in hypothetical supervision scenarios.

All three elements are described as key to successful supervision (Proctor, 1988; Kadushin, 1976). However, results from the content analysis in Chapter 2 indicated that supervision models often only emphasise one or two of the elements, and a focus on all three elements was found in fewer than 40% of supervision models. Looking at how supervisors say they would actually use these aspects of supervision, Studies 1 to 3 found that most clinical supervisors would address all three elements in their supervision. However, the majority of supervisors in these studies fall into groups that can be described as *Unfocused* or *Moderate Focus*. This indicates that although supervisors address all three elements, they do not have a high focus on any of them and often appear to have such a low focus on all elements that it is unclear what they intend to do in the supervision session. This apparent lack of focus from supervisors might be a reflection of the confusing nature of the models literature, leaving supervisors unsure of the best ways in which to conduct supervision.

Findings from this thesis show that the core aspects of supervision are not all focused on to an equal extent. Supervisors in Study 1 place a greater emphasis on technique over case management, and in Study 2, they place emphasis on technique work over both case management and alliance. The pattern from the supervision models literature is similar. Most models emphasise technique work but only around 60% emphasise alliance or case management. Therapy manuals offer support for this pattern of focus. For example, Beck et al. (1979) stress that technique is key to patient change in CT.

Supervisors appear to lose this preference for techniques when there are issues of non-adherence in therapy (as in Studies 3a, b, and c). Supervisors in this series of studies consistently focus most on alliance, then on case management, and least on technique. This apparent avoidance of technique work when faced with non-adherence might be due to supervisors worrying about upsetting or ‘breaking’ the ‘fragile’ patient or therapist (Meehl, 1973). Therefore, supervisors are focusing on potentially more comfortable aspects of supervision (alliance and case management work).

To summarise, it appears that both in the supervision literature and in supervision practice, there is a preference for technique-focused supervision. That is, unless other issues (such as non-adherence) are present in supervision. Whilst the therapy literature suggests that this is perhaps an effective pattern of focus (e.g., Beck et al., 1979), few empirical studies investigating supervision outcomes actually describe how they conduct supervision (Chapter 3). Therefore, it is very difficult to know which aspects of supervision might lead to the most positive clinical outcomes.

### 7.2.4 Factors that impact supervisory focus and outcomes

Although it is unclear which aspects of supervision might be most beneficial to patients, there is an assumption that supervisors will maintain a certain level of consistency in their supervisory practice. Such consistency might be necessary when ensuring therapist adherence. There is much evidence indicating that therapists do not always stick to therapy protocols, a phenomenon known as therapist drift (Waller, 2009). This is seen across a variety of settings and disorders (e.g. Stobie et al., 2007; van Minnen, Hendriks & Olff, 2010; Waller et al., 2012), and can be due to a number of reasons, such as anxiety (Meyer et al., 2014), negative beliefs (Farrell et al., 2013), and a lack of knowledge (Addis & Krasnow, 2000). There is some evidence that supervision can increase therapist adherence (Sholomskas et al., 2005). However, it is unclear whether supervisors provide the neutral input required to ensure that all therapy remains on track, regardless of external factors. The studies in this thesis have shown that supervisors might not always approach supervision in a consistent manner, and that they drift in their practice in a similar way to therapists. Factors that influence supervisory focus are discussed below.

#### 7.2.4.1 Patient factors

Patient factors appear to play a key role in supervision sessions. In the first empirical study in this thesis (Chapter 4), supervisors focused more on technique work for both the straightforward and complex patient cases, than for the diffuse case. The finding that supervisors change supervisory focus depending on the qualities of the patient might not seem particularly surprising. Individual patients can have different needs and differing prospects of recovery. Those with a lower level of complexity make greater gains in treatment (Piette et al. 2011), and those with more severe pre-treatment presentation have a poorer response in therapy (Jarrett et al., 1991; Persons, Burns, & Perloff, 1988).

However, when this finding is assessed alongside findings from the content analysis of supervision models in Chapter 2, it becomes perhaps more surprising. As fewer than half of the supervision models analysed mention the patient (and even fewer discuss patient complexity), the implication is that supervision should remain constant, regardless of the qualities of the patient. Whether adapting to different patients or keeping supervision content fixed leads to the most positive outcomes is unclear as the models are rarely empirically tested and the empirical studies into supervision outcomes do not outline how the supervisors work with different types of patient.

When there is an added element of non-adherence from the patient (as in Chapter 6), supervisors no longer adapt their supervision content to the different types of patient. This approach implies that the supervisors prioritise dealing with non-adherence. This would appear to be a logical step to take as successful completion of between-session tasks in cognitive therapy for depression has a positive impact on patient outcomes (Detweiler & Whisman, 2006). To work with patient non-adherence, supervisors lean towards alliance and case management aspects of supervision over general technique work. It is possible that supervisors view these as more comfortable aspects of supervision, and so are trying to avoid upsetting or ‘breaking’ the ‘fragile’ patient (Meehl, 1973). Alternatively, supervisors might believe that there is a rupture in the therapeutic alliance, and that this needs repairing before proceeding with further technique work (Safran et al., 2001). Indeed, increased adherence to technique work can exacerbate problems with the alliance leaning to less positive patient outcomes (Castonguay et al., 1996).

#### 7.2.4.2 Therapist factors

There is evidence that supervisors have biases (whether implicit or explicit) that lead them to overestimate the abilities of their supervisees (Dennhag et al., 2012; Gonsalvez & Freestone, 2007). Studies in this thesis investigated whether such supervisory bias extends beyond the existence of a prior relationship with the supervisee. Specifically, whether such biases extend to the characteristics of the supervisees. The supervision models literature indicates that these aspects are key to the supervisory process as almost all supervision models focused on the supervisee (94.23%), and 65% of them focused on the supervisee’s characteristics.

Many of the supervision models assessed in Chapter 2 take a developmental approach to supervision, suggesting that as supervisees gain experience the structure and content of supervision should adapt to their needs. Such models often suggest a heavy focus on educational approaches for low-level supervisees but peer work for those at higher levels (e.g., Hogan, 1964; Stoltenberg & Delworth, 1987). As the meta-analysis in Chapter 3 found that supervision has a medium to large positive effect on trainee outcomes but a non-significant effect for qualified outcomes, it appears that there could be differential treatment of supervisees of different experience levels.

However, Study 3b found this was not the case. All of the supervisees in this study were treated the same, regardless of their experience level. Therefore, outcome differences might not be due to supervisors varying their supervision focus for those of different experience levels. It is possible that supervision has particular benefits for early-career supervisees. Indeed, Ost et al. (2012) found supervision could produce treatment effects for trainees that are on par with those of qualified supervisees. Alternatively, supervision might play a lesser role for qualified supervisees as other factors possibly contribute more to their outcomes (e.g., experience; Eells et al., 2005). However, it is worth noting that although supervisee experience did not impact supervisory focus in Study 3b, this could be due to the presence of non-adherence from the patient. Perhaps when a patient is not adhering to therapeutic techniques, supervisors will direct supervision in a way to increase adherence, regardless of the experience level of their supervisee. Such adherence is important for patient improvement (Detweiler & Whisman, 2006).

Therapist anxiety can impact how therapy is conducted (Waller et al., 2016). Evidence indicates that anxious therapists drift from therapeutic protocols, thereby affecting the content of therapy sessions (e.g., Meyer et al., 2014; Waller et al., 2012). Despite this, more than half of the supervision models analysed in Chapter 2 do not acknowledge the possibility of supervisee anxiety. This is potentially problematic as, within this thesis, therapist anxiety was found to impact the content of supervision sessions. The presence of therapist anxiety leads supervisors to place a lesser focus on therapeutic techniques (and behavioural activation more specifically) in supervision sessions. However, this pattern of focus only applies when the supervisee is female.

There are a number of possible explanations for why supervisors are avoiding technique work with anxious supervisees. First, supervisors might feel that establishing a good therapeutic alliance with the patient is being prevented by the therapist’s anxiety (Hardy et al., 2009). Indeed, Study 2 indicated that supervisors placed a greater focus on alliance work when working with an anxious supervisee. Second, supervisors might be aware that anxious therapists often focus on immediate patient comfort to the exclusion of more change-oriented methods (e.g. behavioural activation). This parallels the avoidance of exposure work in therapy for anxiety disorders (e.g., Schumacher et al., 2014). Finally, supervisors might not want to disrupt the supervisee relationship by challenging their supervisee, as poor supervisee relationships can be harmful to supervisee growth (Gray et al., 2001).

However, none of these explanations can account for why technique work is avoided specifically with anxious female supervisees but not with anxious male supervisees. Perhaps supervisors feel that female supervisees are more likely to pick up on problems with the therapeutic alliance that might hinder therapeutic progress. Patients have been found to report higher alliance ratings with female (rather than male) therapists (Staczan et al., 2017). Therefore, supervisors might take the anxiety of female supervisees more seriously. In doing so, supervisors could be holding off on encouraging aspects of therapy that might be more challenging to the patient or those that the patient or supervisee has previously not adhered to. A greater focus on alliance work with female supervisees (rather than male supervisees) in Study 2 lends support to this explanation.

An alternative explanation is that supervisors feel that female supervisees are likely to have a more anxious disposition, by virtue of their gender (e.g. Leahy et al., 2012). Therefore, such displays of anxiety might lead supervisors to view their female supervisees as more vulnerable and unable to cope with technique work, or to return to potentially anxiety-provoking techniques that were previously not adhered to. Supervisors are encouraged to play a nurturing role with their own patients and a formative role with their often vulnerable supervisees (Gonsalvez & Freestone, 2007), and so they might strive to protect and not ‘break’ their supervisee (Meehl, 1973), particularly if the supervisee is female and relatively anxious.

Such assumptions that female supervisees might be more vulnerable or more unable to cope appear ill-founded as therapist gender has little impact on therapy outcome, and sometimes female therapists perform better than males (Branson, & Shafran, 2015; Huppert at al., 2001). However, it remains possible that providing different supervisory guidance to male and female supervisees can still lead to equivalent clinical outcomes. Indeed, Bearman et al. (2013) found that discussion of evidence-based practices in supervision predicted adherence to those practices from male but not from female supervisees.

#### 7.2.4.3 Supervisor factors

The supervisor themselves is a key aspect of the supervision process; 80.77% of models analysed in Chapter 2 focus in some way on the supervisor. However, details of which specific supervisor aspects impact supervision is somewhat lacking in the models literature. A cluster analysis of supervisor elements indicated that the majority of models fall into an *Unfocused* cluster, which contains models that do not provide any particular detail about the supervisor as a person. The second largest group of models focuses in on the supervisor being an authority figure, again without discussing the supervisor’s personal qualities. Representing the majority of supervision models, these two clusters suggest that the supervisor’s personal characteristics are not relevant to the supervision process. However, as there is a wealth of evidence indicating that therapists drift from therapeutic protocols for reasons relating to their own characteristics (e.g., anxiety, Meyer et al., 2014; mood, Waller et al., 2013; personality, Peters-Scheffer, Didden, Korzilius & Sturmey, 2013), there is little reason to believe that supervisors are immune to such drift within their own practice. Indeed, the empirical studies presented within this thesis found a number of supervisor characteristics that are related to supervisory focus in supervision sessions.

Despite only three supervision models taking a focus on the anxiety of the supervisor (Chapter 2), supervisors’ anxiety (specifically prospective anxiety) appears to have an impact on the supervisory focus. Results from Study 1 indicated that those supervisors with a greater anxiety towards future events mainly focused on the case management aspects of supervision (rather than technique or alliance work). Whereas, in Study 2, those scoring higher on the prospective anxiety scale focused more on alliance work than those with lower prospective anxiety scores. Combined, these results indicate that supervisors who have higher anxiety relating to future events seem to focus more on the non-technique aspects of supervision. These findings parallel those indicating that anxious therapists avoid the use of core CBT techniques in therapy (e.g., Meyer, et al., 2014; Waller et al., 2012). A fear over future events can lead supervisors to focus on patient safety or ensuring a positive relationship to the exclusion of more change-oriented methods. This is potentially due to case management and alliance aspects of therapy being viewed as less anxiety-provoking than technique work.

Supervisor self-esteem appears to have some impact on supervisory focus. In Study 1, supervisors with high self-esteem focused more on alliance and technique work than those with lower self-esteem. Although a similar effect of supervisor self-esteem was not found in the other studies in this thesis, this finding ties in with research concerning therapist characteristics by Waller et al. (2013) who that found that therapists with a higher mood have more positive beliefs about the use treatment manuals. The finding from Study 1 is also in line with previous work by Moldovan & David (2013) suggesting that high supervisor self-acceptance and self-efficacy positively affects trainees’ outcomes. Combined, these findings indicate that the self-esteem or mood of the supervisor has a role to play in how supervision is conducted. Despite this, these aspects did not appear in any of the supervision models analysed in Chapter 2.

While the theme of development runs throughout the supervision models literature, many models focus on supervisee development (55.77% of models), but only a few (9.62%) focus on the development of the supervisor. Within the empirical studies in this thesis, the development of the supervisor emerged as an important variable. In Study 1, the *Case-Management focused* group of supervisors had been qualified, using CBT, and accredited as a therapist for longer than those who were *Unfocused.* This could be viewed as supervisory drift with time – experienced supervisors no longer focusing on the core aspects of therapy that lead to patient change. In contrast, Study 3a indicated that those who had been using CBT for longer had a higher focus on all aspects of supervision than those with less experience. This perhaps suggests that having more experience in beneficial when working with more difficult cases, such as those with a lack of adherence (as in Study 3). This explanation ties in with research into the impact therapist experience on therapeutic outcomes by Mason et al. (2016) that found qualified therapists only outperform trainees when working with patients with severe anxiety (rather than mild or moderate).

Although supervisor experience had an impact in some of the studies in this thesis, it did not have an impact in all, and the direction of the effect of supervisor experience upon supervisory content is slightly unclear. This is similar to findings from the therapeutic experience literature. Some studies indicate that experience has a positive impact on therapy (Eells et al., 2005), while others indicate a negative impact (Bjaastad et al., 2018; Goldberg et al., 2016), or even an intermediate effect (Witteman & van de Bercken; 2007). Perhaps measurements of experience other than time are key to the assessing the impact of experience. For example, perhaps the focus needs to be on the quality of experience, or the similarly of previous situations to the current one.

A final supervisor characteristic that must be discussed is supervisor gender. Results from all three empirical chapters in this thesis indicated that supervisor gender had no impact on supervisory focus in supervision. When supervisor ‘types’ were identified based on supervision focus through cluster analyses, supervisors of each gender were evenly split between the clusters. This finding resonates with research showing that therapist gender often has no impact on therapy outcomes or therapeutic performance (e.g., Branson & Shafran, 2015; Huppert at al., 2001).

In addition, supervisor gender was unrelated to the differential treatment of male and female supervisees in Study 2. Both male and female supervisors focused less on technique work with anxious female supervisees, than with anxious male supervisees. Nelson and Holloway (1990) found a similar pattern of gender relevance in a study of power balance in supervision in which, regardless of their gender, supervisors assumed more power with female than with male supervisees. There is similar evidence in other domains. For example, in a study by Steinpreis et al. (1999), both male and female employers were more likely to offer positions at higher starting salaries to men than women with identical curricula vitae

#### 7.2.4.4 Summary

There is much research indicating that therapists can drift from ‘best practice’ in therapy (e.g., Meyer et al., 2014; Stobie et al., 2007; Waller et al., 2012). This leads to patients receiving treatment that deviates from the evidence-base and so reduces their chances of improvement (Waller et al., 2016). Clinical supervision is an aspect of therapy that is often expected to ensure that therapists stay on track. However, this thesis has found that there might be different ‘types’ of supervisor who conduct their supervision in different ways. In addition, the way in which supervisors are conducting their supervision is related to factors similar to those that impact therapists when conducting therapy. Such factors can be related to the patients being treated, the supervisee in supervision, and the supervisor themselves. Therefore, supervisors appear to drift, just as therapists do. Some of these factors are taken into account in models of supervision; however, many of them are not. Here, these findings have been discussed in relation to the empirical evidence and in the following section; they will be discussed in relation to psychology theory.

## 7.3 Wider psychology literature

As the supervision models literature lacks an evidence base, it is difficult to use it to draw meaningful conclusions about the empirical studies in this thesis. Here, the findings will be discussed in the context of wider psychology theory.

### 7.3.1 Social Psychology theory

Previous research suggests that supervisors to have biases towards their supervisees. There is evidence of leniency bias, where supervisors overestimate the abilities of their own supervisees (Dennhag et al., 2012; Gonsalvez & Freestone, 2007). Gonsalvez & Freestone (2007) also found evidence of a halo-effect type of bias (Thorndike, 1920). When supervisors rated their supervisees highly on one performance dimension, they tended to rate them highly on others, but there was weak between-supervisor agreement. The positive relationship that supervisors are encouraged to have with their supervisees can leave them vulnerable to this type of bias. Supervisors view their supervisee in a positive light and therefore attribute them other positive qualities, such as high competency scores.

The findings from this thesis indicate the potential for other implicit (or explicit) social cognitions from supervisors, in the form of stereotypes. Stereotypes are beliefs shared by members of society about traits characteristic of members of a specific social category (Greenwald & Banaji, 1995). The differential treatment of male and female supervisees could be due to supervisors acting on gender stereotypes. A few gender stereotypes might be influencing supervisory decisions. First, there is the widely held stereotype of women as nurturers (Hamilton, Anderson, Broddus & Young, 2006; Hyde, 2005). Women are often rated higher on communion traits, such as warmth (Haines, Deaux & Lofaro, 2016). Supervisors might feel that female supervisees are more attuned to relationship problems in therapy, and so their anxieties around certain techniques are taken more seriously than those of their male colleagues. In addition, supervisors are more inclined to focus on alliance work with female, rather than male, supervisees. Second, men tend to be rated higher on agency measures, such as competence or assertiveness (Haines et al., 2016). Supervisors might assume that an anxious male supervisee is competent enough to continue with therapeutic techniques despite their anxiety, or that they are assertive enough to push on with aspects of therapy that are being met with resistance.

### 7.3.2 CBT theory

The findings from this thesis can be related to the theory underpinning CBT. Cognitive Theory proposed by Beck (1967) suggests that an individual bases their behaviours on underlying beliefs about the self, the world, and the future. However, these beliefs can be irrational, therefore leading to cognitive biases and maladaptive behaviours. Understanding and challenging these beliefs is the core mechanism through which CBT leads to behaviour change and clinical improvement. Just like their patients, it is possible that supervisors will also have irrational beliefs, and this is shown in some of the findings from this thesis. For example, some supervisors appear to base their supervision recommendations on their own anxiety and worry surrounding potential future events. This leads them to choose courses of action that appear to defy their knowledge of the evidence-base.

The ease with which these results fit to the theory underlying CBT can be viewed as both troubling and reassuring. Supervisors working with CBT should be well educated on the theory and mechanisms leading to patient change. However, some supervisors appear to lack an awareness of how this theory can apply to their own behaviours. On the other hand, as this is a theory that clinicians should know well, it is perhaps easy for them to assess their own beliefs. This could lead to a change in any cognitive biases that they might have.

## 7.4 Clinical and service improvement

When looking at the clinical implications of this research, it is first important to highlight that although the supervision models literature is unclear and there is limited empirical research, the meta-analysis of supervision in Chapter 3 found that clinical supervision has a positive impact on supervisees. Therefore, supervision appears to have some value. However, its value might lie in limiting supervisee deterioration, rather than directly improving patient outcomes. In order to maximise supervision impact, the supervision process needs to be tidied up. To do this, supervision perhaps needs to move towards being more patient-oriented. Factors that have an impact on supervision sessions (other than the patient in treatment) need to be taken into account when setting out supervision protocols.

### 7.4.1 Monitoring of supervision

To ensure that supervision stays on track, there is an argument for greater monitoring of supervision. Patients appear to have better clinical outcomes within RCT settings (Gibbons et al., 2013), where the supervisory conditions are more regulated (Roth et al., 2010; Tracey et al., 2012). Monitoring might be conducted in a number of ways. First, there is the option for analysis at the practice level. Clinical practices should be aware of how their own supervisory procedures might relate to outcomes. Outcome data might include both session-by-session patient outcome monitoring and feedback from supervisees. Such session-by-session monitoring of therapy has been successfully used within IAPT services (Clark et al., 2018). Supervision data can be incorporated into existing systems and expanded to practices outside of IAPT.

Second, supervisors might require some form of supervision themselves. Some therapeutic organisations recommend that supervisors should receive supervision (e.g., BABCP, 2019), and therapy centres are beginning to offer courses in supervision of supervision. Such supervision might take the form of a group discussion. This allows supervisors to present their case and then take a step back to avoid any biases that might occur due to their prior knowledge of and relationship with the supervisee. As these biases can be explained through Cognitive Theory (Beck, 1967), it should be straightforward for other supervisors trained in this theory to identify them.

Finally, supervisors should set aside some time to monitor themselves. They should request supervisee feedback, look at their patient outcome data, and seek out any patterns in their treatment of different types of individuals. Supervisors must assess their focus in supervision and decide what their ultimate aim is – supervisee comfort or patient improvement. Supervisors need to monitor of their own anxieties around upsetting their supervisees, as holding off potentially anxiety-provoking techniques might be detrimental to the patient in the long term.

### 7.4.2 Training and professional development

Improving monitoring of supervision can lead to supervisors becoming aware of potential biases that they might hold. Supplementing monitoring with training around identifying and understanding biases might be sufficient to eliminate such biases. Simple consciousness raising is an effective strategy for avoiding unintended discrimination (Greenwald & Banaji, 1995). Such training and professional development might also look to incorporate aspects of CBT to counter cognitive biases, just as exposure therapy has been recommended for anxious therapists (Farrell et al., 2013).

The empirical studies within this thesis indicated that many supervisors conduct their supervision without much focus. Therefore, clearer protocols on what should happen in supervision are required. Current guidelines for supervision focus are not clear; the empirical research does not outline details of what effective supervision looks like, and it is unclear which supervision models (if any) are appropriate. Although the use of supervision is required in accreditation guidelines set out by various therapy organisations (e.g., BABCP, 2012; BACP, 2016), the specifics of what this supervision should entail are vague. Such organisations commonly suggest one and a half hours of supervision per month, but do not detail what should go into this supervision. Therefore, there is a need for more detail in protocols and guidelines, such as acknowedgement of how the supervisor’s own characteristics might impact supervision, or methods to ensure gender-neutral practice in supervision.

## 7.5 Research implications

Analysis of both the theoretical and empirical literature for this thesis has highlighted a number of implications for conducting research in this area. Regarding the supervision models literature, it is possible that a number of models fail to include core aspects of supervision because it is assumed knowledge. When laying out guidance for supervisors, there is a need to be more explicit so that the literature as a whole does not present a confusing and disordered picture. In particular, authors should always aim to explicitly address patient perspectives and outcomes when outlining supervision processes.

Aspects of supervision that authors discuss in their models should be based on empirical evidence and the models should then be tested to investigate their impact on both supervisees and patients. Findings from the empirical studies within this thesis can inform the development of supervision models. Results indicate that supervisor, supervisee, and patient characteristics have an impact on the supervision process. Such aspects should be taken into account in the supervision models literature. Currently, these aspects are not discussed in many models.

Regarding empirical literature, use of supervision in study designs as a tool to ensure that therapists stay on track is perhaps problematic. Research within this thesis indicates that supervisors might drift as therapists do. Therefore, study designs need to include further monitoring or regulation of supervision. Study designs should take into account how different types of therapists and supervisors can impact supervision and, ultimately, research outcomes.

In addition, when reporting studies, researchers should be more explicit when explaining the supervision processes that they have used. It is difficult for supervisors to replicate results from these studies in their clinical practice because the way in which supervision is conducted in these studies is unclear. Greater study detail is also required for synthesis of the empirical literature. A lack of detail creates problems when researchers are looking to compare one piece of research with another or to categorise studies when investigating moderating effects (as in the meta-analyses in Chapter 3).

## 7.6 Limitations and directions for future research

The majority of supervision models are not disorder-specific and the empirical literature into supervision outcomes is limited. Therefore, synthesis of the theoretical and empirical literature could not focus on clinical supervision specifically for depression. For the meta-analysis in Chapter 3, conclusions had to be drawn about the impact of clinical supervision in all contexts. It was not possible to find supervision effects for specific disorders. The empirical studies in this thesis focused on supervision content in CBT for depression and similar research should be carried out for other disorders and therapies. This would indicate whether the application of supervision is universal (as many supervision models suggest) or whether there should be specific protocols for each disorder and therapy.

In addition to investigating other disorders and therapies, study protocols similar to the ones used in this thesis could investigate other variables. Although the moderator analyses from Chapter 3 are somewhat speculative due to the small study numbers, these moderators highlight areas that are of potential research interest. Supervisee experience level is one area that requires further investigation. The meta-analysis indicated a positive impact of supervision on trainee supervisees, but no impact on qualified supervisees. However, in Study 3b of this thesis, supervisee experience level appeared not to have an impact on supervision content. This could be due to a couple of reasons. First, the supervisors might have been basing their recommendations purely on the presence of non-adherence. To investigate whether this is the case, supervisor experience needs to be investigated without the added element of non-adherence. Second, the impact of supervisee experience might only have an effect when comparing trainees with those who are qualified. Study 3b only varied the experience level of qualified supervisees. Therefore, future studies should investigate whether having trainee supervisees impacts the supervision advice.

There are a number of other ways in which the empirical studies in this thesis can be improved upon. First, these studies only investigated supervisor variables of anxiety and self-esteem that were within a non-clinical range. It is possible that patterns of supervisor behaviour are exacerbated when focusing on levels of anxiety and self-esteem that are more representative of clinical groups. Second, as the impact of supervisor experience produced mixed results within this thesis (greater experience indicating less focus in Study 1, but more focus in Study 3), this requires further study. Within this thesis, experience was measured by time but it could be measured in other ways. Some examples include, quality of experience and similarity of the current situation to previous situations. Third, it would be useful to consider further the role of supervisor gender. Although in Study 2, supervisor gender was found not to impact supervisee treatment; it could not be investigated in Study 3 due to limited participant numbers. Finally, the impact of non-adherence needs to be investigated further. For example, does non-adherence to aspects of therapy other than behavioural activation lead to the same patterns of supervisor behaviour?

### 7.6.1 Addressing methodological limitations of the empirical studies

Limitations of the questionnaire-style experimental design used in this thesis should be noted. The use of self-report anxiety and self-esteem measures is potentially problematic. Results might have been impacted by demand characteristics, due to participants having an awareness of what the study looked to measure. Attempts were made to reduce the impact of demand characteristics through the use of a less well-known anxiety measure (IUS; Carleton et al., 2007) and by presenting these measures last in the questionnaire. However, it is not possible to rule out any effect of demand characteristics, given the study design.

As there was a need to keep the questionnaires concise, there might not have been enough information to ensure that the supervisory content items did not confuse the participants. Although the items were grouped in specific categories (e.g., ‘therapeutic alliance’), confusion might have caused overlap between categories. In addition, there could have been some response bias towards selecting items in the ‘therapeutic techniques’ category as it was the largest. Definitions of terms could be added to ensure that all participants have the same understanding of each of the terms being presented to them. Alternatively, observational studies could be used to avoid confusion over terms or definitions. In such studies, raters trained to identify specific aspects of supervision could rate supervision sessions.

Due to the need to keep the questionnaires short and manageable, the vignettes did not provide a large amount of detail about the patients or supervisees. In actual supervisory practice, sometimes there is only a limited amount of time to talk about a patient, and these vignettes reflect that experience. The vignettes were based on case examples that supervisors would be used to seeing in supervision manuals. However, it is noted that supervisors will often have more information to base any decisions on. Therefore, the supervisor responses might not truly reflect their actions within clinical practice.

Although two clinical psychologists helped develop the vignettes based on their clinical experience, further testing of the validity of the vignettes would have been beneficial. This could have been done through the use of a pilot study in which clinical supervisors were asked to comment on the realistic nature of the vignettes. Feedback from this process could have fed into the further development of the vignettes.

The benefit of limiting the information provided in the vignettes is that it allows for controlled examination of the variables of interest. Video recordings of therapists were considered, but as these would provide such a wealth of information to participants, it would be more difficult to identify the specific variables influencing their decisions. This series of studies using vignettes has highlighted some variables that appear to influence supervisory practice (e.g., therapist gender). Such variables can then be explored further in studies with designs which are closer to ‘real-world’ scenarios, such as those using recordings and/or observation. In these scenarios, supervisors will have much more information about the patient and supervisee on which to base their decisions.

Finally, the studies in this thesis would benefit from the addition of actual clinical data. Such data would allow for investigation into how decisions made in supervision impact the supervisee and patient. Which aspects of supervision are beneficial/detrimental to the supervisee or patient? And if supervision has a positive impact only on the supervisees (as found in Chapter 3), how might this effect be translated to patients? Perhaps patients receive an indirect positive effect through reduced supervisee burnout or increased satisfaction (Delgadillo et al., 2018). As with using recordings, using clinical data allows for a wealth of information to be collected. This series of studies has highlighted specific areas to focus on (e.g., clinician gender) when looking at clinical data.

## 7.7 Conclusion

This thesis investigated recommendations for clinical supervision, the impact of supervision, and factors that affect the content of supervision sessions. Although this research was originally intended to focus on the use of supervision in depression treatments, the generic nature of the supervision models and the lack of empirical outcome studies meant that the background literature across all disorders was assessed together. However, the original empirical studies in this thesis focus on depression treatment. There are many models of supervision. However, there are few empirical studies investigating supervision outcomes. The models literature presents a confused picture of what should happen in supervision, as many models recommend different approaches to supervision, few are based on empirical evidence, and even fewer are tested. Meta-analyses of the empirical literature found that supervision had a moderate, positive impact on supervisees but no impact on patients. Indeed, there was generally a lack of focus on the patient in both the models literature and the empirical literature.

Original research in this thesis found that although the patient is often ignored in the literature, patient characteristics affect the content of supervision sessions. In addition to the patient in treatment, both supervisee and supervisor characteristics have an impact on the recommendations given in supervision. Many supervisors have a general lack of focus in supervision, which perhaps reflects a lack of clarity in the supervision literature. In addition, there is a tendency for supervisors to hold back on therapeutic techniques (despite these being key to patient change), or to instead focus on other aspects of supervision (case management and alliance). This pattern of focus tends to occur when the patient has a more diffuse depression presentation, when the supervisee is female and anxious, or when the supervisor themselves is more anxious.

Clinical training and/or protocols should consider the impact of patient, supervisee, and supervisor factors. There should also be further monitoring of supervision in both research and practice, particularly in relation to patient outcomes. Research from this thesis needs to be replicated with other therapies and disorders, and these studies should be expanded to include observational and clinical outcome data.

# References

Achenbach, T. M. (1991). *Manual for the Teacher’s Report Form and 1991 profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1-33.

Addis, M. E. (1997). Evaluating the treatment manual as a means of disseminating empirically validated psychotherapies. *Clinical Psychology: Science and Practice*, *4*, 1–11.

Addis, M. E., & Krasnow, A. D. (2000). A national survey of practicing psychologists’ attitudes towards psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology, 68,* 331–339.

Addy, K., Gold, A. J., Christianson, L. E., David, M. B., Schipper, & Ratigan, N. A. (2016). Denitrifying bioreactors for nitrate removal: A meta-analysis. *Journal of Environmental Quality, 43*, 873-881.

Alfonsson, S., Olsson, E., & Hursti, T. (2015). The effects of therapist support and treatment presentation on the clinical outcomes of an internet based applied relaxation program. *Internet Interventions, 2*, 289-296.

Alfonsson, S., Parling, T., Spännargård, Å., Andersson, G., & Lundgren, T. (2017). The effects of clinical supervision on supervisees and patients in cognitive behavioral therapy: a systematic review. *Cognitive Behaviour Therapy, 47,* 206-228.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: American Psychiatric Publishing.

Amos, T. B., Tandon, N, Lefebvre, P, Pilon, D., Kamstra, R. L., Pivneva, I., & Greenberg, P. E. (2018). Direct and indirect cost burden and change of employment status in treatment-resistant depression: a matched-cohort study using a US commercial claims database. *Journal of Clinical Psychiatry, 79*, 17m11725

Andrade, L., Caraveo-Anduaga, J. J., Berglund, P., Bijl, R. V., De Graaf, R., Vollebergh, W., Dragomirecka, E., … Wittchen, H. U. (2003). The epidemiology of major depressive episodes: results from the International Consortium of Psychiatric Epidemiology (ICPE) Surveys. *International Journal of Methods in Psychiatric Research, 12,* 3-21.

Ard, B. N. (1973). Providing clinical supervision for marriage counselors : A model for supervisor and supervisee. *The Family Coordinator*, *22*, 91–97.

Armstrong, P. V., & Freeston, M. H. (2006). Conceptualising and formulating cognitive therapy supervision. In N. Tarrier (Ed.), *Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases* (pp. 349–371). Hove, UK: Routledge.

A-Tjak, J. G. L., Morina, N., Topper, M., & Emmelkamp, P. M. G. (2018). A randomized controlled trial in routine clinical practice comparing Acceptance and Commitment Therapy with Cognitive Behavior Therapy in the treatment of Major Depressive Disorder. *Psychotherapy and Psychosomatics, 87*, 154-163.

Ault-Riché, M. (1988). Teaching an integrated model of family therapy: Women and students, women as supervisors. *Journal of Psychotherapy and the Family*, *3*, 175–192.

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16*, 317-331.

Barber, J. P., Sharpless, B. A., Klostermann, S., & McCarthy, K. S. (2007). Assessing intervention competence and its relation to therapy outcome: A selected review derived from the outcome literature. *Professional Psychology: Research and Practice, 38,* 493-500.

Barkham, M., & Hardy, G. E. (2001). Counselling and interpersonal therapies for depression: towards securing an evidence-base. *British Medical Bulletin, 57,* 115-132.

Bear, T. M., & Kivlighan, D. M. (1994). Single-subject examination of the process of supervision of beginning and advanced supervisees. *Professional Psychology: Research and Practice*, *25*, 450–457.

Bearman, S. K., Weisz, J. R., Chorpita, B. F., Hoagwood, K., Ward, A., Ugueto, A. M., Bernstein, A., The Research Network on Youth Mental Health (2013). More practice, less preach? The role of supervision processes and therapist characteristics in EBP implementation. *Administrative Policy in Mental Health, 40,* 518-529.

Bebbington, P. E., Brugha, T. S., Meltzer, H., Jenkins, R., Ceresa, C., Farrell, M., & Lewis, G. (2000). Neurotic disorders and the receipt of psychiatric treatment. *Psychological Medicine, 30,* 1369-1376.

Beck, A. T. (1976). *Cognitive therapy and emotional disorders*. New York, NY: Meridian.

Beck, A.T., Epstein, N., Brown, G., & Steer, R.A. (1988). An inventory for measuring clinical anxiety: psychometric properties. *Journal of Consulting & Clinical Psychology, 56,* 893-897.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*, 561–571.

Becker, C., Zayfert, C., & Anderson, E. (2004). A survey of psychologists’ attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy, 42,* 277-292.

Beidas, R. S., Barmish, A. J., & Kendall, P. C. (2009). Training as usual: Can therapist behavior change after reading a manual and attending a brief workshop on cognitive behavioral therapy for youth anxiety? *Behavior Therapist*, *32*, 97–101.

Beidas, R. S., Edmunds, J. M., Marcus, S. C., & Kendall, P. C. (2012). Training an consultation to promote implementation of an empirically supported treatment: A randomized trial. *Psychiatric Services*, *63*, 660–665.

Beier, E. G., & Young, D. M. (1980). Supervision in communications analytic therapy. In A. K. Hess (Ed.), *Psychotherapy supervision: Theory, research and practice* (pp. 192–205). New York, NY: Wiley.

Berg, K. S., & Stone, G. L. (1980). Effects of conceptual level and supervision structure on counselor skill development. *Journal of Counseling Psychology*, *27*, 500–509.

Bernard, J. M. (1979). Supervisor training: A discrimination model. *Counselor Education and Supervision*, *19*, 60–68.

Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd ed.). Boston, MA.: Pearson Education.

Bjaastad, J. F., Henningsen Wergeland, G. J., Mowatt Haugland, B. S., Gjestad, R., Havik, O. E., Heiervang, E. R., & Ost, L. G. (2018). Do clinical experience, formal cognitive behavioural therapy training, adherence, and competence predict outcome in cognitive behavioural therapy for anxiety disorders in youth? *Clinical Psychology and Psychotherapy, 25,* 865-877*.*

Bland, R. C., Newman, S. C., & Orn, H. (1997). Help-seeking for psychiatric disorders. *Canadian Journal of Psychiatry, 42,* 935-942.

Blascovich, J., & Tomaka, J. (1991). Measures of self-esteem. *Measures of Personality and Social Psychological Attitudes, 1*, 115-160.

Blazer, D. G., Kessler, R. C., McGonagle, K.A., & Swartz, M. S. (1994). The prevalence and distribution of major depression in a national community sample: the National Comorbidity Survey. *American Journal of Psychiatry, 151,* 979-986.

Blocher, D. H. (1983). Toward a cognitive developmental approach to counseling supervision. *The Counseling Psychologist*, *11*, 27–34.

Bloom, B. S., Engelhard, M. D., Furst, F. J., Hill, W. H., & Krathwohl, D. R. (1956). *Taxonomy of educational objectives*. New York, NY: McKay.

Bob, S. R. (1999). Narrative approaches to supervision and case formulation. *Psychotherapy*, *36*, 146–153.

Borders, L. D. (1991). Developmental changes during their supervisees’ first practicum*. The* *Clinical Supervisor*, *8*, 157–167.

Borders, L. D. (2014). Best practices in clinical supervision: Another step in delineating effective supervision practice. *American Journal of Psychotherapy*, *68*, 151–162.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16,* 252-260.

Bordin, E. S. (1983). A working alliance based model of supervision. *The Counseling Psychologist*, *11*, 35–41.

Borenstein, M., Hedges, L., V., Higgins, J. P. T., & Rothstein, H. R. (2009). *Introduction to meta-analysis.* Chichester, UK: John EWiley & Sons.

Boswell, J. F., Gallagher, M. W., Sauer-Zavala, S. E., Bullis, J., Gorman, J. M., Shear, M. K., … Barlow, D. H. (2013). Patient characteristics and variability in adherence and competence in cognitive-behavioural therapy for panic disorder. *Journal of Consulting and Clinical Psychology, 81,* 443-454.

Bradshaw, T., Butterworth, A., & Mairs, H. (2007). Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? *Journal of Psychiatric and Mental Health Nursing*, *14*, 4–12.

Branson, A., & Shafran, R. (2015). Therapist characteristics and their effect on training outcomes: What counts? *Behavioural and Cognitive Psychotherapy, 43,* 374-380.

Brauhardt, A., de Zwaan, M., Herpertz, S., Zipfel, S., Svaldi, J., Friederich, H-C., & Hilbert, A. (2014). Therapist adherence in individual cognitive-behavioral therapy for binge-eating disorder: Assessment, course, and predictors. *Behaviour Research and Therapy, 61,* 55-60.

Breuer, J., & Freud, S. (1895). *Studies in hysteria*. (J. Strachey, & A. Strachey, Trans.). New York, NY: Hogarth Press.

British Association for Behavioural and Cognitive Psychotherapies. (2012). *British Association for Behavioural and Cognitive Psychotherapies minimum training standards for the practice of cognitive behavioural therapy (CBT).* Retrieved January 31, 2018, from http://www.babcp.com/Accreditation/Minimum-Training-Standards.aspx

British Association for Counselling and Psychotherapy. (2016). *Ethical framework for the counselling professions*. Leicestershire, UK: British Association for Counselling and Psychotherapy.

British Association for Behavioural and Cognitive Psychotherapies. (2019). *Supervision guidance*. Retrieved September, 2019, from <https://www.babcp.com/Accreditation/Supervision.aspx>

Burke, K.C., Burke, J. D., Regier, D. A., & Rae, D. S. (1990). Age at onset of selected mental disorders in five community populations. *Archives of General Psychiatry, 47,* 511-518.

Burlingame, G. M., Earnshaw, D., Ridge, N. W., Matsumo, J., Bulkley, C., Lee, J., & Hwang, A. D. (2007). Psycho-educational group treatment for the severely and persistently mentally ill: How much leader training is necessary? *International Journal of Group Psychotherapy*, *57*, 187–218.

Callahan, J. L., Almstrom, C. M., Swift, J. K., Borja, S. E., & Heath, C. J. (2009). Exploring the contribution of supervisors to intervention outcomes. *Training and Education in Professional Psychology*, *3*, 72–77.

Care Quality Commission. (2013). *Supporting information and guidance: Supporting effective clinical supervision.* Retrieved 22/10/14, from http://www.cqc.org.uk/sites/default/files/documents/20130625\_800734\_v1\_00\_supporting\_information-effective\_clinical\_supervision\_for\_publication.pdf

Carleton, R. N., Norton, M. A., & Asmundson, G. J. G. (2007). Fearing the unknown: A short version of the Intolerance of Uncertainty Scale. *Journal of Anxiety Disorders, 21*, 105-117.

Carroll, K. M., Nich, C., Sifry, R. L., Nuro, K. F., Frankforter, T. L., Ball, S. A., … Rounsaville, B. J. (2000). A general system for evaluating therapist adherence and competence in psychotherapy research in the addictions. *Drug and Alcohol Dependence*, *57*, 225–238.

Carroll, M. (1996). *Counselling supervision: Theory skills and practice*. London, UK: Cassell.

Carroll, M. (2007). One more time: What is supervision? *Psychotherapy in Australia, 13,* 34-40.

Carter, J. D., Luty, S. E., McKenzie, J. M., Mulder, R. T. Frampton, C. M., & Joyce, P. R. (2011). Patient predictors of response to cognitive behaviour therapy and interpersonal psychotherapy in a randomised clinical trial for depression. *Journal of Affective Disorders, 128,* 252-261.

Cashwell, T. H., & Dooley, K. (2001). The impact of supervision on counselor self-efficacy. *The Clinical Supervisor*, *20*, 39–47.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64*, 497-504.

Chagnon, J., & Russell, R. K. (1995). Assessment of supervisee developmental level and supervision environment across supervisor experience. *Journal of Counseling & Development*, *73*, 553-558.

Chen, P., Furukawa, T. A., Shinohara, K., Honyashiki, M., Imai, H., Ichikawa, K., … Churchill, R. (2014). Quantity and quality of psychotherapy trials for depression in the past five decades. *Journal of Affective Disorders, 165,* 190-195.

Churchill, R., Hunot, V., Corney, R., Knapp, M., McGuire, P., Tylee, A., & Wessely, S. (2001). A systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression. *Health Technology Assessment, 5*, 1-173.

Cipriani, A., Furukawa, T. A., Salanti, G., Chaimani, A., Atkinson, L. Z., Ogawa, Y., … Geddes, J. R. (2018). Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. *The Lancet, 391,* 1357-1366.

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry, 23,* 318-327.

Clark, D. M., Canvin, L., Green, J., Layard, R., Piling, S., & Janecka, M. (2018). Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data. *Lancet, 391,* 679-686.

The Cochrane Collaboration (2011). *Cochrane Handbook for Systematic Reviews of Interventions* *Version 5.1.0.* Retrieved from [www.handbook.cochrane.org](http://www.handbook.cochrane.org).

Cohen, J. (1969). *Statistical power analysis for the behavioural sciences*. Academic Press: New York, NY.

Connell, G. M. (1984). An approach to supervision of symbolic experimental psychotherapy. *Journal of Marital and Family Therapy*, *10*, 273–280.

Coyne, J. C. (1976). Toward an interactional description of depression. *Psychiatry, 39*, 28-40

Cristea, I. A., Stefan, S., Karyotaki, E., David, D., Hollon, S. D., & Cuijpers, P. (2017). The effects of cognitive behavioural therapy are not systematically falling: A revision of Johnsen & Friborg (2015). *Psychological Bulletin, 143,* 326-340.

Crits-Christoph, P., & Mintz, J. (1991). Implications of therapist effects for the design and analysis of comparative studies of psychotherapies. *Journal of Consulting and Clinical Psychology, 59,* 20-26.

Crutchfield, L. B., & Borders, L. D. (1997). Impact of two clinical peer supervision models on practicing school counselors. *Journal of Counseling & Development*, *75*, 219–230.

Cuijpers, P., van Straten, A., Andersson, G., & van Oppen, P. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology, 76*, 909-922.

Cuijpers, P., van Straten, A., Bohlmeijer, E., Hollon, S. D., & Andersson, G. (2010). The effects of psychotherapy for adult depression are overestimated: a meta-analysis of study quality and effect size. *Psychological Medicine, 40,* 211-223.

Cuijpers, P., van Straten, A., Smit, F., & Andersson, G. (2009). Is psychotherapy for depression equally effective in younger and older adults? A meta-regression analysis. *International Psychogeriatrics, 21,* 16-24.

Cuijpers, P., Weitz, E., Cristea, I. A., & Twisk, J. (2017). Pre-post effect sizes should be avoided in meta-analyses. *Epidemiology and Psychiatric Sciences, 26*, 364-368.

Cuijpers, P., Weitz, E., Twisk, J., Kuehner, C., Cristea, I., David, D., … Hollon, S. D. (2014). Gender as predictor and moderator of outcome in cognitive behavior therapy and pharmacotherapy for adult depression: An “Individual patient data” meta-analysis. *Depression and Anxiety, 31,* 941-951.

Davidson, R. T., Miller, R. D., Turnbull, C. D., & Sullivan, J. L. (1982). Atypical depression. *Archives of General Psychiatry, 39,* 527-534.

Deacon, B. J., Farrell, N. R., Kemp, J. J., Dixon, L. J., Sy, J. T., Zhang, A. R., & McGrath, P. B. (2013). Assessing therapist reservations about exposure therapy for anxiety disorders: The Therapist Beliefs about Exposure Scale. *Journal of Anxiety Disorders, 27*, 772-780.

Delaney, D. J. (1972). A behavioral model for the practicum supervision of counselor candidates. *Counselor Education and Supervision*, *12*, 46–50.

Delgadillo, J., Saxon, D., & Barkham, M. (2018). Associations between therapists' occupational burnout and their patients' depression and anxiety treatment outcomes. *Depression and Anxiety, 35*, 844-850.

Dennhag, I., Gibbons, M. B. C., Barber, J. P., Gallop, R., & Crits-Christoph, P. (2012). Do supervisors and independent judges agree on evaluations of therapist adherence and competence in the treatment of cocaine dependence? *Psychotherapy Research, 22*, 720-730.

DeRubeis, R. J., & Feeley, M. (1990). Determinants of change in cognitive therapy for depression. *Cognitive Therapy and Research, 14,* 469-482.

Detweiler, J. B., & Whisman, M. A. (2006). The role of homework assignments in cognitive therapy for depression: Potential methods for enhancing adherence. *Clinical Psychology: Science and Practice, 6,* 267-282.

Diguer, L., Barber, J., & Luborsky, L. (1993). Three concomitants: personality disorders, psychiatric severity, and outcome of dynamic psychotherapy of major depression. *American Journal of Psychiatry, 150,* 1246-1248.

Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E., … Jacobson, N. S. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology, 74,* 658-670.

Dodenhoff, J. T. (1981). Interpersonal attraction and direct-indirect supervisor influence as predictors of counselor trainee effectiveness. *Journal of Counseling Psychology*, *28*, 47–52.

Downs, S. H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology & Community Health*, *52*, 377–384.

Duval, S., & Tweedie, R. (2000). Trim and fill: A simple funnel-plot-based method of testing and adjusting for publication bias in meta-analysis. *Biometrics, 56*, 455-463.

Edwards, J. K., & Chen, M. (1999). Strength-based supervision: Frameworks, current practice, and future directions. *The Family Journal: Counseling and Therapy for Couples and Families*, *7*, 349–357.

Eells, T.D., Lombart, K.G., Kendjelic, E. M., Turner, L. C., & Lucas, C. P. (2005). The quality of psychotherapy case formulations: A comparison of expert, experienced, and novice cognitive-behavioral and psychodynamic therapists. *Journal of Consulting and Clinical Psychology, 73*, 579-789.

Eisler, R. (1987). *The chalice and the blade*. New York, NY: Harper and Row.

Ekstein, R., & Wallerstein, R. S. (1972). *The teaching and learning of psychotherapy* (2nd ed.). New York, NY: International Universities Press.

Ellington, D. (n.d.). Basic skills observation. *Unpublished Instrument*.

Ellis, M. (1991). Critical incidents in clinical supervision and in supervisor supervision: Assessing supervisory issues. *Training and Education in Professional Psychology*, *38*, 342–349.

Ellis, M., & Dell, D. M. (1986). Dimensionality of supervisor roles: Supervisors’ perceptions of supervision. *Journal of Counseling Psychology*, *33*, 282–291.

Ellis, M., Dell, D. M., & Good, G. E. (1988). Counselor trainees’ perceptions of supervisor roles: Two studies testing the dimensionality of supervision. *Journal of Counseling Psychology*, *35*, 315–324.

Ellis, M. V., & Ladany, N. (1997). Interferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 447-507). New York, NY: Wiley.

Ellis, M. V, Ladany, N., Schult, D., & Krengel, M. (1996). Clinical supervision research from 1981 to 1993 : A methodological critique. *Journal of Counseling Psychology*, *43*, 35–50.

Evans, M. D., Hollon, S. D., DeRubeis, R. J., Piasecki, J. M., Grove, W. M., Garvey, M. J., & Tuason, V. B. (1992). Differential relapse following cognitive therapy and pharmacotherapy for depression. *Archives of General Psychiatry, 49*, 802-808.

Falkenström, F., Markowitz, J. C., Jonker, H., Philips, B., & Holmqvist, R. (2013). Can psychotherapists function as their own controls? Meta-analysis of the “crossed therapist” design in comparative psychotherapy trials. *Journal of Clinical Psychology, 74,* 482-491.

Farrell, N. R., Deacon, B. J., Dixon, L. J., and Lickel, J. J. (2013). Theory-based training strategies for modifying practitioner concerns about exposure therapy. *Journal of Anxiety Disorders, 27*, 781-787.

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G\*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences*. Behavior Research Methods, 39,* 175-191.

Fenell, D. L., Hovestadt, A. J., & Harvey, S. J. (1986). A comparison of delayed feedback and live supervision models of marriage and family therapist clinical training. *Journal of Marital and Family Therapy*, *12*, 181–186.

Fennell, M. V. J. (1989). Depression. In K. Hawton, P. M. Salkovskis, J. Kirk., & D. M. Clark (Eds.), *Cognitive behaviour therapy for psychiatric problems: a practical guide.* (pp. 169-234). New York, NY: Oxford University Press.

Fournier, J., DeRubeis, R. J., Hollon, S. D., Dimidjian, S., Amsterdam, J. D., Shelton, R. C., & Fawcett, J. (2010). Antidepressant drug effects and depression severity: A patient-level meta-analysis. *The Journal of the American Medical Association, 303,* 47-53.

Franklin, M. E., Abramowitz, J. S., Furr, J. M., Kalsy, S., & Riggs, D. S. (2003). A naturalistic examination of therapist experience and outcome of exposure and ritual prevention for OCD. *Psychotherapy Research, 13,* 153-167.

Frawley-O’Dea, M. G., & Sarnat, J. E. (2001). *The supervisory relationship: A contemporary psychodynamic approach*. New York, NY: Guilford.

Freeman, A., Pretzer, J., Fleming, B., & Simon, K. M. (1990). *Clinical applications of cognitive therapy*. New York, NY: Plenum Press.

Freitas, G. (2002). The imapct of psychotherapy supervision: A critical examination of 2 decades of research. *Psychotherapy: Theory, Research, Practice, Training, 39,* 354-367.

Freud, S. (1917/2001). *Mourning and melancholia in the standard edition of the complete psychological works of Sigmund Freud* (J. Strachey, Trans.). London, UK: The Hogarth Press.

Friedlander, M. L., & Snyder, J. (1983). Trainees’ expectations of the supervisory process: Testing a developmental model. *Counselor Education and Supervision*, *22*, 342–348.

Friedman, M. A., Detweiler-Bedell, J. B., Leventhal, H. E., Home, R., Keitner, G. I., & Miller, I. W. (2004). Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clinical Psychology: Science and Practice, 11,* 47-68.

Friedman, D., & Kaslow, N. J. (1986). The development of professional identity in psychotherapists: Six stages in the supervision process. In F. W. Kaslow (Ed.), *Supervision and training: Models, dilemmas, and challenges* (pp. 29–49). New York, NY: Haworth.

Fryers, T., Melzer, D., & Jenkins, R. (2003). Social inequalities and the common mental disorders: A systematic review of the evidence. *Social Psychiatry and Psychiatric Epidemiology, 38,* 229-237.

Gamerman, V., Cai T., & Elsäßer, A. (2018). Pragmatic randomized clinical trials: best practices and statistical guidance. *Health Services and Outcomes Research Methodology, 19*, 23-35.

Gibbons, C. J., Fournier, J. C., Stirman, S. W., DeRubeis, R. J., Crits-Christoph, P., & Beck, A. T. (2010). The clinical effectiveness of cognitive therapy for depression in an outpatient clinic. *Journal of Affective Disorders, 125,* 169-176.

Gibbons, C. R., Stirman, S. W., DeRubeis, R. J., Newman, C. F., & Beck, A. T. (2013). Research setting versus clinic setting: Which produces better outcomes in cognitive therapy for depression? *Cognitive Therapy and Research, 37*, 605-612.

Gilbert, M. C., & Evans, K. (2000). *Psychotherapy supervision: An integrated relational approach to psychotherapy supervision*. Buckingham, UK: Open University.

Gloaguen, V., Cottraux, J., Cucherat, M., & Blackburn, I. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders, 49*, 59-72.

Goldberg, S. B, Rousmniere, T., Miller, S. D., Whipple, J., Nielson, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology, 63,* 1-11.

Gonsalvez, C., & Freestone, J. (2007). Field supervisors’ assessments of trainee performance: Are they reliable and valid? *Australian Psychologist, 42*, 23-32.

Gortner, E. T., Gollan, J. K., Dobson, K. S., & Jacobson, N. S. (1998). Cognitive-behavioral treatment for depression: Relapse prevention. *Journal of Consulting and Clinical Psychology, 66,* 377-384.

Granello, D. H. (2000). Encouraging the cognitive development of supervisees: Using Bloom’s Taxonomy in supervision. *Counselor Education and Supervision*, *40*, 31–46.

Grater, H. A. (1985). Stages in psychotherapy supervision: From therapy skills to skilled therapist. *Professional Psychology: Research and Practice*, *16*, 605–610.

Gray, L. A., Ladany, N., Walker, J. A., & Ancis, J,. R. (2001). Psychotherapy trainees’ experience of counterproductive events in supervision. *Journal of Counseling Psychology, 48,* 371-383.

Gray-Little, B., Williams, V.S.L., & Hancock, T. D. (1997). An item response theory analysis of the Rosenberg Self-Esteem Scale. *Personality and Social Psychology Bulletin, 23,* 443-451.

Green, H., Barkham, M., Kellett, S., & Saxon, D. (2014). Therapist effects and IAPT Psychological Wellbeing Practitioners (PWPs): A multilevel modelling and mixed methods analysis. *Behaviour Research and Therapy, 63,* 43-54.

Greenberg, L. S. (2009). Emotion in the therapeutic relationship in emotion-focused therapy. In P. Gilbert, & R. L. Leahy (Ed.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 24-42). Hove, UK: Routledge.

Greenberg, G. (2013). *The book of woe: The DSM and the unmaking of psychiatry.* New York, NY: Scribe.

Greenberg. P. E., Kessler, R. C., Birnbaum, H. G., Leong, S. A., Lowe, S. W., Berglund, P. A., & Corey-Lisle, P. K. (2003). The economic burden of depression in the United States: How did it change between 1990 and 2000? *Journal of Clinical Psychiatry, 12,* 1465-1475.

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review, 102*, 4-27.

Grossl, A. B., Reese, R. J., Norsworthy, L. A., & Hopkins, N. B. (2014). Client feedback data in supervision: Effects on supervision and outcome. *Training and Education in Professional Psychology*, *8*, 182–188.

Gyani, A., Shafran, R., Layard, R., & Clark, D. M. (2013). Enhancing recovery rates: Lessons from year one of IAPT. *Behaviour Research and Therapy, 51,* 597-606.

Haber, R. (1996). *Dimensions of psychotherapy supervision: Maps and means*. New York, NY: Norton.

Hamilton, K. E., & Dobson, K. S. (2002). Cognitive therapy of depression: Pretreatment patient predictors of outcome. *Clinical Psychology Review, 22,* 875-893.

Hamilton, M. C., Anderson, D., Broaddus, M., & Young, K. (2006). Gender stereotyping and under-representation of female characters in 200 popular children’s picture books: A twenty-first century update*. Sex Roles, 55*, 757-765.

Hammen, C., & Watkins, E. (2008). *Depression.* Hove, UK: Psychology Press.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services*. Clinical Psychology: Science and Practice, 9,* 329-343.

Hansen, P. E. B., Ravnkilde, B., Videbech, P., Clemmensen, K., Sturlason, R., Reiner, M., …Vestergaard, P. (2011). Low-frequency repetitive transcranial magnetic stimulation inferior to electroconvulsive therapy in treating depression. *The Journal of ECT, 27,* 26-32.

Hardy, G., Cahill, J., & Barkham, M. (2009). Active ingedients of the therapeutic relationship that promote client change. In P. Gilbert, & R. L. Leahy (Ed.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 24-42). Hove, UK: Routledge.

Hardy, G., Stiles, W., Barkham, M. & Startup, M. (1998). Therapist responsiveness to client interpersonal styles during time-limited treatments for depression. *Journal of Consulting and Clinical Psychology, 66,* 304-312.

Hawkins, P., & Shohet, R. (1989). *Supervision in the helping professions*. Milton Keynes, UK: Open University Press.

Hawkins, P., & Shohet, R. (1993). *Supervision in the helping professions*. Buckingham, UK: Open University.

Healy, D. (2009). *Psychiatric drugs explained* (5th Ed). London, UK: Livingstone Elsevier.

Heilman, M. E. (2012). Gender stereotypes and workplace bias. *Research in Organizational Behaviour, 32*, 113-135.

Helbig, S., & Fehm, L. (2004). Problems with homework in CBT: Rare exception or rather frequent? *Behavioural and Cognitive Psychotherapy, 32,* 291-301.

Henriksson, M. M., Aro, H. M., Marttunen, M. J., Heikkinen, M. E., Isometsa, E. T., Kuoppasalmi, K. I., & Lonnqvist, J. K. (1993). Mental disorders and comorbitidy in suicide. *American Journal of Psychiatry, 150*, 935-940.

Heppner, P. P., & Roehlke, H. J. (1984). Differences among supervisees at different levels of training: Implications for a developmental model of supervision. *Journal of Counseling Psychology*, *31*, 76–90.

Hess, A. K. (1986). Growth in supervision: Stages of supervisee and supervisor development. *The Clinical Supervisor*, *4*, 51–67.

Hipp, J. L., & Munson, C. E. (1995). The partnership model: A feminist supervision/consultation perspective. *The Clinical Supervisor*, *13*, 23–38.

Hoffart, A., & Martinsen, E. (1993). The effect of personality disorders and anxious-depressive comorbidity on outcome in patients with unipolar depression and with panic disorder and agoraphobia. *Journal of Personality Disorders, 7,* 304-311.

Hogan, R. A. (1964). Issues and approaches in supervision. *Psychotherapy: Theory, Research & Practice*, *1*, 139–141.

Hollon, S. D., Shelton, R. C., Wisniewski, S., Warder, D., Biggs, M. M., Friedman, E. S., … Rush, A. J. (2006). Presenting characteristics of depressed outpatients as a function of recurrence: Preliminary findings from the STAR\*D clinical trial. *Journal of Psychiatric Research, 40,* 59-69.

Holloway, E. L. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*, 223–233.

Horwitz, A. (2015). The DSM-5 and the continuing transformation of normal sadness into depressive disorder. *Emotion Review, 7,* 209-215.

Hosford, R. E., & Barmann, B. (1983). A social learning approach to counselor supervision. *The Counseling Psychologist*, *11*, 51–58.

Hunter, J. E., Jensen, J. L., & Rodgers, R. (2014). The control group and the meta-analysis. *Journal of Methods and Measurement in the Social Sciences, 5,* 3-21.

Huppert, J. D., Barlow, D. H., Gorman, J. M., Shear, M. K., Woods, S. W. (2006). The interaction of motivation and therapist adherence predicts outcome in cognitive behavioural therapy for panic disorder: Preliminary findings. *Cognitive and Behavioral Practice, 13,* 198-204.

Huppert, J. D., Bufka, L. F., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2001). Therapists, therapist variables, and cognitive-behavioural therapy outcome in a multicenter trial for panic disorder. *Journal of Consulting and Clinical Psychology, 69*, 747-755.

Hutter, R. I. V., Oldenhof-Veldman, T., & Oudejans, R. R. D. (2015). What trainee sport psychologists want to learn in supervision. *Psychology of Sport and Exercise*, *16*, 101–109.

Hyde, J. S. (2005). The gender similarities hypothesis. *American Psychologist, 60,* 581-592.

Improving Access to Psychological Therapies. (2010a). *Curriculum for counselling for depression: Continuing professional development for qualified therapists delivering high intensity interventions.* London, UK: National IAPT Programme Team.

Improving Access to Psychological Therapies. (2010b). Interpersonal psychotherapy for depression (IPT) competency framework. Retrieved 07/10/15, from <http://www.iapt.nhs.uk/silo/files/interpersonal-psychotherapy-for-depression-ipt-competency-framework.pdf>

Inskipp, F., & Proctor, B. (2009). *The art, craft and task of counselling supervision: Making the most of supervision*. Twickenham, UK: Cascade.

Jacobson, N. S., Dobson, K.S., Truax, P. A., Addis, M. E., Koerner, K., Gollan, J. K., … Prince, S. E. (1996). A component analysis of cognitive-behavioral treatment for depression. *Journal of Consulting and Clinical Psychology, 64,* 295-304.

Jarrett, R. B., Eaves, G. G., Grannemann, B. D., & Rush, A. J. (1991). Clinical, cognitive, and demographic predictors of response to cognitive therapy for depression: a preliminary report. *Psychiatry Research, 37,* 245–260.

Johansson, H., & Jansson, J-A. (2010). Therapeutic alliance and outcome in routine psychiatric out-patient treatment: Patient factors and outcome. *Psychology and Psychotherapy: Theory, Research and Practice, 83,* 193-206.

Johnsen T. J., Friborg O. (2015). The effects of cognitive behavioral therapy as an anti-depressive treatment is falling: A meta-analysis. *Psychological Bulletin, 141*, 747-768.

Jones, I. H., & Pansa, M. (1979). Some nonverbal aspects of depression and schizophrenia occurring during the interview. *Journal of Nervous Mental Disease, 30,* 402-409.

Kadushin, A. (1976). *Supervision in social work*. New York, NY: Columbia University Press.

Kanter, J. W., Busch, A. M., & Rusch, L. C. (2009). *The CBT distinctive features series: Behavioural activation.* New York, NY: Routledge.

Kazantzis, N., & Lampropoulos, G. K. (2002). Reflecting on homework psychotherapy: What can we conclude from research and experience? *Journal of Clinical Psychology, 58*, 577-585.

Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist, 63*, 146-159.

Keijsers, G., Schaap, C., & Hoogduin, C. (2000). The impact of interpersonal patient and therapist behavior on outcome in cognitive-behavior therapy. A review of empirical studies. *Behavior Modification, 24,* 264-297.

Keller, M. B., McCullough, J. P., Klein, D. N., Arnow, B., Dunner, D. L., Gelenberg, A., J., … Zajecka, J. (2000). A comparison of Nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *The New England Journal of Medicine, 342,* 1462-1470.

Kendler, K., S. (2016). The phenomenology of major depression and the representativeness and nature of DSM criteria. *American Journal of Psychiatry, 173,* 771-780.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., … Wang, P.S. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R). *Journal of the American Medical Association, 289,* 3095-3105.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions on DSM-IV disorders in the National Comorbidity Survey Replication*. Archives of General Psychiatry, 62,* 593-602.

Kessler, R. C., Nelson, C. B., McGonagle, K. A., Lui, J., Swartz, M., & Blazer, D. G. (1996). Comorbidity of DSM-III-R major depressive disorder in the general population: results from the US National Comorbidity Survey. *British Journal of Psychiatry, 168,* 17-30.

Kilminster, S. M., & Jolly, B. C. (2000). Effective supervision in clinical practice settings: A literature review. *Medical Education, 34*, 827-840.

Kirsch, I. (2014). Antidepressants and the placebo effect. *Zeitschrift Fur Psychologie, 222*, 128–134.

Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J., & Johnson, B. T. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. *PLoS Medicine, 5:* e45.

Kivlighan, D. M., Angelone, E. O., & Swafford, K. G. (1991). Live supervision in individual psychotherapy: Effects on therapist’s intention use and client’s evaluation of session effect and working alliance. *Professional Psychology: Research and Practice*, *22*, 489–495.

Klinger, E. (1993). Loss of interest. In C. G. Costello (Ed.), *Symptoms of depression* (pp. 43-62). New York, NY: Wiley.

Krause, A. A., & Allen, G. J. (1988). Perceptions of counselor supervision: An examination of Stoltenberg’s model from the perspectives of supervisor and supervisee. *Journal of Counseling Psychology*, *35*, 77–80.

Krawiecka, M., Goldberg, D., & Vaughan, M. (1977). A standardized psychiatric assessment scale for rating chronic psychotic patients. *Acta Psychiatrica Scandinavica*, *55*, 299–308.

Kupfer, D. J. (1995). Sleep research in depressive illness: clinical implications – a tasting menu. *Biological Psychiatry, 38,* 391-403.

Ladany, N., Ellis, M., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development*, *77*, 447–455.

Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). *Critical events in psychotherapy supervision*. Washington, DC: American Psychological Association.

Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*, 10–24

Lambert, M. J., Hansen, N. B., Umpress, V., Lunnen, K., Okiishi, J., Burlingame, G. M., & Reisinger, C. W. (1996). *Administration and scoring manual for the OQ-45.2*. Weston, FL: American Credentialing Services.

Lambert, M., J., & Ogles, B. M. (1997). The effectiveness of psychotherapy supervision. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 421-446). New York, NY: Wiley.

Langs, R. J. (1980). Psychotherapy supervision: Theory, research and practice. In A. K. Hess (Ed.), *Psychotherapy supervision: Theory, research and practice* (pp. 103–125). New York, NY: Wiley.

Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. L. (1992). Development and validation of the Counseling Self-Estimate Inventory. *Journal of Counseling Psychology*, *39*, 105–120.

Leahy, R. L., Holland, S. J. F., & McGinn, L. K. (2012). *Treatment plans and interventions for depression and anxiety disorders* (2nd Ed.). New York, NY: Guilford.

Lee, R. E., & Everett, C. A. (2004). *The integrative family therapy supervisor*. New York, NY: Brunner-Routledge.

Lemma, A., Target, M., & Fonagy, P. (2010). The development of a brief psychodynamic protocol for depression: Dynamic interpersonal therapy (DIT). *Psychoanalytic Psychotherapy, 24,* 329-346.

Leon, S. C., Martinovich, Z., Luts, W., & Lyons, J. S. (2005). The effect of therapist experience on psychotherapy outcomes. *Clinical Psychology and Psychotherapy, 12,* 417-426.

Lepping, P., Schönfeldt-Lecuona, C., Sambhi, R. S., Lanka, S. V. N., Lane, S., Whittington, R., … & Poole, R. (2014). A systematic review of the clinical relevance of repetitive transcranial magnetic stimulation*. Acta Psychiatrica Scandinavica, 130,* 326-341.

Lichtenberg, J. W. (2007). What makes for effective supervision? In search of clinical outcomes. *Professional Psychology: Research and Practice*, *38*, 275.

Liese, B. S., & Beck, J. S. (1997). Cognitive therapy supervision. In *Handbook of psychotherapy supervision* (pp. 114–133). New York, NY: Wiley.

Lilenfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2013). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review, 33*, 883-900.

Linehan, M. M. (1980). Supervision of behavior therapy. In A. K. Hess (Ed.), *Psychotherapy supervision: Theory, research and practice* (pp. 148–180). New York, NY: Wiley.

Littrell, J. M., Lee-Borden, N., & Lorenz, J. (1979). A developmental framework for counseling supervision. *Counselor Education and Supervision*, *19*, 119–136.

Livni, D., Crowe, T. P., & Gonsalvez, C. J. (2012). Effects of supervision modality and intensity on alliance and outcomes for the supervisee. *Rehabilitation Psychology*, *57*, 178–186.

Lizzio, A., Wilson, K., & Que, J. (2009). Relationship dimensions in the professional supervision of psychology graduates: Supervisee perceptions of processes and outcome. *Studies in Continuing Education*, *31*, 127–140.

Ljótsson, B., Hedman, E., Mattsson, & Andersson, E. (2017). The effects of a cognitive-behavioural therapy for depression are not falling: A re-analysis of the Johnsen and Friborg (2015). *Psychological Bulletin, 143*, 321-325

Loeb, K. L., Wilson, G. T., Labouvie, E., Pratt, E. M., Hayaki, J., Walsh, B. T., … Fairburn, C. G. (2005). Therapeutic alliance and treatment adherence in two interventions for bulimia nervosa: A study of process and outcome. *Journal of Consulting and Clinical Psychology, 73,* 1097-1107.

Loganbill, C. R., Hardy, E. V., & Delworth, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist*, *10*, 3–42.

Lohr, J. M., Lilenfeld, S. O., & Rosen, G. M. (2012). Anxiety and its treatment: Promoting science-based practice. *Journal of Anxiety Disorders, 26,* 719-727.

Loo, C., & Mitchell, P. (2005). A review of the efficacy of transcranial magnetic stimulation (TMS) treatment for depression, and current and future strategies to optimize efficacy. *Journal of Affective Disorders, 88,* 255-267.

Lorenz, N., Sander, C., Ivanova, G., & Hegerl, U. (2020). Temporal associations of daily changes in sleep and depression core symptoms in patients suffering from major depressive disorder: Idiographic time-series analysis. *Journal of Medical Internet Research Mental Health, 7,* e17071

Luborsky, L., Diguer, L., Cacciola, J., Barber, J. P., Moras, K., Schmidt, K., & DeRubeis, R. J. (1996). Factors in outcomes of short-term dynamic psychotherapy for chronic vs. nonchronic major depression. *Journal of Psychotherapy Practice and Research, 5,* 152-159.

Lyth, G. M. (2000). Clinical supervision: A concept analysis. *Journal of Advanced Nursing*, *31*, 722–729.

Maj, M. (2010). Depression vs. "understandable sadness": Is the difference clear, and is it relevant to treatment decisions? *Asian Journal of Psychiatry, 3*, 96-98.

Marcus, M., Yasamy, M. T., van Ommeren, M., Chisholm, D., & Saxena, S. (2012). *Depression: A global public health concern*. from http://wfmh.com/wp-content/uploads/2013/11/2012\_wmhday\_english.pdf

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68,* 438-450.

Mason, L., Grey, N., & Veale, D. (2016). My therapist is a student? The impact of therapist experience and client severity on cognitive behavioural therapy outcomes for people with anxiety disorders. *Behavioural and Cognitive Psychotherapy, 44,* 193-202.

Mausbach, B. T., Moore, R., Roesch, S., Cardenas, V., & Patterson, T. L. (2010). The relationship between homework compliance and therapy outcomes: An updated meta-analysis. *Cognitive Therapy and Research, 34*, 429-438.

McLeod, B. D. (2009). Understanding why therapy allegiance is linked to clinical outcomes. *Clinical Psychology: Science and Practice, 16,* 69-72.

McNeill, B. W., Stoltenberg, C. D., & Pierce, R. A. (1985). Supervisees’ perceptions of their development: A test of the counselor complexity model. *Journal of Counseling Psychology*, *32*, 630–633.

McNeill, B. W., Stoltenberg, C., & Romans, J. S. C. (1992). The integrated developmental model of supervision: Scale development and validation procedures. *Professional Psychology: Research and Practice*, *23*, 504–508.

Mead, D. E. (1990). *Effective supervision: A task-oriented model for the mental health professions.* Philadelphia, PA: Brunner/Mazel.

Meehl, P. E. (1973). Why I do not attend case conferences. In *P. E. Meehl: Psychodiagnosis: Selected papers (pp. 225–302)*. Minneapolis, MN: University of Minnesota Press.

Mehin, R., Burnett, R. S., & Brasher, P. M. A. (2010). Does the new generation of high-flex knee prostheses improve the post-operative range of movement? *The Journal of Bone and Joint Surgery*, 92-B, 1429-1434.

Mehr, K. E., Ladany, N., & Caskie, G. I. L. (2015) Factors influencing trainee willingness to disclose in supervision*. Training and Education in Professional Psychology, 9,* 44-51.

Meyer, J. M., Farrell, N. R., Kemp, J. J., Blakey, S. M., and Deacon, B. J. (2014). Why do clinicians exclude anxious clients from exposure therapy? *Behaviour Research and Therapy, 54*, 49-53.

Miars, R. D., Tracey, T. J., Ray, P. B., Cornfeld, J. L., O’Farrell, M., & Gelso, C. J. (1983). Variation in supervision process across trainee experience levels. *Journal of Counseling Psychology*, *30*, 403–412.

Miller, S. D., & Duncan, B. L. (2000). *The outcome rating scale*. Chicago, IL: Author.

Milne, D. (1998). Clinical supervision: Time to reconstruct or to retrench? *Clinical Psychology and Psychotherapy*, *5*, 199–203.

Milne, D., & James, I. (2000). A systematic review of effective cognitive-behavioural supervision. *British Journal of Clinical Psychology, 39*, 111-127.

Milne, D., Pilkington, J., Gracie, J., & James, I. (2003). Transferring skills from supervision to therapy: a qualitative and quantitative N=1 analysis. *Behavioural and Cognitive Psychotherapy*, *31*, 193–202.

Missinne, S., & Bracke, P. (2012). Depressive symptoms among immigrants and ethnic minorities: a population based study in 23 European countries. *Social Psychiatry and Psychiatric Epidemiology, 47,* 97-109.

Moldovan, R., & David, D. (2013). The impact of supervisor characteristics on trainee outcome in clinical supervision: A brief report. *Journal of Cognitive and Behavioral Psychotherapies, 13*, 517-527.

Morgan, M. M., & Sprenkle, D. H. (2007). Toward a common-factors approach to supervision. *Journal of Marital and Family Therapy*, *33*, 1–17.

Morris, S. B., & DeShon, R. P. (2002). Combining effect size estimates in meta-analysis with repeated measures and independent-groups designs. *Psychological Methods, 7*, 105-125

Mrazek, D. A., Hornberger, J. C., Altar, C. A., & Degtiar, I. (2014). A review of the clinical, economic, and societal burden of treatment-resistent depression: 1996-2013. *Psychiatric Services, 65*, 977-987.

Mueller, W. J., & Kell, B. L. (1972). *Coping with conflict: Supervision counselors and psychotherapists*. New York, NY: Appleton-Century-Crofts.

Murphy, J. M., Laird, N. M., Monson R. R., Sobol, A. M., & Leighton, A. H. (2000). A 40-year perspective on the prevalence of depression. *Archives of General Psychiatry, 57,* 209-215.

Murphy, M. F., & Moller, M. D. (1998). *My symptom management workbook: A wellness expedition* (2nd ed.). Nine Mile Falls, WA: Psychiatric Rehabilitation Nurses, Inc.

Narrow, W. E., Rae, D. S., Robbins, L. N., & Regier, D. A. (2002). Revised prevalence estimates of mental disorder in the United States: Using a clinical significance criterion to reconcile 2 surveys’ estimates. *Archives of General Psychiatry, 59,* 115-123.

National Health Service Providers. (2016). *Funding for mental health at a local level: Unpicking the variation*. Retrieved from https://www.nhsproviders.org/media/1945/nhs-providers\_hfma\_mental-health-survey.pdf

National Institute for Health and Care Excellence. (2011). *Depression in adults (QS8)*. Retrieved 10/10/14, from https://www.nice.org.uk/guidance/qs8

Nelson, J., Klumparendt, A., Doebler, P., & Thomas, E. (2020). Everyday emotional dynamics in major depression. *Emotion, 20*, 179-191.

Nelson, M. D., & Johnson, P. (1999). School counselors as supervisors: An integrated approach for supervising school counseling interns. *Counselor Education and Supervision*, *39*, 89–100.

Nelson, M. L., & Holloway, E. L. (1990). Relation of gender to power and involvement in supervision. *Journal of Counseling Psychology, 37*, 473-481.

Neuendorf, K. A. (2002). *The content analysis guidebook*. Thousand Oaks, CA: Sage.

Newman, M. G., Zuellig, A. R., Kachin, K. E., Constantino, M. J., Przeworski, A., Erickson, T., Cashman-McGrath, L. (2002). Preliminary reliability and validity of the generalized anxiety disorder questionnaire-IV: A revised self-report diagnostic measure of generalized anxiety disorder. *Behavior Therapy, 33,* 215-233.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients’ psychotherapy outcome. *Journal of Clinical Psychology, 62,* 1157-1172.

O’Donovan, A. O., Halford, W. K., & Walters, B. (2011). Towards best practice supervision of clinical psychology trainees. *Australian Psychologist*, *46*, 101–112.

O’Malley, S. S., Foley, S. H., Rounsaville, B. J., Watkins, J. T., Sotsky, S. M., Imber, S. D., & Elkin, I. (1988). Therapist competence and patient outcome in interpersonal psychotherapy for depression. *Journal of Consulting and Clinical Psychology, 56,* 496-501.

Ost, L-G., Karlstedt, A., & Widen, S. (2012). The effects of cognitive behavior therapy delivered by students in a psychologist training program: An effectiveness study. *Behavior Therapy, 43*, 160-173.

Padesky, C. A., & Mooney, K. A. (1990). Presenting the cognitive model to clients. *International Cognitive Therapy Newsletter, 6,* 13-14.

Page, S., & Wosket, V. (2015). *Supervising the counsellor and psychotherapist: A cyclical model*. Hove, UK: Routledge.

Patten, S. B. (2009). Accumulation of major depressive episodes over time in a prospective study indicates that retrospectively assessed lifetime prevalence estimates are too low. *BMC Psychiatry, 9,* 19.

Patterson, C. H. (1983). A client-centered approach to supervision. *The Counseling Psychologist*, *11*, 21–25.

Patton, M., & Kivlighan, D. (1997). Relevance of the supervisory alliance to the counseling alliance and to treatment adherence in counselor training. *Journal of Counseling Psychology, 44,* 108-115.

Paykel, E. S. (1977). Depression and appetite. *Journal of Psychosomatic Research, 21,* 401-407.

Paykel, E. S., Brugha, T., & Fryers, T. (2005). Size and burden of depressive disorders in Europe. *European Neuropsychopharmacology, 15,* 411-423.

Pearce, P., Sewell, R., Hill, A., & Coles, H. (2012). Counselling for depression. *Therapy Today, 23,* 20-23.

Persons, J. B., Bostrom, A., & Bertagnolli, A. (1999). Results of randomised controlled trials of cognitive therapy for depression generalize to private practice. *Cognitive Therapy and Research, 23,* 535-548.

Persons, J. B., Burns, D. D., & Perloff, J. M. (1988). Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognitive Therapy and Research, 12,* 557–575.

Persons, J. B., Roberts, N. A., Zalecki, C. A., & Brechwald, W. A. G. (2006). Naturalistic outcome of case formulation-driven cognitive-behavior therapy for anxious depressed outpatients. *Behaviour Research and Therapy, 44,* 1041-1051.

Peake, T. H., Nussbaum, B. D., & Tindell, S. D. (2002). Clinical and counseling supervision references: Trends and needs. *Psychotherapy: Theory/Research/Practice/Training*, *39*, 114–125.

Peters-Scheffer, N., Didden, R., Korzilius, H., & Sturmey, P. (2013). Therapist characteristics predict discrete trial teaching procedural fidelity. *Intellectual and Developmental Disabilities, 51,* 263-272.

Pierce, R. M., & Schauble, P. G. (1970). Toward the development of facilitative counselors: The effects of practicum instruction and individual supervision. *Journal of Counseling Psychology*, *17*, 210–215.

Piercy, F., Laird, R., & Mohammed, Z. (1983). A family therapy rating scale. *Journal of Marital and Family Therapy*, *9*, 49–60.

Piette, J. D., Valenstein, M., Himle, J., Duffy, S., Torres, T., Vogel, M., & Richardson, C. (2011). Clinical complexity and the effectiveness of an intervention for depressed diabetes patients. *Chronic Illness, 7,* 267-278.

Proctor, B. (1988). Supervision: a co-operative exercise in accountability. In M. Marken & M. Payne (Eds). *Enabling and ensuring: Supervision in practice*. Leicester, UK: National Youth Bureau and Council for Education and Training in Youth and Community Work.

Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology*, *3*, 157–168.

Reising, G. N., & Daniels, M. H. (1983). A study of Hogan’s model of counselor development and supervision. *Journal of Counseling Psychology*, *30*, 235–244.

Rice, L. N. (1980). A client-centered approach to the supervision of psychotherapy. In A. K. Hess (Ed.), *Psychotherapy supervision: Theory, research and practice* (pp. 136–147). New York, NY: Wiley.

Ridgeway, C. L., & Correll, S. J. (2004). Unpacking the gender system: A theoretical perspective on gender beliefs and social relations. *Gender and Society, 18,* 510-531.

Rief, W., Bleichhardt, G., Dannehl, K., Euteneuer, F. & Wambach, K. (2018). Comparing the efficacy of CBASP with two versions of CBT for depression in a routine care centre: A randomized clinical trial. *Psychotherapy and Psychosomatics, 87*, 164-178.

Rigazio-DiGilio, S. A., & Anderson, S. A. (1994). A cognitive-developmental model for marital and family therapy supervision. *The Clinical Supervisor*, *12*, 93–118.

Robinson, L. A., Berman, J. S., & Neimeyer, R. A. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. *Psychological Bulletin, 108,* 34-49.

Rodenhauser, P. (1994). Toward a multidimensional model for psychotherapy supervision based on developmental stages. *Journal of Psychotherapy Practice and Research*, *3*, 1–15.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Roth, A., & Fonagy, P. (2005). *What works for whom? A critical review of psychotherapy research (2nd Ed.*). New York, NY: Guilford.

Roth, A. D., Hill, A., & Pilling, S. (2009). *The competences required to deliver effective Humanistic Psychological Therapies.* Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.572.6986&rep=rep1&type=pdf

Roth, A. D., & Pilling, S. (2007). *A competence framework for the supervision of psychological therapies.* Retrieved April 4, 2016, from http://webcache.googleusercontent.com/search?q=cache:4UgjZrIovkwJ:www.nes.scot.nhs.uk/media/3226173/roth\_\_\_pilling\_\_2008\_\_supervision\_competences.rtf+&cd=4&hl=en&ct=clnk&gl=uk

Roth, A. D., Pilling, S., & Turner, J. (2010). Therapist training and supervision in clinical trials: Implications for clinical practice. *Behavioural and Cognitive Psychotherapy, 38*, 291-302.

Rousmaniere, T. G., Swift, J. K., Babins-Wagner, R., Whipple, J. L., & Berzins, S. (2016). Supervisor variance in psychotherapy outcome in routine practice. *Psychotherapy Research*, *26*, 196–205.

Rush, A., J., Trivedi, M. H., Wisniewski, S. R., Nierenberg, A. A., Stewart, J. W., Warden, D. … Fava, M. (2006). Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: A STAR\*D report. *American Journal of Psychiatry, 163,* 1905-1917.

Ryff, C. D. (1989). Happiness is everything or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, *69*, 1069–1081.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2001). Repairing alliance ruptures*. Psychotherapy: Theory/Research/Practice/Training, 38*, 406-412.

Salekin, R. T. (2002). Psychopathy and therapeutic pessimism: Clinical lore or clinical reality? *Clinical Psychology Review, 22*, 79-112.

Saxon, D., & Barkham, M. (2012). Patterns of therapist variability: Therapist effects and the contribution of patient severity and risk. *Journal of Consulting and Clinical Psychology, 80,* 535-546.

Scaife, J. (2001). *Supervision in the mental health professions: A practitioner’s guide*. Hove, UK: Brunner-Routledge.

Schindler, A. C., Hiller, W., & Witthoft, M. (2011). Benchmarking of cognitive-behavioral therapy for depression in efficacy and effectiveness studies - How do exclusion criteria affect treatment outcome? *Psychotherapy Research, 21*, 644-657.

Schoenwald, S. K., Sheidow, A. J., & Chapman, J. E. (2009). Clinical supervision in treatment transport: Effects on adherence and outcomes. *Journal of Consulting and Clinical Psychology*, *77*, 410–421.

Schumacher, S., Gaudlitz, K., Plag, J., Miller, R., Kirschbaum, C., Fehm, L., … Ströhle, A. (2014). Who is stressed? A pilot study of salivary cortisol and alpha-amylase concentrations in agoraphobic patients and their novice therapists undergoing in vivo exposure. *Psychoneuroendocrinology, 49,* 280-289.

Scott, J., Watkins, E. (2004). Brief psychotherapies for depression: Current status. *Current Opinion in Psychiatry, 17,* 3-7.

Seligman, M. E. P. (1975). *Helplessness: On Depression, Development, and Death.* San Francisco, CA: Freeman.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist, 50,* 965-974.

Shapiro, D. A., Barkham, M., Rees, A., Hardy, G. E., Reynolds, S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive–behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 62,* 522–534.

Shapiro, D. A., & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin, 92,* 581-604.

Shaw, B. F. (1999). How to use the allegiance effect to maximise competence and therapeutic outcomes. *Clinical Psychology: Science and Practice, 6,* 131-132.

Shea, M. T., Widiger, T. A., & Klein, M. H. (1992). Comorbidity of personality disorders and depression: Implications for treatment. *Journal of Consulting and Clinical Psychology, 60,* 857-868.

Sholomskas, D. E., Syracuse-Siewert, G., Rounsaville, B. J., Ball, S. A., Nuro, K. F., & Carroll, K. M. (2005). We don’t train in vain: A dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology*, *73*, 106–115.

Silverstein, B., Edwards, T., Gamma, A., Ajdacic-Gross, V., Rossler, W., & Angst, J. (2013). The role played by depression associated with somatic symptomatology in accounting for the gender difference in the prevalence of depression. *Social Psychiatry and Psychiatric Epidemiology, 48,* 257-263.

Silverstein, B., Ajdacic-Gross, V., Rossler, W., & Angst, J. (2017). The gender difference in depressive prevalence is due to high prevalence of somatic depression among women who do not have depressed relatives. *Journal of Affective Disorders, 210*, 269-272.

Simons, A. D., Gordon, J. S., Monroe, S. M., & Thase, M. E. (1995). Toward an integration of psychological, social, and biologic factors in depression: effects on outcome and course of cognitive therapy. *Journal of Consulting and Clinical Psychology, 63,* 369–377.

Simpson-Southward, C., Waller, G., & Hardy, G. E. (2016). Supervision for treatment of depression: An experimental study of the role of therapist gender and anxiety*. Behaviour Research and Therapy, 77*, 17 – 22.

Simpson-Southward, C., Waller, G., & Hardy, G. E. (2017). How do we know what makes for “best practice” in clinical supervision for psychological therapists? A content analysis of supervisory models and approaches. *Clinical Psychology and Psychotherapy*, *24*, 1228–1245.

Simpson-Southward, C., Waller, G., & Hardy, G. E. (2018). Supervisor practice when guiding therapists working with depression: The impact of supervisor and patient characteristics. *The Cognitive Behaviour Therapist, 11,* E9.

Singo, W. E. (1991). *The effects of peer group supervision and individual supervision on the anxiety, self-efficacy, and basic skill competency of counselor trainees in practicum* (Unpublished doctoral dissertation). Wayne State University, Detroit, MI.

Sobin, C., & Sackeim, H. A. (1997). Psychomotor symptoms of depression. *American Journal of Psychiatry, 154,* 4-17.

Solomon, D. A., Keller, M. B., Leon, A. C., Mueller, T. I., Lavori, P. W., Shea, M. T., … Endicott, J. (2000). Multiple recurrences of major depressive disorder. *American Journal of Psychiatry, 157,* 229-233.

Sotsky, S. M., Glass, D. R., Shea, M. T., Pilkonis, P. A., Collins, J. F., Elkin, I., … & Oliveri, M. E. (1991). Patient predictors of response to psychotherapy and pharmacotherapy: finding in the NIMH Treatment of Depression Collaborative Research Program. *American Journal of Psychiatry, 148,* 997–1008.

Spence, S. H., Wilson, J., Kavanagh, D., Strong, J., & Worrall, L. (2001). Clinical supervision in four mental health professions: A review of the evidence. *Behaviour Change*, *18*, 135–155.

Spielmans, G., I., Berman, M. I., & Usitalo, A. N. (2011). Psychotherapy versus second-generation antidepressants in the treatment of depression: A meta-analysis. *Journal of Nervous and Mental Disease, 199,* 142-149.

Squire, L. (1974). Amnesia for remote events following electroconvulsive therapy. *Behavioral Biology, 12,* 119-125.

Staczan, P., Schmuecher, R., Koehler, M., Berglar, J., Crameri, A., von Wyl, A., … Tschuschke, V. (2017). Effects of sex and gender in ten types of psychotherapy. *Psychotherapy Research, 27*, 74-88.

Steinpreis, R. E., Anders, K. A., & Ritzke, D. (1999). The impact of gender on the review of the curricula vitae of job aplicants and tenure candidates: A national empirical study. *Sex Roles, 41*, 509-528.

Stenack, R. J., & Dye, H. A. (1982). Behavioural descriptions of counseling supervision roles. *Counselor Education and Supervision*, *21*, 295–304.

Stewart, R. E., Stirman, S. W., & Chambless, D. L. (2012). A qualitative investigation of practicing psychologists' attitudes toward research-informed practice: Implications for dissemination strategies. *Profession Psychology: Research and Practice, 43,* 100-109.

Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R., & Morganstein, D. (2003). Cost of lost productive work time among US workers with depression. *Journal of the American Medical Association, 289,* 3135-3144.

Stiles, W. B. (2009). Responsiveness as an obstacle for psychotherapy outcome research: It's worse than you think. *Clinical Psychology: Science and Practice, 16,* 86-91.

Stirman, S. W., DeRubeis, R. J., Crits-Christoph, P., & Brody, P. E. (2003). Are samples in randomized controlled trials of psychotherapy representative of community outpatients? A new methodology and initial findings. *Journal of Consulting and Clinical Psychology, 71*, 963-972.

Stirman, S. W., DeRubeis, R. J., Crits-Christoph, P., & Rothman, A. (2005). Can the randomized controlled trial literature generalize to nonrandomized patients? *Journal of Consulting and Clinical Psychology, 73*, 127-135.

Stobie, B., Taylor, T., Quigley, A., Ewing, S., & Salkovskis, P. M. (2007). “Contents may vary”: A pilot study of treatment histories of OCD patients. *Behavioural and Cognitive Psychotherapy, 35,* 273-282.

Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. *Journal of Counseling Psychology*, *28*, 59–65.

Stoltenberg, C. D., & Delworth, U. (1987). *Supervising counselors and therapists.* San Francisco, CA: Jossey-Bass.

Stoltenberg, C., McNell, B. W., Crethar, H. C. (1994). Changes in supervision as counsellors and therapists gain experience: A review. *Professional Psychology: Research and Practice, 25*, 416-449.

Stoltenberg, C., Pierce, R. A., & McNeill, B. W. (1987). Effects of experience on counselor trainees’ needs. *The Clinical Supervisor*, *5*, 23–32.

Stoltenberg, C., Solomon, G. S., & Ogden, L. (1986). Comparing supervisee and superviseor initial perceptions of supervision: Do they agree? *The Clinical Supervisor*, *4*, 53–61.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York, NY: Norton.

Suurmond R, van Rhee, H, & Hak T. (2017). Introduction, comparison and validation of Meta-Essentials: A free and simple tool for meta-analysis. *Research Synthesis Methods, 8,* 537-553.

Szabadi, E., Bradshaw, C. M., & Besson, J. A. (1976). Elongation of pause-time in speech: a simple, objective measure of motor retardation in depression. *British Journal of Psychiatry, 129,* 592-597.

Tanner, M. A., Gray, J. J., & Haaga, D. A. F. (2012). Association of cotherapy supervision with client outcomes, attrition, and trainee effectiveness in a psychotherapy training clinic. *Journal of Clinical Psychology*, *68*, 1241–1252.

Terrin, N, Schmid, C. H., Lau, J., & Olkin, I. (2003). Adjusting for publication bias in the presence of heterogeneity. *Statistics in Medicine, 22*, 2113-2126.

Thase, M. E., Greenhouse, J. B., Frank, E., Reynolds, C. F., Pilkonis, P. A., Hurley, K., … Kupfer, D. J. (1997). Treatment of major depression with psychotherapy or psychotherapy-pharmacotherapy combinations. *Archives of General Psychiatry, 54,* 1009-1015.

Thase, M. E., Reynolds, C. F., Frank, E., Simons, A. D., Garamoni, G. D., McGeary, … & Cahalane, J. F. (1994). Response to cognitive–behavioral therapy in chronic depression. *Journal of Psychotherapy Practice and Research, 3,* 204–214.

Thomas, F. N. (1994). Solution-oriented supervision: The coaxing of expertise. *The Family Journal: Counseling and Therapy for Couples and Families*, *2*, 11–18.

Thorndike, E. L. (1920). A constant error in psychological ratings. *Journal of Applied Psychology, 4,* 25-29.

Tracey, T. J. G., Bludworth, J., & Glidden-Tracey, C. E. (2012). Are there parallel processes in psychotherapy supervision? An empirical examination. *Psychotherapy, 49*, 330-343.

Trepka, C., Rees, A., Shapiro, D. A., Hardy, G. E., & Barkham, M. (2004). Therapist competence and outcome of cognitive therapy for depression. *Cognitive Therapy and Research, 28,* 143-157.

Trivedi, M. H., Rush, A. J., Wisniewski, S. R., Nierenberg, A. A., Warden, D., Ritz, L. … Fava, M. (2006). Evaluation of outcomes with citalopram for depression using measurement-based care in STAR\*D: implications for clinical practice. *The American Journal of Psychiatry, 163,* 28-40.

Turner, H., Tatham, M., Lant, M., Mountford, V. A., & Waller, G. (2014). Clinicians' concerns about delivering cognitive-behavioural therapy for eating disorders. *Behaviour Research and Therapy, 57*, 38-42.

UK ECT Review Group (2003). Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. *Lancet, 361,* 799-808.

van Minnen, A., Hendriks, L., & Olff, M. (2010). When do trauma experts choose exposure therapy for PTSD patients? A controlled study of therapist and patient factors. *Behaviour Research and Therapy, 48,* 312–320.

van Ooijen, E. (2000). *Clinical supervision: A practical guide*. London, UK: Harcourt.

Wakefield, J. (2016). Diagnostic issues and controversies in DSM-5: Return of the false positives problem. *Annual Review of Clinical Psychology, 12,* 105-132.

Waller, G. (2009). Evidence-based treatment and therapist drift. *Behaviour Research and Therapy, 47*, 119-127.

Waller, G., Mountford, V. A., Tatham, M., Turner, H., Gabriel, C., & Webber, R. (2013). Attitudes towards psychotherapy manuals among clinicians treating eating disorders. *Behaviour Research and Therapy, 51*, 840-844.

Waller, G., Stringer, H., & Meyer, C. (2012). What cognitive behavioral techniques do therapists report using when delivering cognitive behavioral therapy for the eating disorders? *Journal of Consulting and Clinical Psychology, 80*, 171-175.

Waller, G., & Turner, H. (2016). Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track. *Behaviour Research and Therapy, 77*, 129-137.

Walsh, B. B., Gillespie, C. K., Greer, J. M., & Eanes, B. E. (2003). Influence of dyadic mutuality on counsellor trainee willingness to self-disclose clinical mistakes to supervisors. *The Clinical Supervisor, 21*, 83-98.

Waltz, J., Addis, M., Koerner, K., & Jacobson, N.S. (1993). Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. *Journal of Consulting and Clinical Psychology, 61,* 620-630.

Wampold, B. E., & Holloway, E. L. (1997). Methodology, design, and evaluation in psychotherapy supervision research. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 11-27). New York, NY: Wiley.

Wampold, B. E., Minami, T., Baskin, T. W., & Callen-Tierney, S. (2002). A meta-(re)analysis of the effects of cognitive therapy versus ‘other therapies’ for depression. *Journal of Affective Disorders, 68*, 159-165.

Wang, J. L. (2004). Rural – urban differences in the prevalence on major depression and associated impairment. *Social Psychiatry and Psychiatric Epidemiology, 39,* 19-25.

Wang, P. S., Demler, O., and Kessler, R. C. (2002). Adequacy of treatment for serious mental illness in the United States. *American Journal of Public Health, 92*, 92-98.

Ward, C. C., & House, R. M. (1998). Counseling supervision: A reflective model. *Counselor Education and Supervision*, *38*, 23–33.

Watkins, C. E. (1990). Development of the psychotherapy supervisor. *Psychotherapy: Theory, Research & Practice*, *4*, 553–560.

Watkins, C. E. Jr. (1998). Psychotherapy supervision in the 21st century: Some pressing needs and impressing possibilities. *The Journal of Psychotherapy Practice and Research, 7,* 93-101.

Watkins, C. E. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *The Clinical Supervisor, 30*, 235-256.

Webb, C. A., DeRubeis, R. J., Amsterdam, J. D., Shelton, R. C., Hollon, S. D., & Dimidjian, S. (2011). Two aspects of the therapeutic alliance: Differential relations with depressive symptom change. *Journal of Consulting and Clinical Psychology, 79,* 279-283.

Weck, F., Hautzinger, M., Heidenreich, T., & Stangier, U. (2010). Erfassung psychotherapeutischer Kompetenzen: Validierung einer deutschsprachigen version der Cognitive Therapy Scale. *Zeitschrift Fur Klinische Psychologie Und Psychotherapie*, *39*, 244–250.

Weck, F., Jakob, M., Neng, J. M. B., Höfling, V., Grikscheit, F., & Bohus, M. (2016). The effects of bug-in-the-eye supervision on therapeutic alliance and therapist competence in cognitive-behavioural therapy: A randomized controlled trial. *Clinical Psychology and Psychotherapy*, *23*, 386–396.

Weich, S., Nazroo, J., Sproston, K., McManus, S., Blanchard, M., Erens, B., … Tyrer, P. (2004). Common mental disorders and ethnicity in England: the EMPIRIC study. *Psychological Medicine, 34,* 1543-1551.

Wessler, R. L., & Ellis, A. (1983). Supervision in counseling: Rational-emotive therapy. *The Counseling Psychologist*, *11*, 43–49.

Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic, and generalised anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology, 69*, 875-899.

Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130,* 631-663.

Wetchler, J. L. (1990). Solution-focused supervision. *Family Therapy*, *17*, 129–138.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research*, *7*, 54–65.

White, E., & Winstanley, J. (2010). A randomised controlled trial of clinical supervision: Selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *Journal of Research in Nursing, 15*, 151-167.

Wiley, M. O., & Ray, P. B. (1986). Counseling supervision by developmental level. *Journal of Counseling Psychology*, *33*, 439–445.

Willner, P. (1984). Cognitive functioning in depression: a review of theory and research. *Psychological Medicine, 14,* 807-823.

Wilson, G. T. (1996). Manual-based treatments: the clinical application of research findings. *Behaviour Research and Therapy*, *34*, 295–314.

Witteman, C. L. M., & van den Bercken, J. H. L. (2007). Intermediate effects in psychodiagnostic classification. *European Journal of Psychological Assessment, 23*, 56-61.

World Health Organisation (2003). *Adherence to long-term therapies: Evidence for action.* Retrieved 29/08/18 from http://www.who.int/chp/knowledge/publications/adherence\_full\_report.pdf?ua=1

World Health Organisation. (2012a). *Depression (Fact sheet No. 369)*. Retrieved 30/09/14, from http://www.who.int/mediacentre/factsheets/fs369/en/

World Health Organisation. (2012b). *World suicide prevention day.* Retrieved 07/10/15, from https://www.iasp.info/wspd/pdf/2012\_wspd\_press\_package.pdf

World Health Organisation. (2014). *Preventing suicide: A global imperative.* Retrieved 07/10/15, from http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779\_eng.pdf?ua=1&ua=1

Worthington, E. L. (1987). Changes in supervision as counselors and supervisors gain experience: A review. *Professional Psychology, 18*, 189-208.

Yogev, S. (1982). An eclectic model of supervision: A developmental sequence for beginning psychotherapy students. *Professional Psychology*, *13*, 236–243.

Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis, 37,* 369-376.

Zimmerman, M., McDermut, W., & Mattia, J. I. (2000). Frequency of anxiety disorders in psychiatric outpatients with major depressive disorder. American *Journal of Psychiatry, 157,* 1337-1340.

# Appendices

## Appendix 2A. Definitions and examples of content variables.

* **Formative content** – mention of the learning and/or development of the supervisee *(functions; f)*
  + ‘*The second early stage in the development of beginning therapists focuses on the acquisition and mastery of skills and knowledge.*’ (Yogev, 1982, p. 241)
* **Normative content** – mention of managerial and/or ethical responsibilities in the supervision process (*f)*
  + ‘*These* [professional issues] *may include the exploration of ethical, legal, or other standards…*’ (Morgan & Sprenkle, 2007, p. 9)
* **Restorative content** – recognition of the emotional effects of work (*f)*
  + ‘*The supervisor has the responsibility for creating a working alliance, through which the counsellor is supported…*’ (Inskipp & Proctor, 2009, p. 9)
* **Focus on supervisor** – any specific focus on the supervisor e.g. their characteristics or their responsibilities not just a mention of the existence of supervisors *(people; p)*
  + ‘*During this stage, it is helpful for school supervisors to primarily assume both a teaching and a counseling role.*’ (Nelson & Johnson, 1999, p. 94)
* **Supervisor's personal characteristics** – any mention of any personal characteristics that are be attributed to the supervisor e.g. personality, gender etc. *(aspects of the supervisor; s)*
  + ‘*During the supervision process, new supervisors can be expected to emotionally manifest tentativeness, insecurity, and ambivalence.*’ (Watkins, 1990, p. 556)
* **Supervisor gender** – any mention of the gender of the supervisor *(s)*
  + ‘*When the supervisor and supervisee are experiencing difficulties due to sex or ethnic differences, the supervisor may choose to provide live or symbolic models of the same sex or ethnicity as that of the supervisee if it appears that such a procedure would enhance supervisee effectiveness.*’ (Hosford & Barmann, 1983, p. 54)
* **Supervisor ethnicity/culture** – any mention of the ethnicity/culture of the supervisor *(s)*
  + ‘*The supervisor brings to the relationship his or her way of viewing human behaviour, interpersonal relations, and social institutions that is largely influenced by cultural socialization.*’ (Holloway, 1995, p. 74)
* **Supervisor anxiety** – any mention of the anxiety of the supervisor *(s)*
  + ‘*The supervisor who functions in a relationship defined by mutual self-disclosure and mutual generation and processing of data makes himself vulnerable, and that vulnerability evokes anxiety.*’ (Frawley-O’Dea & Sarnat, 2001, p. 104)
* **Development of supervisor** – any mention of supervisor development *(s)*
  + ‘*Four stages of psychotherapy supervisor development are proposed.*’ (Watkins, 1990, p. 554)
* **Supervisor as authority figure/expert** – mention of the supervisor being superior to the supervisee *(s)*
  + ‘*Because the trainee is in a position of relatively lesser evaluation and expert power, the supervisor has a responsibility to ensure that the trainee is clearly informed of the evaluative structure of the relationship, the expectancies and goals for supervision, the criteria for evaluation, and the limits of confidentiality in supervision.*’ (Holloway, 1995, p. 52)
* **Focus on supervisee** – any specific focus on the supervisee e.g. their characteristics or their responsibilities not just a mention of the existence of supervisees *(p)*
  + ‘*In this mode the focus of the supervision is on the internal processes of the supervisee…*’ (Hawkins & Shohet, 2012, p. 95)
* **Supervisee’s personal characteristics** – any mention of any personal characteristics that are attributed to the supervisee e.g. personality, gender etc. *(aspects of the supervisee; s’ee)*
  + ‘*Novice counselors are plagued by guilt, anxiety, perfectionism, confusion, and anger.*’ (Ward & House, 1998, p. 26)
* **Supervisee gender** – any mention of the gender of the supervisee *(s’ee)*
  + ‘*One of the initial challenges of family systems work, particularly for female trainees is the ability to function flexibly in an authoritative, instrumental “take charge” manner*.’ (Ault-Riché, 1988, p. 182)
* **Supervisee ethnicity/culture** - any mention of the ethnicity/culture of the supervisee *(s’ee)*
  + ‘*Since many minority supervisees have experiences with prejudice and racism, they are usually more sensitive to diversity issues and problems than majority supervisors.*’ (Haber, 1996, p. 59)
* **Supervisee anxiety** – any mention of supervisee development *(s’ee)*
  + ‘*Student therapists are very anxious and feel that since they are* only *interns they do not possess “what it takes” to be effective therapists.*’ (Yogev, 1982, p.237)
* **Supervisee motivation** – any mention of supervisee motivation *(s’ee)*
  + ‘*This period is characterized also by vast* fluctuation in motivation*, from deep commitment to grave misgivings.*’ (Hogan, 1964, p. 140)
* **Supervisee autonomy vs dependency** – any mention of supervisee autonomy and dependency *(s’ee)*
  + ‘*The supervisee may feel that the supervisor is an intrusion or a threat to his or her autonomy.*’ (Loganbill, Hardy, & Delworth, 1982, p. 22)
* **Supervisee awareness of self and/or others** – any mention of supervisee self-awareness and/or awareness of others *(s’ee)*
  + ‘*Awareness of both self and others is highly limited in the typical Level 1 supervisee*.’ (Stoltenberg & Delworth, pg. 53)
* **Development of supervisee** – any mention of supervisee development *(s’ee)*
  + ‘*Distinct stages in the development of the counsellor/therapist exist.*’ (Loganbill, Hardy, & Delworth, 1982, p. 15)
* **Supervisee individual learning styles** – mention of supervisees having individual learning styles *(s’ee)*
  + ‘*It is worthwhile reassessing your own leaning needs and style from time to time*.’ (Inskipp & Proctor, pg. 26)
* **Focus on client** – any specific focus on the client e.g. their characteristics or their responsibilities not just a mention of the existence of clients *(p)*
  + ‘*This theme involves the ability to view the client as a person, and to appreciate differences in backgrounds, values, and physical appearance.*’ (Loganbill, Hardy, & Delworth, 1982, p. 23)
* **Client’s personal characteristics -** any mention of any personal characteristics that are attributed to the client e.g. personality, gender etc.
  + ‘*This domain includes both an awareness of sexual, racial, and cultural difference among clients and diagnostic classifications of client disorders.*’ (Stoltenberg & Delworth, pg. 57)
* **Client ethnicity/culture -** any mention of the ethnicity/culture of the client
  + ‘*An increasing awareness of individual differences is incorporated in more complex client conceptualizations. Greater awareness of cultural and gender differences influences decision regarding interventions and diagnosis.*’ (Stoltenberg & Delworth, pg. 77)
* **Client gender -** any mention of the gender of the client
  + ‘*An increasing awareness of individual differences is incorporated in more complex client conceptualizations. Greater awareness of cultural and gender differences influences decision regarding interventions and diagnosis.*’ (Stoltenberg & Delworth, pg. 77)
* **Client expectations** – any mention of the client’s expectations
  + ‘*Expanding the range of therapy skills and roles to match the client's problems and role expectations.*’ (Grater, 1985, pg. 605)
* **Development of client** – any mention of client development *(aspects of the client; c)*
  + ‘*The patient, who provides the primary source of material and/or stimulation for learning in psychotherapy supervision, also experiences stages of development.*’ (Rodenhauser, 1994, pg. 6)
* **Relationship between supervisor and supervisee** – any specific focus on the relationship between supervisor and supervisee *(relationships; r)*
  + ‘*Finally, ideally, the relationship becomes one of peership, where the supervisor treats the supervisee as an equal, a professional colleague, perhaps even as a friend.*’ (Ard, 1973, p. 95)
* **Relationship between supervisee and client** – any specific focus on the relationship between supervisee and client *(r)*
  + ‘*Recognizing that basic patterns are introduced into the therapy relationship is essential.*’ (Grater, 1985, p. 606)
* **Relationship between supervisor and client** – any specific focus on the relationship between supervisor and client *(r)*
  + ‘*The thoughts and feelings that the supervisor has about the client can clearly be useful’* (Hawkins & Shohert, 2012, pg. 103)
* **Interactive discussion between supervisor and supervisee to further understanding/ decide on focus** – mention of collaborative discussion of what to focus on *(content of session; con)*
  + *‘Strength-based models of supervision attempt to sidestep hierarchy in favor of coconstructing ideas with those supervised.’* (Edwards & Chen, 1999, p. 351)
* **Supervisee takes charge of what is shared in supervision** – the content of supervision is decided on by the supervisee *(con)*
  + ‘*The supervisee is responsible for the control of the session, bringing in tapes for reviewing, locating sessions to be heard, and raising questions.*’ (Patterson, 1983, pg. 24)
* **Discussion of theories and reading of literature** – discussion of appropriate theories or direction to specific readings are part of supervision *(con)*
  + ‘*At that point. the supervisor could use various interventions to help move the student, from participating in guided discussions with the student to asking the student to perform library research or talk with other professionals to demonstrating to the student how particular objectives are attained in the supervisor's own work.*’ (Granello, 2000, p. 38)
* **Shared experience from the supervisor** – the supervisor shares personal experiences during supervision *(con)*
  + ‘*The supervisory relationship is now becoming more of a peer interaction, with an increased emphasis on sharing and exemplification by both partners*’ (Stoltenberg, 1981, p. 63)
* **Reporting on therapy sessions** – mention that supervisees discuss therapy sessions in supervision *(con)*
  + ‘*Supervisees are assigned the task of identifying what they have done well within a clinical session, or what they have done that led to change, however brief, and reporting it to their supervisor*.’ (Wetchler, 1990, 132)
* **Live supervision/ observation** – supervisor observes therapy sessions live e.g. by being in the therapy room or watching through a one-way mirror. *(con)*
  + ‘*Live supervision, unlike consultation and cotherapy, usually involves a one-way mirror that forms a physical boundary between the supervisory and therapeutic systems.*’ (Haber, 1996, p. 163)
* **Recorded therapy sessions** – supervisor listens/watches to recorded therapy sessions *(con)*
  + ‘*Videotape supervision offers supervisors and the training system ongoing access to raw data.*’ (Lee & Everett, 2004, p. 73)
* **Enactment of therapy sessions/ role-play** – hypothetical role play or re-enactment of events from therapy used in supervision sessions *(con)*
  + ‘*Other tactics (e.g., modeling, role-playing, feedback) can and should be used.*’ (Granello, 2000, p. 38)
* **Phone/ email / tele-conferencing** – mentions the use of phone/video calls or emailing as a method of conducting supervision *(general aspects of model; gen)*
  + ‘*Long distance phone calls can be expensive but conference calls can be arranged and can prove helpful.*’ (Ard, 1973, pg. 96)
* **Feedback from supervisor and/or supervisee** – mentions any form of feedback from the supervisor to the supervisee and/or vice versa *(evaluation; e)*
  + ‘*Feedback will have no positive effect unless offered in the context of a sustaining supervisory environment.*’ (Scaife, 2001, pg. 216)
* **Assessment/ evaluation** – mention of any formal assessment or evaluation process (results can be for the supervisor and/or the wider organisation within which the supervisee is working) *(e)*
  + ‘*No supervision can take place without evaluation (constructive criticism).*’ (Yogev, 1982, p. 239)
* **Evaluating/monitoring work with clients** – mention that evaluation or assessment should specifically cover work with clients e.g. do client’s symptoms improve? *(e)*
  + ‘*Using Bloom's Taxonomy, a supervisor might use supervision time to help a counsellor trainee begin to conduct her or his own outcome research.’* (Granello, 2000, p. 41)
* **Goal setting** – mentions using goals in supervision and/or therapy *(gen)*
  + ‘*The goals should be positively framed and as specific as possible.*’ (Thomas, 1994, p. 15)
* **Supervisor using enquiry as learning technique** – mentions that the supervisor specifically uses questions to further knowledge or development of the supervisee *(con)*
  + ‘*Regardless of the cognitive developmental level of the supervisee, supervisor's questions (when approaching new material or new cases) could start at the knowledge level and proceed through the subsequent levels.*’ (Granello, 2000, pg. 36)
* **Use of imagery/ metaphor** – mentions that imagery or metaphor may be used in supervision sessions *(gen)*
  + ‘*Using metaphor and imagery is a valuable way to play with the material in supervision*.’ (Page, & Wokset, 2015, pg. 98)
* **Homework** – mentions that homework may be set for the supervisee by the supervisor *(gen)*
  + ‘*Assigning and reviewing homework (e.g., reading, conceptualizing patients in writing, experimenting with new techniques) is an essential part of cognitive therapy supervision.*’ (Liese & Beck, 1997, pg. 121)
* **Transference and/or parallel processes** – mention of the possibility of (counter)transference and/or parallel processes *(gen)*
  + ‘*In this mode of paralleling, the processes at work currently in the relationship between client and supervisee are uncovered through how they are reflected in the relationship between supervisee and supervisor.*’ (Hawkins & Shohet, 2012, p. 99)
* **Acknowledgement of wider context of therapy process** – mention of the surrounding context to supervision and therapy e.g. that they happen within an organisation *(gen)*
  + ‘*The interventions and strategies that a supervisee utilizes will not just be the result of personal choices, but framed by the context of the tradition they work within and the policies, culture and practice of their organisation*’ (Hawkins & Shohet, 2012, p. 103)
* **Expects preparation from therapist coming to supervision** – specifically mentions that the therapist should come to supervision with work prepared *(gen)*
  + ‘*As a counsellor in supervision, with the help of your supervisor, you should become increasingly able to bring your work and share it freely and accessible.*’ (Inskipp & Proctor, pg. 9)
* **Stage/ level/ step model** – the model has distinct steps/levels/stages *(gen)*
  + ‘*During his development as a psychotherapist, the clinician goes through four stages of development.*’ (Hogan, 1964, p. 139)
* **Focus mainly on trainee rather than therapist** – Model mainly discusses supervision with trainee therapists rather than qualified therapists *(gen)*
  + ‘*Therefore, the model proposed here provides a format that needs to be considered within the context of several factors, including the length of the internship, the skill level and unique needs of individual trainees, and the pace at which individual trainees progress through the stages.*’ (Nelson & Johnson, 1999, p. 94)
* **Group supervision** – mentions the use of group supervision *(structure of supervision; str)*
  + ‘*Group supervision can be conducted as a form of consciousness raising*.’ (Hipp & Munson, 1995, p. 33)
* **Peer supervision** – mentions the use of peer supervision *(str)*
  + ‘*At later stages, a peer supervisor is someone we choose, and the process is outside of the formal evaluation process.*’ (Stoltenberg & Delworth, p. 165)
* **Self-supervision** – mentions the use of self-supervision *(str)*
  + ‘*It seems prudent to culminate the evaluation process with a focus on self-supervision skills.*’ (Nelson & Johnson, 1999, p. 97-98)
* **Supervisor has ability to assign clients** – mentions that the supervision can choose which clients their supervisee works with *(s)*
  + ‘*It is essential that the supervisor provide information and support during this period. Included should be the assurance that the trainee will be assigned selected clients. Careful selection is the ethical responsibility of the supervisor*.’ (Grater, 1985, p. 606)
* **Supervisor can take on variety of roles** – mentions that the supervisee can take on a variety of roles e.g. counsellor role, ethical role *(s)* 
  + *‘The four roles represented by this dimension structure underlying supervision activities are Coach, Teacher, Administrator, and Mentor.’* (Morgan and Sprenkle, 2007, p. 10)
* **Supervisee can take on a variety of roles** – mentions that the supervisor can take on a variety of roles e.g. counsellor role, teacher role *(s’ee)*
  + ‘*The trainee assumes the role of counsellor, teacher and consultant to achieve the goal of effectively helping clients.*’ (Littrell, Lee-Borden & Lorenz, 1979, p. 134)
* **Contract** – mentions that supervisors and supervisees should lay out a contract before embarking on the supervision process *(gen)*
  + ‘*The contracting phase involves the initial development of cooperation to work on mutually agreed-upon problem areas in supervision.*’ (Connell, 1984, p. 275)
* **Re-contracting** – mentions that the contract should be reassessed on a regular basis and re-drafted *(gen)*
  + ‘*Contracting should occur at the beginning of any supervisory relationship. It can also occur as re-contracting throughout the ongoing work…*’ (Page & Wokset, p.41)
* **Termination** – mention of the termination process of supervision and/or therapy *(gen)*
  + ‘*The supervision may end successfully in any phase of the process provided both the supervisor and supervisee agree.*’ (Connell, 1984, p. 279)
* **Supervision of supervision** – mentions that supervisors should be supervised *(gen)*
  + *‘A training system includes at least three and often four generations: 1. The supervisory mentor/supervisor, 2. The Approved Supervisor candidate, 3. The therapist or trainee, 4. The client-family’* (Lee & Everett, 2004, p. 7)
* **Regression accepted in supervision** – mentions that regression can occur in supervision *(gen)*
  + ‘*They* [regressive experiences] *enliven the supervisory situation and may become a rich source of information about the supervisory and therapeutic processes.*’ (Frawley-O’Dea & Sarnat, 2001, p. 135)
* **Supervisor can treat/counsel supervisee if agreed by both parties** – mentions that supervisors can treat or counsel their own supervisees in supervision *(gen)*
  + ‘*We have found the Cyclical Model to be an effective structure for using in consultative supervision of supervisors*.’ (Page & Wokset, p. 254)
* **Acknowledgement of emergency situations** – mentions the occurrence of emergency situations *(gen)*
  + ‘*These emergencies can be created and felt by the patient, by his therapist, by the therapist’s supervisor, and also by the administrator.*’ (Ekstein & Wallerstein, 1972, p. 200)
* **Acknowledgement of how an administrator fits into the supervisory process** – mentions that an administrator has a specific role in the supervision process *(p)*
  + ‘*If we add an administrator of the clinic who is "over" the supervisor in the organization, we can have a complex relationship between the therapist or counselor (supervisee or student), the supervisor, the client(s), and the administrator.*’ (Ard, 1973, p. 92)
* **Focus on solutions/strengths over problems** – model suggests that strengths and of the supervisee and solutions not problems should be focused on in supervision *(gen)*
  + ‘*A solution orientation to supervision can be very useful when one considers an important aspect of the process: the expectations and anticipated needs of the therapist.*’ (Thomas, 1994, p. 12)
* **Client invited into supervision** – mentions that the client should be invited into supervision sessions *(str)*
  + *‘To bring forth more respect into the manner we and our co-visees discuss clients, co-visees’ clients are invited to join us in the supervision.*’ (Edwards & Chen, 1999, p. 354)
* **Feedback from clients** – mentions that feedback should be taken from clients *(e)*
  + ‘*Whatever the techniques and processes employed, feedback-centered supervision values, and sometimes privileges, the opinions of clients about their experiences in therapy.*’ (Lee & Everett, p.103)
* **Co-therapy with supervisor** – mention that they supervisor can be invited into the therapy session to provide therapy alongside the supervisee *(gen)*
  + ‘*In our setting the supervisor is the co-therapist with the budding clinician in group therapy providing an experience together which is instructive for both*.’ (Hogan, 1964, p.139-140)
* **Supervisors have their own individual styles** – mention that supervisors how their own styles of conducting supervision *(s)*
  + ‘*The supervision process should probably represent some balance between the two aspects, depending on the needs and the learning styles of the supervisees and the style of the supervisor.*’ (Rice, 1980, p. 146)
* **Cites empirical evidence** *(evidence; ev) –* cites empirical work in the text describing the model, not just other models or quotes.
* **Based on empirical evidence** *(ev) –* the model is derived from an empirical study.

## Appendix 2B. Individual focus in supervision models

Table 2B. Models that focus on each individual in the supervision process.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Focus on supervisor** | **Focus on supervisee** | **Focus on client** |
| **No. of models**  **with**  **element**  **Model/ approach** | 42  (80.77%) | 49  (94.23%) | 25  (48.08%) |
| Hogan (1964) |  | ✓ |  |
| Ekstein & Wallerstein (1972) | ✓ | ✓ | ✓ |
| Mueller & Kell (1971) | ✓ | ✓ | ✓ |
| Delaney (1972) | ✓ | ✓ | ✓ |
| Ard (1973) | ✓ | ✓ | ✓ |
| Bernard (1979) | ✓ | ✓ |  |
| Littrell et al. (1979) | ✓ | ✓ |  |
| Langs (1980) | ✓ | ✓ | ✓ |
| Rice (1980) |  | ✓ |  |
| Linehan (1980) | ✓ | ✓ |  |
| Beier & Young (1980) |  | ✓ |  |
| Stoltenberg (1981) | ✓ | ✓ |  |
| Loganbill et al. (1982) | ✓ | ✓ | ✓ |
| Yogev (1982) | ✓ | ✓ |  |
| Blocher (1983) | ✓ | ✓ |  |
| Bordin (1983) |  | ✓ | ✓ |
| Hosford & Barmann (1983) |  | ✓ |  |
| **Model/ approach** | **Focus on supervisor** | **Focus on supervisee** | **Focus on client** |
| Patterson (1983) | ✓ | ✓ | ✓ |
| Wessler & Ellis (1983) | ✓ | ✓ | ✓ |
| Connell (1984) | ✓ | ✓ |  |
| Grater (1985) | ✓ | ✓ | ✓ |
| Friedmand & Kaslow (1986) | ✓ | ✓ | ✓ |
| Hess (1986) | ✓ |  |  |
| Stoltenberg & Delworth (1987) |  | ✓ | ✓ |
| Ault-Riche (1988) | ✓ | ✓ |  |
| Watkins (1990) | ✓ |  |  |
| Wetchler (1990) | ✓ | ✓ |  |
| Mead (1990) | ✓ | ✓ | ✓ |
| Hawkins & Shohet (1993) | ✓ | ✓ | ✓ |
| Rodenhauser (1994) | ✓ | ✓ | ✓ |
| Thomas (1994) |  | ✓ |  |
| Rigazio-DiGilio & Anderson (1994) | ✓ | ✓ | ✓ |
| Holloway (1995) | ✓ | ✓ | ✓ |
| Hipp & Munson (1995) | ✓ | ✓ | ✓ |
| Carroll (1996) | ✓ | ✓ |  |
| Carroll (1996) | ✓ | ✓ |  |
| Haber (1996) | ✓ | ✓ | ✓ |
| Liese & Beck (1997) | ✓ | ✓ |  |
| Ward & House (1998) |  | ✓ |  |
| **Model/ approach** | **Focus on supervisor** | **Focus on supervisee** | **Focus on client** |
| Nelson & Johnson (1999) | ✓ | ✓ |  |
| Edwards & Chen (1999) |  |  |  |
| Granello (2000) |  | ✓ |  |
| Gilbert & Evans (2000) | ✓ | ✓ |  |
| Scaife (2001) | ✓ | ✓ |  |
| Frawley-O'Dea & Sarnat (2001) | ✓ | ✓ |  |
| Lee & Everett (2004) | ✓ | ✓ | ✓ |
| Ladany et al. (2005) | ✓ | ✓ | ✓ |
| Armstrong & Freeston (2006) | ✓ | ✓ | ✓ |
| Morgan & Sprenkle (2007) | ✓ | ✓ |  |
| Inskipp and Proctor (2009) | ✓ | ✓ | ✓ |
| Page and Wosket (2015) | ✓ | ✓ | ✓ |

## Appendix 2C. Supervisor aspects focus in supervision models

Table 2C. Model focus on supervisor aspects

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Supervisor's personal characteristics** | **Supervisor gender** | **Supervisor ethnicity/ culture** | **Supervisor anxiety** | **Supervisor as authority figure/ expert** | **Development of supervisor** | **Supervisor has ability to assign clients** | **Supervisor can take on a variety of roles** | **Supervisors have their own individual styles** |
| **No. of models**  **with**  **element**  **Model/**  **approach** | 18  (34.62%) | 9  (17.31%) | 7  (13.46%) | 3  (5.77%) | 19  (36.54%) | 5  (9.62%) | 4  (7.69%) | 11  (21.15%) | 2  (3.85%) |
| Hogan (1964) |  |  |  |  | ✓ |  |  |  |  |
| Ekstein & Wallerstein (1972) | ✓ |  |  |  |  |  |  |  |  |
| Mueller & Kell (1971) | ✓ |  |  | ✓ | ✓ |  |  |  |  |
| Delaney (1972) |  |  |  |  |  |  |  |  |  |
| Ard (1973) |  |  |  |  |  |  |  | ✓ |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Supervisor's personal characteristics** | **Supervisor gender** | **Supervisor ethnicity/ culture** | **Supervisor anxiety** | **Supervisor as authority figure/ expert** | **Development of supervisor** | **Supervisor has ability to assign clients** | **Supervisor can take on a variety of roles** | **Supervisors have their own individual styles** |
| Bernard (1979) |  |  |  |  |  |  |  | ✓ |  |
| Littrell et al. (1979) |  |  |  |  |  |  |  | ✓ |  |
| Langs (1980) |  |  |  |  |  |  |  |  |  |
| Rice (1980) |  |  |  |  |  |  |  |  | ✓ |
| Linehan (1980) |  |  |  |  |  |  |  |  |  |
| Beier & Young (1980) |  |  |  |  |  |  |  |  |  |
| Stoltenberg (1981) |  |  |  |  | ✓ |  |  |  |  |
| Loganbill et al. (1982) |  |  |  |  | ✓ |  |  |  |  |
| Yogev (1982) |  |  |  |  |  |  |  |  |  |
| Blocher (1983) |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Supervisor's personal characteristics** | **Supervisor gender** | **Supervisor ethnicity/ culture** | **Supervisor anxiety** | **Supervisor as authority figure/ expert** | **Development of supervisor** | **Supervisor has ability to assign clients** | **Supervisor can take on a variety of roles** | **Supervisors have their own individual styles** |
| Bordin (1983) |  |  |  |  | ✓ |  |  |  |  |
| Hosford & Barmann (1983) | ✓ | ✓ | ✓ |  |  |  |  |  |  |
| Patterson (1983) |  |  |  |  |  |  |  |  |  |
| Wessler & Ellis (1983) |  |  |  |  |  |  |  |  |  |
| Connell (1984) |  |  |  |  |  |  |  |  |  |
| Grater (1985) |  |  |  |  |  |  | ✓ |  |  |
| Friedmand & Kaslow (1986) |  |  |  |  | ✓ |  | ✓ |  |  |
| Hess (1986) | ✓ |  |  |  |  | ✓ |  |  |  |
| Stoltenberg & Delworth (1987) |  |  |  |  | ✓ |  | ✓ |  |  |
| Ault-Riche (1988) | ✓ | ✓ |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Supervisor's personal characteristics** | **Supervisor gender** | **Supervisor ethnicity/ culture** | **Supervisor anxiety** | **Supervisor as authority figure/ expert** | **Development of supervisor** | **Supervisor has ability to assign clients** | **Supervisor can take on a variety of roles** | **Supervisors have their own individual styles** |
| Watkins (1990) | ✓ |  |  |  |  | ✓ |  |  |  |
| Wetchler (1990) |  |  |  |  |  |  |  |  |  |
| Mead (1990) | ✓ | ✓ |  |  | ✓ |  | ✓ |  |  |
| Hawkins & Shohet (1993) | ✓ |  |  |  |  |  |  |  |  |
| Rodenhauser (1994) | ✓ |  | ✓ |  |  | ✓ |  |  |  |
| Thomas (1994) |  |  |  |  |  |  |  |  |  |
| Rigazio-DiGilio & Anderson (1994) |  |  |  |  |  |  |  | ✓ |  |
| Holloway (1995) | ✓ | ✓ | ✓ |  | ✓ |  |  | ✓ |  |
| Hipp & Munson (1995) | ✓ | ✓ |  |  |  |  |  |  |  |
| Carroll (1996) |  |  |  |  |  |  |  | ✓ |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Supervisor's personal characteristics** | **Supervisor gender** | **Supervisor ethnicity/ culture** | **Supervisor anxiety** | **Supervisor as authority figure/ expert** | **Development of supervisor** | **Supervisor has ability to assign clients** | **Supervisor can take on a variety of roles** | **Supervisors have their own individual styles** |
| Carroll (1996) | ✓ |  |  |  |  |  |  |  |  |
| Haber (1996) | ✓ | ✓ | ✓ |  | ✓ | ✓ |  |  |  |
| Liese & Beck (1997) |  |  |  |  |  |  |  |  |  |
| Ward & House (1998) |  |  |  |  |  |  |  |  |  |
| Bob (1999) |  |  |  |  | ✓ |  |  |  |  |
| Nelson & Johnson (1999) |  |  |  |  | ✓ |  |  | ✓ |  |
| Edwards & Chen (1999) |  |  |  |  |  |  |  |  |  |
| Granello (2000) |  |  |  |  |  |  |  |  |  |
| Gilbert & Evans (2000) | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  |  |
| Scaife (2001) |  |  |  |  | ✓ |  |  | ✓ |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Supervisor's personal characteristics** | **Supervisor gender** | **Supervisor ethnicity/ culture** | **Supervisor anxiety** | **Supervisor as authority figure/ expert** | **Development of supervisor** | **Supervisor has ability to assign clients** | **Supervisor can take on a variety of roles** | **Supervisors have their own individual styles** |
| Frawley-O'Dea & Sarnat (2001) | ✓ |  |  | ✓ | ✓ |  |  |  |  |
| Lee & Everett (2004) | ✓ | ✓ | ✓ |  | ✓ |  |  |  |  |
| Ladany et al. (2005) | ✓ | ✓ | ✓ |  | ✓ | ✓ |  | ✓ | ✓ |
| Armstrong & Freeston (2006) |  |  |  |  |  |  |  |  |  |
| Morgan & Sprenkle (2007) |  |  |  |  | ✓ |  |  | ✓ |  |
| Inskipp and Proctor (2009) |  |  |  |  | ✓ |  |  | ✓ |  |
| Page and Wosket (2015) | ✓ |  |  |  |  |  |  |  |  |

| Appendix 2D. Supervisee aspects focus in supervision models | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Table 2D. Model focus on supervisee aspects | | | | | | | | | | |
|  | **Supervis-ee's personal character-istics** | **Supervi-see gender** | **Supervisee ethnicity/ culture** | **Supervi-see anxiety** | **Supervisee motivation** | **Supervisee autonomy vs dependen-cy** | **Supervisee awareness of self and/or others** | **Developm-ent of supervisee** | **Supervisee individual learning styles** | **Supervisee can take on variety of roles** | |
| **No. of models**  **with**  **element**  **Model/**  **approach** | 38  (73.08%) | 18  (34.62%) | 13  (25%) | 23  (44.23%) | 10  (19.23%) | 12  (23.08%) | 15  (28.85%) | 29  (55.77%) | 12  (23.08%) | 6  (11.54%) | |
| Hogan (1964) |  |  |  |  | ✓ | ✓ |  | ✓ |  |  | |
| Ekstein & Wallerstein (1972) | ✓ |  |  | ✓ |  |  |  |  | ✓ |  | |
| Mueller & Kell (1971) | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |  |  | |
| Delaney (1972) |  |  |  |  | ✓ |  |  | ✓ |  |  | |
| Ard (1973) |  |  |  | ✓ |  |  | ✓ | ✓ |  | ✓ | |
| Bernard (1979) | ✓ |  |  |  |  |  |  |  |  |  | |

| **Model/**  **approach** | **Supervis-ee's personal characteristics** | **Supervi-see gender** | **Supervisee ethnicity/ culture** | **Supervi-see anxiety** | **Supervisee motivation** | **Supervisee autonomy vs dependen-cy** | **Supervisee awareness of self and/or others** | **Developm-ent of supervisee** | **Supervisee individual learning styles** | **Supervisee can take on variety of roles** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Littrell et al. (1979) |  |  |  |  |  | ✓ |  | ✓ |  | ✓ |
| Langs (1980) | ✓ |  |  | ✓ |  |  |  |  |  |  |
| Rice (1980) | ✓ |  |  | ✓ |  | ✓ |  | ✓ | ✓ |  |
| Linehan (1980) | ✓ |  |  | ✓ |  |  |  |  |  |  |
| Beier & Young (1980) | ✓ | ✓ |  |  |  |  |  |  |  |  |
| Stoltenberg (1981) | ✓ |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |
| Loganbill et al. (1982) | ✓ | ✓ |  | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ |
| Yogev (1982) | ✓ |  |  | ✓ |  |  | ✓ | ✓ |  | ✓ |
| Blocher (1983) | ✓ |  |  | ✓ |  |  |  |  | ✓ |  |
| Bordin (1983) | ✓ |  |  |  |  |  | ✓ |  |  |  |
| Hosford & Barmann (1983) | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ |  |  |  |
| Patterson (1983) |  |  |  |  |  |  |  |  |  |  |

| **Model/**  **approach** | **Supervis-ee's personal character-istics** | **Supervi-see gender** | **Supervisee ethnicity/ culture** | **Supervi-see anxiety** | **Supervisee motivation** | | **Supervisee autonomy vs dependen-cy** | **Supervisee awareness of self and/or others** | | **Developm-ent of supervisee** | | **Supervisee individual learning styles** | **Supervisee can take on variety of roles** | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Connell (1984) | ✓ |  |  | ✓ |  | |  |  | | ✓ | |  |  | | |
| Grater (1985) | ✓ |  |  | ✓ |  | |  |  | | ✓ | |  | ✓ | | |
| Friedmand & Kaslow (1986) | ✓ |  |  | ✓ |  | | ✓ | ✓ | | ✓ | |  |  | | |
| Hess (1986) |  |  |  |  |  | |  |  | |  | |  |  | | |
| Stoltenberg & Delworth (1987) | ✓ | ✓ | ✓ |  | ✓ | | ✓ | ✓ | | ✓ | | ✓ |  | | |
| Ault-Riche (1988) | ✓ | ✓ |  |  |  | |  |  | |  | |  |  | | |
| Watkins (1990) |  |  |  |  |  | |  |  | |  | |  |  | | |
| Wetchler (1990) | ✓ |  |  |  |  | |  |  | | ✓ | |  |  | | |
| Mead (1990) | ✓ | ✓ | ✓ | ✓ | ✓ | |  | ✓ | | ✓ | |  |  | | |
| Hawkins & Shohet (1993) | ✓ | ✓ | ✓ |  |  | |  |  | | ✓ | | ✓ |  | | |
| Rodenhauser (1994) | ✓ |  |  | ✓ |  |  | |  | | ✓ | |  |  | | |
| Thomas (1994) |  |  |  |  | ✓ |  | |  | ✓ | | ✓ | | |  |
| Rigazio-DiGilio & Anderson (1994) |  |  |  |  |  |  | |  | | ✓ | | ✓ |  | | |

| **Model/**  **approach** | **Supervis-ee's personal character-istics** | **Supervi-see gender** | **Supervisee ethnicity/ culture** | | **Supervi-see anxiety** | | **Supervisee motivation** | **Supervisee autonomy vs dependen-cy** | | | **Supervisee awareness of self and/or others** | **Developm-ent of supervisee** | | | **Supervisee individual learning styles** | **Supervisee can take on variety of roles** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Holloway (1995) | ✓ | ✓ | ✓ | |  | |  |  | | | ✓ |  | | | ✓ |  | |
| Hipp & Munson (1995) | ✓ | ✓ |  | |  | |  |  | | |  |  | | |  |  | |
| Carroll (1996) |  |  |  | |  | |  |  | | |  |  | | |  |  | |
| Carroll (1996) | ✓ |  |  | |  | |  |  | | |  | ✓ | | | ✓ |  | |
| Haber (1996) | ✓ | ✓ | ✓ | |  | |  | ✓ | | |  | ✓ | | |  |  | |
| Liese & Beck (1997) |  |  |  | |  | |  |  | | |  |  | | |  |  | |
| Ward & House (1998) | ✓ |  |  | | ✓ | |  | ✓ | | |  | ✓ | | |  |  | |
| Bob (1999) | ✓ |  |  |  | |  | | |  | ✓ | | | ✓ |  | | |  |
| Nelson & Johnson (1999) | ✓ |  |  | | ✓ | |  |  | | |  |  | | |  |  | |
| Edwards & Chen (1999) |  |  |  | |  | |  |  | | |  |  | | |  |  | |
| Granello (2000) |  |  |  |  | |  | | |  |  | | |  |  | | |  |
| Gilbert & Evans (2000) | ✓ | ✓ | ✓ | | ✓ | |  |  | | | ✓ | ✓ | | | ✓ |  | |

| **Model/**  **approach** | **Supervis-ee's personal character-ristics** | **Supervi-see gender** | **Supervisee ethnicity/ culture** | **Supervi-see anxiety** | **Supervisee motivation** | **Supervisee autonomy vs dependen-cy** | **Supervisee awareness of self and/or others** | **Developm-ent of supervisee** | **Supervisee individual learning styles** | **Supervisee can take on variety of roles** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Scaife (2001) | ✓ |  |  |  |  |  |  |  |  |  |
| Frawley-O'Dea & Sarnat (2001) | ✓ | ✓ |  | ✓ |  |  |  |  |  |  |
| Lee & Everett (2004) | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ |  |  |
| Ladany et al. (2005) | ✓ | ✓ | ✓ | ✓ |  |  | ✓ | ✓ |  |  |
| Armstrong & Freeston (2006) | ✓ |  |  |  |  |  |  |  |  |  |
| Morgan & Sprenkle (2007) |  |  | ✓ |  |  | ✓ | ✓ | ✓ |  |  |
| Inskipp and Proctor (2009) | ✓ | ✓ | ✓ |  |  |  |  | ✓ | ✓ | ✓ |
| Page and Wosket (2015) | ✓ | ✓ | ✓ |  | ✓ |  |  | ✓ |  |  |

| Appendix 2E. Client aspects focus in supervision models | | | |  | | |  | |  |  | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Table 2E. Model focus on client aspects | | | |  | | |  | |  |  | |
|  | **Focus on client** | **Client's personal characteristics** | **Client’s culture/ ethnicity** | | **Client’s gender** | **Client’s expectations** | | **Development of client** | | |
| **No. of models**  **with**  **element**  **Model/ approach** | 25  (48.08%) | 4  (7.69%) | 4  (7.69%) | | 2  (3.85%) | 1  (1.92%) | | 1  (1.92%) | | |
| Hogan (1964) |  |  |  | |  |  | |  | | |
| Ekstein & Wallerstein (1972) | ✓ |  |  | |  |  | |  | | |
| Mueller & Kell (1971) | ✓ |  |  | |  |  | |  | | |
| Delaney (1972) | ✓ |  |  | |  |  | |  | | |
| Ard (1973) | ✓ |  |  | |  |  | |  | | |
| Bernard (1979) |  |  |  | |  |  | |  | | |
| Littrell et al. (1979) |  |  |  | |  |  | |  | | |
| Langs (1980) | ✓ |  |  | |  |  | |  | | |

| **Model/ approach** | **Focus on client** | **Client's personal characteristics** | **Client’s culture/ ethnicity** | **Client’s gender** | **Client’s expectations** | **Development of client** |
| --- | --- | --- | --- | --- | --- | --- |
| Rice (1980) |  |  |  |  |  |  |
| Linehan (1980) |  |  |  |  |  |  |
| Beier & Young (1980) |  |  |  |  |  |  |
| Stoltenberg (1981) |  |  |  |  |  |  |
| Loganbill et al. (1982) | ✓ |  |  |  |  |  |
| Yogev (1982) |  |  |  |  |  |  |
| Blocher (1983) |  |  |  |  |  |  |
| Bordin (1983) | ✓ |  |  |  |  |  |
| Hosford & Barmann (1983) |  |  |  |  |  |  |
| Patterson (1983) | ✓ |  |  |  |  |  |
| Wessler & Ellis (1983) | ✓ |  |  |  |  |  |
| Connell (1984) |  |  |  |  |  |  |
| Grater (1985) | ✓ | ✓ |  |  | ✓ |  |
| Friedmand & Kaslow (1986) | ✓ |  |  |  |  |  |

| **Model/ approach** | **Focus on client** | **Client's personal characteristics** | **Client’s culture/ ethnicity** | **Client’s gender** | **Client’s expectations** | **Development of client** |
| --- | --- | --- | --- | --- | --- | --- |
| Hess (1986) |  |  |  |  |  |  |
| Stoltenberg & Delworth (1987) | ✓ | ✓ | ✓ | ✓ |  |  |
| Ault-Riche (1988) |  |  |  |  |  |  |
| Watkins (1990) |  |  |  |  |  |  |
| Wetchler (1990) |  |  |  |  |  |  |
| Mead (1990) | ✓ |  |  |  |  |  |
| Hawkins & Shohet (1993) | ✓ |  |  |  |  |  |
| Rodenhauser (1994) | ✓ |  |  |  |  | ✓ |
| Thomas (1994) |  |  |  |  |  |  |
| Rigazio-DiGilio & Anderson (1994) | ✓ |  |  |  |  |  |
| Holloway (1995) | ✓ |  |  |  |  |  |
| Hipp & Munson (1995) | ✓ |  |  |  |  |  |
| Carroll (1996) |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Focus on client** | **Client's personal characteristics** | **Client’s culture/ ethnicity** | **Client’s gender** | **Client’s expectations** | **Development of client** |
| Carroll (1996) |  |  |  |  |  |  |
| Haber (1996) | ✓ |  |  |  |  |  |
| Liese & Beck (1997) |  |  |  |  |  |  |
| Ward & House (1998) |  |  |  |  |  |  |
| Bob (1999) | ✓ |  |  |  |  |  |
| Nelson & Johnson (1999) |  |  |  |  |  |  |
| Edwards & Chen (1999) |  |  |  |  |  |  |
| Granello (2000) |  |  |  |  |  |  |
| Gilbert & Evans (2000) |  |  |  |  |  |  |
| Scaife (2001) |  |  |  |  |  |  |
| Frawley-O'Dea & Sarnat (2001) |  |  |  |  |  |  |
| Lee & Everett (2004) | ✓ |  |  |  |  |  |
| Ladany et al. (2005) | ✓ |  |  |  |  |  |
| Armstrong & Freeston (2006) | ✓ | ✓ | ✓ | ✓ |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Focus on client** | **Client's personal characteristics** | **Client’s culture/ ethnicity** | **Client’s gender** | **Client’s expectations** | **Development of client** |
| Morgan & Sprenkle (2007) |  |  |  |  |  |  |
| Inskipp and Proctor (2009) | ✓ |  |  |  |  |  |
| Page and Wosket (2015) | ✓ | ✓ | ✓ |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Appendix 2F. Session elements focus in supervision models | | | | | | | | | |
| Table 2F. Model focus on each content of supervision sessions element | | | | | | | | | |
|  | **Interactive discussion between supervisor and supervisee to further understanding/ decide on focus** | **Supervisee takes charge of what is shared in supervision** | **Discussion of theories and reading of literature** | **Shared experience from the supervisor** | **Live supervis-ion/ observation** | **Recorded therapy sessions** | **Reporting on therapy sessions** | **Enactment of therapy sessions/ role-play** | **Supervisor using enquiry as learning technique** | |
| **No. of models**  **with**  **element**  **Model/**  **approach** | 24  (46.15%) | 3  (5.77%) | 24  (46.15%) | 15  (28.85%) | 20  (38.46%) | 34  (65.38%) | 41  (78.85%) | 24  (46.15%) | 6  (11.54%) | |
| Hogan (1964) |  |  |  | ✓ |  |  |  |  |  | |
| Ekstein & Wallerstein (1972) | ✓ |  |  |  | ✓ | ✓ | ✓ |  |  | |
| Mueller & Kell (1971) | ✓ |  |  |  |  | ✓ | ✓ |  |  | |
| Delaney (1972) |  |  | ✓ |  | ✓ |  |  | ✓ |  | |
| Ard (1973) | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |  |  | |
| Bernard (1979) | ✓ |  | ✓ |  |  | ✓ | ✓ | ✓ |  | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Interactive discussion between supervisor and supervisee to further understanding/ decide on focus** | **Supervisee takes charge of what is shared in supervision** | **Discussion of theories and reading of literature** | **Shared experience from the supervisor** | **Live supervis-ion/ observation** | **Recorded therapy sessions** | **Reporting on therapy sessions** | **Enactment of therapy sessions/ role-play** | **Supervisor using enquiry as learning technique** |
| Littrell et al. (1979) | ✓ |  | ✓ |  |  |  | ✓ |  |  |
| Langs (1980) |  |  |  |  |  |  | ✓ |  |  |
| Rice (1980) |  |  |  |  |  | ✓ | ✓ | ✓ |  |
| Linehan (1980) | ✓ |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |  |
| Beier & Young (1980) |  |  |  |  |  | ✓ | ✓ |  |  |
| Stoltenberg (1981) |  |  | ✓ | ✓ |  | ✓ |  | ✓ |  |
| Loganbill et al. (1982) |  |  | ✓ |  |  | ✓ |  |  |  |
| Yogev (1982) |  |  |  |  |  |  | ✓ | ✓ |  |
| Blocher (1983) |  |  |  |  |  | ✓ | ✓ |  |  |
| Bordin (1983) |  |  | ✓ |  | ✓ | ✓ | ✓ |  |  |
| Hosford & Barmann (1983) |  |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Patterson (1983) |  | ✓ | ✓ |  |  | ✓ | ✓ | ✓ |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Interactive discussion between supervisor and supervisee to further understanding/ decide on focus** | **Supervisee takes charge of what is shared in supervision** | **Discussion of theories and reading of literature** | **Shared experience from the supervisor** | **Live supervis-ion/ observation** | **Recorded therapy sessions** | **Reporting on therapy sessions** | **Enactment of therapy sessions/ role-play** | **Supervisor using enquiry as learning technique** |
| Wessler & Ellis (1983) |  |  | ✓ |  | ✓ | ✓ | ✓ | ✓ |  |
| Connell (1984) | ✓ | ✓ |  |  | ✓ | ✓ | ✓ |  |  |
| Grater (1985) |  |  |  | ✓ |  | ✓ | ✓ | ✓ |  |
| Friedmand & Kaslow (1986) |  |  | ✓ |  |  |  | ✓ | ✓ |  |
| Hess (1986) |  |  |  | ✓ |  |  | ✓ |  |  |
| Stoltenberg & Delworth (1987) |  |  | ✓ | ✓ | ✓ | ✓ |  | ✓ |  |
| Ault-Riche (1988) |  |  |  | ✓ | ✓ | ✓ | ✓ |  |  |
| Watkins (1990) |  |  |  |  |  |  |  |  |  |
| Wetchler (1990) | ✓ |  | ✓ |  | ✓ | ✓ | ✓ |  |  |
| Mead (1990) | ✓ |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hawkins & Shohet (1993) |  |  |  |  |  | ✓ | ✓ |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Interactive discussion between supervisor and supervisee to further understanding/ decide on focus** | **Supervisee takes charge of what is shared in supervision** | **Discussion of theories and reading of literature** | **Shared experience from the supervisor** | **Live supervis-ion/ observation** | **Recorded therapy sessions** | **Reporting on therapy sessions** | **Enactment of therapy sessions/ role-play** | **Supervisor using enquiry as learning technique** |
| Rodenhauser (1994) |  |  |  |  |  |  |  |  |  |
| Thomas (1994) | ✓ |  |  |  |  |  |  |  |  |
| Rigazio-DiGilio & Anderson (1994) |  |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Holloway (1995) | ✓ |  |  | ✓ |  | ✓ | ✓ | ✓ |  |
| Hipp & Munson (1995) | ✓ |  |  |  |  |  |  |  |  |
| Carroll (1996) |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |
| Carroll (1996) | ✓ |  |  |  |  | ✓ | ✓ | ✓ |  |
| Haber (1996) |  |  |  |  | ✓ | ✓ | ✓ | ✓ |  |
| Liese & Beck (1997) |  |  | ✓ |  |  | ✓ | ✓ | ✓ |  |
| Ward & House (1998) |  |  |  |  |  |  | ✓ |  |  |
| Bob (1999) | ✓ |  |  |  |  |  | ✓ |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Interactive discussion between supervisor and supervisee to further understanding/ decide on focus** | **Supervisee takes charge of what is shared in supervision** | **Discussion of theories and reading of literature** | **Shared experience from the supervisor** | **Live supervis-ion/ observation** | **Recorded therapy sessions** | **Reporting on therapy sessions** | **Enactment of therapy sessions/ role-play** | **Supervisor using enquiry as learning technique** |
| Nelson & Johnson (1999) | ✓ |  |  |  |  |  |  |  |  |
| Edwards & Chen (1999) | ✓ |  |  | ✓ |  |  | ✓ |  |  |
| Granello (2000) |  |  | ✓ |  |  |  | ✓ | ✓ | ✓ |
| Gilbert & Evans (2000) | ✓ |  | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ |
| Scaife (2001) | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Frawley-O'Dea & Sarnat (2001) | ✓ |  |  | ✓ |  |  |  |  |  |
| Lee & Everett (2004) | ✓ |  | ✓ |  | ✓ | ✓ | ✓ |  |  |
| Ladany et al. (2005) |  |  | ✓ |  | ✓ | ✓ | ✓ | ✓ |  |
| Armstrong & Freeston (2006) | ✓ |  |  |  | ✓ | ✓ | ✓ | ✓ |  |
| Morgan & Sprenkle (2007) | ✓ |  | ✓ |  |  |  | ✓ |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Interactive discussion between supervisor and supervisee to further understanding/ decide on focus** | **Supervisee takes charge of what is shared in supervision** | **Discussion of theories and reading of literature** | **Shared experience from the supervisor** | **Live supervision/ observation** | **Recorded therapy sessions** | **Reporting on therapy sessions** | **Enactment of therapy sessions/ role-play** | **Supervisor using enquiry as learning technique** |
| Inskipp and Proctor (2009) | ✓ | ✓ |  |  | ✓ | ✓ | ✓ |  |  |
| Page and Wosket (2015) | ✓ |  | ✓ | ✓ |  | ✓ | ✓ | ✓ |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Appendix 2G. Evaluation aspect focus in supervision models | | | | |
| Table 2G. Model focus on evaluation aspects of supervision | | | | |
|  | **Assessment/ evaluation of supervisees** | **Evaluati-ng/monit-oring work with clients** | **Feedback from supervisor and/or supervisee** | **Feed-back from clients** |
| **No. of models**  **with**  **element**  **Model/ approach** | 31  (59.62%) | 7  (13.46%) | 30  (57.69%) | 2  (3.85%) |
| Hogan (1964) |  |  |  |  |
| Ekstein & Wallerstein (1972) | ✓ |  |  |  |
| Mueller & Kell (1971) |  |  |  |  |
| Delaney (1972) |  |  |  |  |
| Ard (1973) |  |  |  |  |
| Bernard (1979) | ✓ |  | ✓ |  |
| Littrell et al. (1979) | ✓ |  |  |  |
| Langs (1980) | ✓ |  | ✓ |  |
| Rice (1980) | ✓ |  | ✓ |  |
| Linehan (1980) | ✓ | ✓ | ✓ | ✓ |
| Beier & Young (1980) | ✓ |  | ✓ |  |
| Stoltenberg (1981) |  |  |  |  |
| Loganbill et al. (1982) | ✓ |  |  |  |
| Yogev (1982) | ✓ |  | ✓ |  |
| Blocher (1983) |  |  | ✓ |  |
| Bordin (1983) | ✓ |  | ✓ |  |
| Hosford & Barmann (1983) | ✓ |  | ✓ |  |
| Patterson (1983) | ✓ |  | ✓ |  |
| **Model/ approach** | **Assessment/ evaluation of supervisees** | **Evaluati-ng/monit-oring work with clients** | **Feedback from supervisor and/or supervisee** | **Feed-back from clients** |
| Wessler & Ellis (1983) | ✓ |  | ✓ |  |
| Connell (1984) |  |  |  |  |
| Grater (1985) |  |  | ✓ |  |
| Friedmand & Kaslow (1986) | ✓ |  |  |  |
| Hess (1986) | ✓ |  | ✓ |  |
| Stoltenberg & Delworth (1987) | ✓ | ✓ | ✓ |  |
| Ault-Riche (1988) |  |  |  |  |
| Watkins (1990) |  |  |  |  |
| Wetchler (1990) |  |  | ✓ |  |
| Mead (1990) | ✓ | ✓ | ✓ |  |
| Hawkins & Shohet (1993) |  |  |  |  |
| Rodenhauser (1994) | ✓ |  |  |  |
| Thomas (1994) |  |  |  |  |
| Rigazio-DiGilio & Anderson (1994) |  |  |  |  |
| Holloway (1995) | ✓ |  |  |  |
| Hipp & Munson (1995) |  |  |  |  |
| Carroll (1996) | ✓ |  | ✓ |  |
| Carroll (1996) | ✓ | ✓ | ✓ |  |
| Haber (1996) | ✓ |  | ✓ |  |
| Liese & Beck (1997) |  |  | ✓ |  |
| Ward & House (1998) |  |  |  |  |
| Bob (1999) |  |  |  |  |
| Nelson & Johnson (1999) | ✓ |  | ✓ |  |
| Edwards & Chen (1999) |  |  |  |  |
| **Model/ approach** | **Assessment/ evaluation of supervisees** | **Evaluating/monitoring work with clients** | **Feedback from supervisor and/or supervisee** | **Feed-back from clients** |
| Granello (2000) | ✓ | ✓ | ✓ |  |
| Gilbert & Evans (2000) | ✓ | ✓ | ✓ |  |
| Scaife (2001) |  |  | ✓ |  |
| Frawley-O'Dea & Sarnat (2001) | ✓ |  | ✓ |  |
| Lee & Everett (2004) | ✓ |  | ✓ | ✓ |
| Ladany et al. (2005) | ✓ |  | ✓ |  |
| Armstrong & Freeston (2006) |  |  |  |  |
| Morgan & Sprenkle (2007) | ✓ |  | ✓ |  |
| Inskipp and Proctor (2009) | ✓ |  | ✓ |  |
| Page and Wosket (2015) | ✓ | ✓ | ✓ |  |

## Appendix 2H. Management aspect focus in supervision models

Table 2H. Model focus on management aspects of supervision.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Contract** | **Re-contracting** | **Terminat-ion** | **Supervision of supervision** |
| **No. of models**  **with**  **element**  **Model/ approach** | 12  (23.08%) | 2  (3.85%) | 9  (17.31%) | 5  (9.62%) |
| Hogan (1964) | ✓ |  |  |  |
| Ekstein & Wallerstein (1972) |  |  |  |  |
| Mueller & Kell (1971) |  |  |  |  |
| Delaney (1972) |  |  |  |  |
| Ard (1973) | ✓ | ✓ |  | ✓ |
| Bernard (1979) | ✓ |  |  |  |
| Littrell et al. (1979) |  |  |  |  |
| Langs (1980) | ✓ |  | ✓ |  |
| Rice (1980) |  |  |  |  |
| Linehan (1980) |  |  |  |  |
| Beier & Young (1980) |  |  |  |  |
| Stoltenberg (1981) |  |  |  |  |
| Loganbill et al. (1982) |  |  |  |  |
| Yogev (1982) |  |  |  |  |
| Blocher (1983) |  |  |  |  |
| Bordin (1983) |  |  |  |  |
| Hosford & Barmann (1983) | ✓ |  |  |  |
| Patterson (1983) |  |  |  |  |
| Wessler & Ellis (1983) |  |  |  |  |
| Connell (1984) |  |  |  |  |
| Grater (1985) |  |  |  |  |
| **Model/ approach** | **Contract** | **Re-contracting** | **Terminat-ion** | **Supervision of supervision** |
| Friedmand & Kaslow (1986) |  |  | ✓ |  |
| Hess (1986) |  |  |  |  |
| Stoltenberg & Delworth (1987) |  |  |  |  |
| Ault-Riche (1988) |  |  |  |  |
| Watkins (1990) |  |  | ✓ |  |
| Wetchler (1990) |  |  |  |  |
| Mead (1990) |  |  |  |  |
| Hawkins & Shohet (1993) | ✓ |  | ✓ |  |
| Rodenhauser (1994) |  |  |  |  |
| Thomas (1994) | ✓ |  |  |  |
| Rigazio-DiGilio & Anderson (1994) |  |  |  |  |
| Holloway (1995) |  |  |  |  |
| Hipp & Munson (1995) | ✓ |  |  |  |
| Carroll (1996) |  |  | ✓ |  |
| Carroll (1996) |  |  |  |  |
| Haber (1996) |  |  |  |  |
| Liese & Beck (1997) | ✓ |  |  | ✓ |
| Ward & House (1998) | ✓ | ✓ |  | ✓ |
| Bob (1999) | ✓ |  |  | ✓ |
| Nelson & Johnson (1999) |  |  | ✓ |  |
| Edwards & Chen (1999) |  |  | ✓ |  |
| Granello (2000) | ✓ |  |  | ✓ |
| Gilbert & Evans (2000) |  |  |  |  |
| Scaife (2001) |  |  |  |  |
| Frawley-O'Dea & Sarnat (2001) |  |  |  |  |
| Lee & Everett (2004) |  |  |  |  |
| Ladany et al. (2005) |  |  | ✓ |  |
| Armstrong & Freeston (2006) |  |  |  |  |
| **Model/ approach** | **Contract** | **Re-contracting** | **Terminat-ion** | **Supervision of supervision** |
| Morgan & Sprenkle (2007) |  |  |  |  |
| Inskipp and Proctor (2009) |  |  |  |  |
| Page and Wosket (2015) |  |  | ✓ |  |

## Appendix 2I. Supervision relationships focus in supervision models

Table 2I. Model focus on relationships in supervision.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Relationship between supervisor and supervisee** | **Relationsh-ip between supervisee and client** | **Relationship between supervisor and client** |
| **No. of models**  **with**  **element**  **Model/ approach** | 43  (82.69%) | 27  (51.92%) | 3  (5.77%) |
| Hogan (1964) | ✓ | ✓ |  |
| Ekstein & Wallerstein (1972) | ✓ |  |  |
| Mueller & Kell (1971) | ✓ | ✓ | ✓ |
| Delaney (1972) | ✓ | ✓ |  |
| Ard (1973) | ✓ |  |  |
| Bernard (1979) | ✓ | ✓ |  |
| Littrell et al. (1979) | ✓ | ✓ |  |
| Langs (1980) | ✓ |  |  |
| Rice (1980) | ✓ | ✓ |  |
| Linehan (1980) | ✓ | ✓ |  |
| Beier & Young (1980) |  |  |  |
| Stoltenberg (1981) | ✓ | ✓ |  |
| Loganbill et al. (1982) |  |  |  |
| Yogev (1982) | ✓ | ✓ |  |
| Blocher (1983) | ✓ |  |  |
| Bordin (1983) | ✓ |  |  |
| Hosford & Barmann (1983) | ✓ | ✓ |  |
| Patterson (1983) | ✓ |  |  |
| **Model/ approach** | **Relationship between supervisor and supervisee** | **Relationsh-ip between supervisee and client** | **Relationship between supervisor and client** |
| Wessler & Ellis (1983) |  | ✓ |  |
| Connell (1984) | ✓ |  |  |
| Grater (1985) | ✓ |  |  |
| Friedmand & Kaslow (1986) | ✓ | ✓ |  |
| Hess (1986) | ✓ |  |  |
| Stoltenberg & Delworth (1987) | ✓ | ✓ | ✓ |
| Ault-Riche (1988) | ✓ | ✓ |  |
| Watkins (1990) | ✓ | ✓ |  |
| Wetchler (1990) |  | ✓ |  |
| Mead (1990) | ✓ | ✓ |  |
| Hawkins & Shohet (1993) | ✓ |  |  |
| Rodenhauser (1994) | ✓ |  |  |
| Thomas (1994) | ✓ |  |  |
| Rigazio-DiGilio & Anderson (1994) | ✓ | ✓ |  |
| Holloway (1995) | ✓ |  |  |
| Hipp & Munson (1995) | ✓ |  |  |
| Carroll (1996) |  | ✓ |  |
| Carroll (1996) | ✓ | ✓ |  |
| Haber (1996) | ✓ |  |  |
| Liese & Beck (1997) | ✓ | ✓ |  |
| Ward & House (1998) | ✓ | ✓ |  |
| Bob (1999) | ✓ | ✓ | ✓ |
| Nelson & Johnson (1999) | ✓ |  |  |
| Edwards & Chen (1999) | ✓ | ✓ |  |
| **Model/ approach** | **Relationship between supervisor and supervisee** | **Relationsh-ip between supervisee and client** | **Relationship between supervisor and client** |
| Granello (2000) | ✓ | ✓ |  |
| Gilbert & Evans (2000) | ✓ | ✓ |  |
| Scaife (2001) |  |  |  |
| Frawley-O'Dea & Sarnat (2001) | ✓ |  |  |
| Lee & Everett (2004) |  |  |  |
| Ladany et al. (2005) | ✓ |  |  |
| Armstrong & Freeston (2006) | ✓ |  |  |
| Morgan & Sprenkle (2007) |  |  |  |
| Inskipp and Proctor (2009) |  |  |  |
| Page and Wosket (2015) | ✓ | ✓ |  |

## Appendix 2J. Supervision formats in supervision models

Table 2J. Model focus on different supervision formats.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Group supervision** | **Peer supervision** | **Self-supervision** | **Phone/ email/ tele-conferencing supervision** | **Client invited into supervision** |
| **No. of models**  **with**  **element**  **Model/ approach** | 21  (40.38%) | 14  (26.92%) | 4  (7.69%) | 2  (3.85%) | 1  (1.92%) |
| Hogan (1964) | ✓ | ✓ |  | ✓ |  |
| Ekstein & Wallerstein (1972) |  |  |  |  |  |
| Mueller & Kell (1971) | ✓ |  |  |  |  |
| Delaney (1972) |  |  |  |  |  |
| Ard (1973) | ✓ | ✓ |  |  |  |
| Bernard (1979) |  |  |  |  |  |
| Littrell et al. (1979) |  |  |  |  |  |
| Langs (1980) |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Group supervision** | **Peer supervision** | **Self-supervision** | **Phone/ email/ tele-conferencing supervision** | **Client invited into supervision** |
| Rice (1980) |  |  |  |  |  |
| Linehan (1980) | ✓ | ✓ |  |  |  |
| Beier & Young (1980) |  |  |  |  |  |
| Stoltenberg (1981) |  |  |  |  |  |
| Loganbill et al. (1982) |  | ✓ |  |  |  |
| Yogev (1982) | ✓ | ✓ |  |  |  |
| Blocher (1983) | ✓ |  |  |  |  |
| Bordin (1983) | ✓ |  |  |  |  |
| Hosford & Barmann (1983) | ✓ |  |  |  |  |
| Patterson (1983) | ✓ |  |  |  |  |
| Wessler & Ellis (1983) | ✓ |  |  |  |  |
| Connell (1984) | ✓ | ✓ |  |  |  |
| Grater (1985) |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Group supervision** | **Peer supervision** | **Self-supervision** | **Phone/ email/ tele-conferencing supervision** | **Client invited into supervision** |
| Friedmand & Kaslow (1986) |  |  |  |  |  |
| Hess (1986) |  |  |  |  |  |
| Stoltenberg & Delworth (1987) |  |  |  |  |  |
| Ault-Riche (1988) | ✓ | ✓ |  |  |  |
| Watkins (1990) |  | ✓ |  |  |  |
| Wetchler (1990) |  |  |  |  |  |
| Mead (1990) |  |  |  |  |  |
| Hawkins & Shohet (1993) |  |  |  |  |  |
| Rodenhauser (1994) |  |  |  |  |  |
| Thomas (1994) |  |  |  |  |  |
| Rigazio-DiGilio & Anderson (1994) |  |  |  |  |  |
| Holloway (1995) |  | ✓ |  |  |  |
| Hipp & Munson (1995) |  |  | ✓ |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Group supervision** | **Peer supervision** | **Self-supervision** | **Phone/ email/ tele-conferencing supervision** | **Client invited into supervision** |
| Carroll (1996) |  |  |  |  |  |
| Carroll (1996) |  |  |  |  | ✓ |
| Haber (1996) | ✓ |  |  | ✓ |  |
| Liese & Beck (1997) | ✓ |  |  |  |  |
| Ward & House (1998) | ✓ | ✓ |  |  |  |
| Bob (1999) |  |  |  |  |  |
| Nelson & Johnson (1999) |  |  | ✓ |  |  |
| Edwards & Chen (1999) |  |  |  |  |  |
| Granello (2000) | ✓ | ✓ |  |  |  |
| Gilbert & Evans (2000) | ✓ |  | ✓ |  |  |
| Scaife (2001) |  |  |  |  |  |
| Frawley-O'Dea & Sarnat (2001) | ✓ | ✓ |  |  |  |
| Lee & Everett (2004) | ✓ | ✓ |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Group supervision** | **Peer supervision** | **Self-supervision** | **Phone/ email/ tele-conferencing supervision** | **Client invited into supervision** |
| Ladany et al. (2005) | ✓ |  |  |  |  |
| Armstrong & Freeston (2006) |  |  | ✓ |  |  |
| Morgan & Sprenkle (2007) |  |  |  |  |  |
| Inskipp and Proctor (2009) | ✓ | ✓ |  |  |  |
| Page and Wosket (2015) |  |  |  |  |  |

## Appendix 2K. General aspect focus in supervision models

Table 2K. General aspects of the supervision models.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Transference and/ or parallel processes** | **Acknowledgement of wider context of therapy process** | **Stage/ level/ step model** | **Focus mainly on trainee rather than therapist** | **Focus on solutions/ strengths over problems** |
| **No. of models**  **with**  **element**  **Model/ approach** | 27  (51.92%) | 22  (42.31%) | 20  (38.46%) | 18  (34.62%) | 5  (9.62%) |
| Hogan (1964) | ✓ | ✓ |  |  |  |
| Ekstein & Wallerstein (1972) | ✓ |  |  |  |  |
| Mueller & Kell (1971) | ✓ | ✓ |  |  |  |
| Delaney (1972) | ✓ | ✓ |  |  |  |
| Ard (1973) | ✓ | ✓ | ✓ |  |  |
| Bernard (1979) | ✓ | ✓ |  | ✓ |  |
| Littrell et al. (1979) | ✓ | ✓ |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Transference and/ or parallel processes** | **Acknowledgement of wider context of therapy process** | **Stage/ level/ step model** | **Focus mainly on trainee rather than therapist** | **Focus on solutions/ strengths over problems** |
| Langs (1980) | ✓ | ✓ | ✓ |  |  |
| Rice (1980) |  |  |  |  |  |
| Linehan (1980) | ✓ | ✓ | ✓ | ✓ |  |
| Beier & Young (1980) |  |  | ✓ | ✓ |  |
| Stoltenberg (1981) |  | ✓ | ✓ |  |  |
| Loganbill et al. (1982) |  |  | ✓ | ✓ |  |
| Yogev (1982) | ✓ | ✓ | ✓ |  |  |
| Blocher (1983) |  | ✓ |  |  |  |
| Bordin (1983) |  |  |  |  |  |
| Hosford & Barmann (1983) |  |  |  |  |  |
| Patterson (1983) |  | ✓ | ✓ |  |  |
| Wessler & Ellis (1983) |  | ✓ |  | ✓ |  |
| Connell (1984) | ✓ |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Transference and/ or parallel processes** | **Acknowledgement of wider context of therapy process** | **Stage/ level/ step model** | **Focus mainly on trainee rather than therapist** | **Focus on solutions/ strengths over problems** |
| Grater (1985) | ✓ |  | ✓ |  |  |
| Friedmand & Kaslow (1986) | ✓ | ✓ |  |  |  |
| Hess (1986) |  | ✓ |  |  |  |
| Stoltenberg & Delworth (1987) | ✓ | ✓ |  | ✓ |  |
| Ault-Riche (1988) |  | ✓ |  |  |  |
| Watkins (1990) | ✓ |  | ✓ | ✓ |  |
| Wetchler (1990) | ✓ | ✓ |  | ✓ |  |
| Mead (1990) | ✓ |  |  |  |  |
| Hawkins & Shohet (1993) |  |  | ✓ |  |  |
| Rodenhauser (1994) | ✓ | ✓ | ✓ |  |  |
| Thomas (1994) |  |  |  | ✓ | ✓ |
| Rigazio-DiGilio & Anderson (1994) |  |  | ✓ | ✓ |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Transference and/ or parallel processes** | **Acknowledgement of wider context of therapy process** | **Stage/ level/ step model** | **Focus mainly on trainee rather than therapist** | **Focus on solutions/ strengths over problems** |
| Holloway (1995) |  |  | ✓ | ✓ |  |
| Hipp & Munson (1995) |  |  | ✓ | ✓ |  |
| Carroll (1996) | ✓ |  | ✓ |  |  |
| Carroll (1996) |  |  |  |  | ✓ |
| Haber (1996) |  |  |  | ✓ |  |
| Liese & Beck (1997) | ✓ |  |  |  | ✓ |
| Ward & House (1998) | ✓ | ✓ |  |  |  |
| Bob (1999) | ✓ | ✓ |  |  |  |
| Nelson & Johnson (1999) |  | ✓ | ✓ |  |  |
| Edwards & Chen (1999) | ✓ |  |  | ✓ |  |
| Granello (2000) | ✓ |  |  |  |  |
| Gilbert & Evans (2000) | ✓ |  |  |  |  |
| Scaife (2001) |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Transference and/ or parallel processes** | **Acknowledgement of wider context of therapy process** | **Stage/ level/ step model** | **Focus mainly on trainee rather than therapist** | **Focus on solutions/ strengths over problems** |
| Frawley-O'Dea & Sarnat (2001) |  |  |  | ✓ |  |
| Lee & Everett (2004) | ✓ |  |  | ✓ |  |
| Ladany et al. (2005) |  |  | ✓ | ✓ | ✓ |
| Armstrong & Freeston (2006) |  |  | ✓ |  |  |
| Morgan & Sprenkle (2007) |  |  |  |  | ✓ |
| Inskipp and Proctor (2009) |  |  |  |  |  |
| Page and Wosket (2015) | ✓ |  | ✓ | ✓ |  |

## Appendix 2L. Other supervision aspects focus in supervision models

Table 2L. Model focus on other aspects of supervision.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Goal setting** | **Homework** | **Use of imagery/ metaphor** | **Regression accepted in supervision** | **Expects preparation from therapist coming to supervision** | **Co-therapy with supervisor** | **Supervisor can treat/ counsel supervisee if agreed by both parties** | **Acknowledge-ment of emergency situations** | **Acknowledge-ment of how an administrator fits into the supervisory process** |
| **No. of models**  **with**  **element**  **Model/ approach** | 31  (59.62%) | 2  (3.85%) | 2  (3.85%) | 2  (3.85%) | 8  (15.38%) | 5  (9.62%) | 3  (5.77%) | 4  (7.69%) | 2  (3.85%) |
| Hogan (1964) |  |  |  |  | ✓ |  |  |  |  |
| Ekstein & Wallerstein (1972) |  |  |  |  |  |  |  |  |  |
| Mueller & Kell (1971) |  |  |  |  |  |  |  |  |  |
| Delaney (1972) |  |  |  | ✓ |  |  | ✓ |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Goal setting** | **Homework** | **Use of imagery/ metaphor** | **Regression accepted in supervision** | **Expects preparation from therapist coming to supervision** | **Co-therapy with supervisor** | **Supervisor can treat/ counsel supervisee if agreed by both parties** | **Acknowledge-ment of emergency situations** | **Acknowledge-ment of how an administrator fits into the supervisory process** |
| Ard (1973) | ✓ |  | ✓ |  | ✓ |  |  |  |  |
| Bernard (1979) |  |  |  |  |  |  |  |  |  |
| Littrell et al. (1979) |  |  |  |  |  |  | ✓ |  |  |
| Langs (1980) | ✓ |  |  |  | ✓ |  |  |  |  |
| Rice (1980) | ✓ |  |  |  |  |  |  |  |  |
| Linehan (1980) | ✓ |  |  |  |  |  |  |  |  |
| Beier & Young (1980) |  |  |  |  |  | ✓ |  |  |  |
| Stoltenberg (1981) | ✓ |  |  |  |  |  |  |  |  |
| Loganbill et al. (1982) |  |  |  |  | ✓ |  |  |  |  |
| Yogev (1982) | ✓ |  |  |  |  |  |  |  |  |
| Blocher (1983) | ✓ |  |  |  | ✓ |  |  |  |  |
| Bordin (1983) | ✓ | ✓ |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Goal setting** | **Homework** | **Use of imagery/ metaphor** | **Regression accepted in supervision** | **Expects preparation from therapist coming to supervision** | **Co-therapy with supervisor** | **Supervisor can treat/ counsel supervisee if agreed by both parties** | **Acknowledge-ment of emergency situations** | **Acknowledge-ment of how an administrator fits into the supervisory process** |
| Hosford & Barmann (1983) | ✓ |  |  |  |  |  |  |  |  |
| Patterson (1983) | ✓ |  |  |  |  |  |  |  |  |
| Wessler & Ellis (1983) |  |  |  |  | ✓ |  |  |  |  |
| Connell (1984) | ✓ | ✓ |  |  |  |  | ✓ |  |  |
| Grater (1985) |  |  |  |  |  |  |  |  |  |
| Friedmand & Kaslow (1986) | ✓ |  |  |  |  |  |  |  |  |
| Hess (1986) |  |  |  |  |  |  |  |  |  |
| Stoltenberg & Delworth (1987) |  |  |  |  |  |  |  | ✓ | ✓ |
| Ault-Riche (1988) | ✓ |  |  |  |  |  |  |  |  |
| Watkins (1990) |  |  |  |  | ✓ |  |  |  |  |
| Wetchler (1990) |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Goal setting** | **Homework** | **Use of imagery/ metaphor** | **Regression accepted in supervision** | **Expects preparation from therapist coming to supervision** | **Co-therapy with supervisor** | **Supervisor can treat/ counsel supervisee if agreed by both parties** | **Acknowledge-ment of emergency situations** | **Acknowledge-ment of how an administrator fits into the supervisory process** |
| Mead (1990) |  |  |  |  |  |  |  |  |  |
| Hawkins & Shohet (1993) | ✓ |  |  |  |  | ✓ |  |  |  |
| Rodenhauser (1994) |  |  |  |  |  |  |  |  |  |
| Thomas (1994) | ✓ |  |  |  | ✓ |  |  |  |  |
| Rigazio-DiGilio & Anderson (1994) |  |  |  |  |  |  |  |  |  |
| Holloway (1995) | ✓ |  |  |  |  |  |  |  |  |
| Hipp & Munson (1995) | ✓ |  |  |  |  |  |  |  |  |
| Carroll (1996) | ✓ |  |  |  |  |  |  |  |  |
| Carroll (1996) | ✓ |  |  |  |  |  |  |  |  |
| Haber (1996) |  |  |  |  |  |  |  |  | ✓ |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Goal setting** | **Homework** | **Use of imagery/ metaphor** | **Regression accepted in supervision** | **Expects preparation from therapist coming to supervision** | **Co-therapy with supervisor** | **Supervisor can treat/ counsel supervisee if agreed by both parties** | **Acknowledge-ment of emergency situations** | **Acknowledge-ment of how an administrator fits into the supervisory process** |
| Liese & Beck (1997) | ✓ |  |  |  |  |  |  |  |  |
| Ward & House (1998) | ✓ |  |  |  |  |  |  |  |  |
| Bob (1999) | ✓ |  | ✓ |  |  | ✓ |  | ✓ |  |
| Nelson & Johnson (1999) | ✓ |  |  |  |  | ✓ |  | ✓ |  |
| Edwards & Chen (1999) | ✓ |  |  | ✓ |  |  |  |  |  |
| Granello (2000) | ✓ |  |  |  |  |  |  |  |  |
| Gilbert & Evans (2000) |  |  |  |  |  |  |  | ✓ |  |
| Scaife (2001) |  |  |  |  |  |  |  |  |  |
| Frawley-O'Dea & Sarnat (2001) | ✓ |  |  |  |  |  |  |  |  |
| Lee & Everett (2004) |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model/ approach** | **Goal setting** | **Homework** | **Use of imagery/ metaphor** | **Regression accepted in supervision** | **Expects preparation from therapist coming to supervision** | **Co-therapy with supervisor** | **Supervisor can treat/ counsel supervisee if agreed by both parties** | **Acknowledge-ment of emergency situations** | **Acknowledge-ment of how an administrator fits into the supervisory process** |
| Ladany et al. (2005) | ✓ |  |  |  |  |  |  |  |  |
| Armstrong & Freeston (2006) | ✓ |  |  |  |  |  |  |  |  |
| Morgan & Sprenkle (2007) | ✓ |  |  |  |  |  |  |  |  |
| Inskipp & Proctor (2009) | ✓ |  |  |  |  | ✓ |  |  |  |
| Page & Wosket (2015) | ✓ |  |  |  |  |  |  |  |  |

## Appendix 2M. Use of empirical evidence in supervision models

Table 2M. Empirical evidence use in models.

|  |  |  |
| --- | --- | --- |
|  | **Cites empirical evidence** | **Based on empirical evidence** |
| **No. of models**  **with element**  **Model/ approach** | 46  (88.46%) | 0 |
| Hogan (1964) |  |  |
| Ekstein & Wallerstein (1972) | ✓ |  |
| Mueller & Kell (1971) |  |  |
| Delaney (1972) |  |  |
| Ard (1973) |  |  |
| Bernard (1979) | ✓ |  |
| Littrell et al. (1979) | ✓ |  |
| Langs (1980) | ✓ |  |
| Rice (1980) | ✓ |  |
| Linehan (1980) | ✓ |  |
| Beier & Young (1980) | ✓ |  |
| Stoltenberg (1981) |  |  |
| Loganbill et al. (1982) | ✓ |  |
| Yogev (1982) | ✓ |  |
| Blocher (1983) | ✓ |  |
| Bordin (1983) | ✓ |  |
| Hosford & Barmann (1983) | ✓ |  |
| Patterson (1983) |  |  |
| **Model/ approach** | **Cites empirical evidence** | **Based on empirical evidence** |
| Wessler & Ellis (1983) | ✓ |  |
| Connell (1984) | ✓ |  |
| Grater (1985) | ✓ |  |
| Friedmand & Kaslow (1986) | ✓ |  |
| Hess (1986) | ✓ |  |
| Stoltenberg & Delworth (1987) | ✓ |  |
| Ault-Riche (1988) | ✓ |  |
| Watkins (1990) |  |  |
| Wetchler (1990) | ✓ |  |
| Mead (1990) | ✓ |  |
| Hawkins & Shohet (1993) | ✓ |  |
| Rodenhauser (1994) | ✓ |  |
| Thomas (1994) | ✓ |  |
| Rigazio-DiGilio & Anderson (1994) | ✓ |  |
| Holloway (1995) | ✓ |  |
| Hipp & Munson (1995) | ✓ |  |
| Carroll (1996) | ✓ |  |
| Carroll (1996) | ✓ |  |
| Haber (1996) | ✓ |  |
| Liese & Beck (1997) | ✓ |  |
| Ward & House (1998) | ✓ |  |
| Bob (1999) | ✓ |  |
| Nelson & Johnson (1999) | ✓ |  |
| Edwards & Chen (1999) | ✓ |  |
| Granello (2000) | ✓ |  |
| Gilbert & Evans (2000) | ✓ |  |
| **Model/ approach** | **Cites empirical evidence** | **Based on empirical evidence** |
| Scaife (2001) | ✓ |  |
| Frawley-O'Dea & Sarnat (2001) | ✓ |  |
| Lee & Everett (2004) | ✓ |  |
| Ladany et al. (2005) | ✓ |  |
| Armstrong & Freeston (2006) | ✓ |  |
| Morgan & Sprenkle (2007) | ✓ |  |
| Inskipp & Proctor (2009) |  |  |
| Page & Wosket (2015) | ✓ |  |

## Appendix 2N. Details of the content, supervisor and supervisee clusters

Table 2N.1 Content clusters

|  |  |  |
| --- | --- | --- |
| **Unfocused**  **(*n* = 16; 30.8%)** | **Fidelity**  **(*n* = 19; 36.5%)** | **Enhanced Fidelity**  **(*n* = 17; 32.7%)** |
| * 56.2% suggested reporting on therapy sessions | * 100% suggested reporting on therapy sessions * 100% suggested recording of therapy sessions * 52.6% focus on live supervision | * 76.5% suggested reporting on therapy sessions * 88.2% suggested recording of therapy sessions * 58.8% focus on live supervision * 100% suggested discussion of theories and reading of the literature * 88.2% suggested the use of role play |

Table 2N.2 Supervisor clusters

|  |  |  |  |
| --- | --- | --- | --- |
| **Unfocused**  **(*n* = 26; 50%)** | **Supervisor as an authority figure**  **(*n* = 11; 21.2%)** | **Supervisor as a multitasker**  **(*n* = 9; 17.3%)** | **Supervisor as an individual**  **(*n* = 6; 11.5%)** |
| * Little focus on any element | * 90.9% focus on supervisor is an authority figure/expert | * 100% focus on supervisor taking on a variety of roles | * 83.3% focus on supervisor is an authority figure/expert * 100% discuss supervisor’s culture * 100% discuss supervisor’s gender |

Table 2N.3 Supervisee clusters

|  |  |  |
| --- | --- | --- |
| **Unfocused**  **(*n* = 20; 38.5%)** | **Supervisee as an individual**  **(*n* = 20; 38.5%)** | **Supervisee as an individual in context**  **(*n* = 12; 23.1%)** |
| * Little focus on any element | * 100% focus on supervisee development * 55% discuss supervisee anxiety * 45% discuss supervisee autonomy vs. dependency | * 75% focus on supervisee development * 50% discuss supervisee anxiety * 100% discuss supervisee culture * 100% discuss supervisee gender * 58.3% discuss supervisee awareness of self and/or others * 41.7% discuss supervisee’s own learning styles |

## Appendix 3A. Downs and Black Checklist for measuring study quality (adapted from Downs and Black, 1998).

### Reporting

1. Is the hypothesis/aim/objective of the study clearly described?

Yes = 1, no = 0

2. Are the main outcomes to be measured clearly described in the Introduction or Methods section? If the main outcomes are first mentioned in the Results section, the question should be answered no.

Yes = 1, no = 0

3. Are the characteristics of the patients included in the study clearly described? *In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.*

Yes = 1, no = 0

4. Are the interventions of interest clearly described? *Treatments and placebo (where relevant) that are to be compared should be clearly described.*

Yes = 1, no = 0

5. Are the distributions of principal confounders in each group of subjects to be compared clearly described?

Yes = 2, partially = 1, no = 0

6. Are the main findings of the study clearly described? *Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below).*

Yes = 1, no = 0

7. Does the study provide estimates of the random variability in the data for the main outcomes? *In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.*

Yes = 1, no = 0

8. Have all important adverse events that may be a consequence of the intervention been reported? *This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events.*

Yes = 1, no = 0

9. Have the characteristics of patients lost to follow-up been described? *This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered no where a study does not report the number of patients lost to follow-up.*

Yes = 1, no = 0

10. Have actual probability values been reported (e.g. 0.035 rather than<0.05) for the main outcomes except where the probability value is less than 0.001?

Yes = 1, no = 0

### External validity

All the following criteria attempt to address the representativeness of the findings of the study and whether they may be generalised to the population from which the study subjects were derived.

11. Were the subjects asked to participate in the study representative of the entire population from which they were recruited? *The study must identify the source population for patients and describe how the patients were selected. Patients would be representative if they comprised the entire source population, an unselected sample of consecutive patients, or a random sample. Random sampling is only feasible where a list of all members of the relevant population exists. Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine.*

Yes = 1, no = 0, unable to determine = 0

12. Were those subjects who were prepared to participate representative of the entire population from which they were recruited? *The proportion of those asked who agreed should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population.*

Yes = 1, no = 0, unable to determine = 0

13. Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive? *For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend.*

Yes = 1, no = 0, unable to determine = 0

### Internal validity - bias

14. Was an attempt made to blind study subjects to the intervention they have received? *For studies where the patients would have no way of knowing which intervention they received, this should be answered yes.*

Yes = 1, no = 0, unable to determine = 0

15. Was an attempt made to blind those measuring the main outcomes of the intervention?

Yes = 1, no = 0, unable to determine = 0

16. If any of the results of the study were based on “data dredging”, was this made clear? *Any analyses that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes.*

Yes = 1, no = 0, unable to determine = 0

17. In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls? *Where follow-up was the same for all study patients the answer should yes. If different lengths of follow-up were adjusted for by, for example, survival analysis the answer should be yes. Studies where differences in follow-up are ignored should be answered no.*

Yes = 1, no = 0, unable to determine = 0

18. Were the statistical tests used to assess the main outcomes appropriate? *The statistical techniques used must be appropriate to the data. For example nonparametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes.*

Yes = 1, no = 0, unable to determine = 0

19. Was compliance with the intervention/s reliable? *Where there was non compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. For studies where the effect of any misclassification was likely to bias any association to the null, the question should be answered yes.*

Yes = 1, no = 0, unable to determine = 0

20. Were the main outcome measures used accurate (valid and reliable*)? For studies where the outcome measures are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcome measures are accurate, the question should be answered as yes.*

Yes = 1, no = 0, unable to determine = 0

### Internal validity - confounding (selection bias)

21. Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population? *For example, patients for all comparison groups should be selected from the same hospital. The question should be answered unable to determine for cohort and casecontrol studies where there is no information concerning the source of patients included in the study.*

Yes = 1, no = 0, unable to determine = 0

22. Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same period of time? *For a study which does not specify the time period over which patients were recruited, the question should be answered as unable to determine.*

Yes = 1, no = 0, unable to determine = 0

23. Were study subjects randomised to intervention groups? *Studies which state that subjects were randomised should be answered yes except where method of randomisation would not ensure random allocation. For example alternate allocation would score no because it is predictable.*

Yes = 1, no = 0, unable to determine = 0

24. Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable? *All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.*

Yes = 1, no = 0, unable to determine = 0

25. Was there adequate adjustment for confounding in the analyses from which the main findings were drawn? *This question should be answered no for trials if: the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders in the different treatment groups was not described; or the distribution of known confounders differed between the treatment groups but was not taken into account in the analyses. In nonrandomised studies if the effect of the main confounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses the question should be answered as no.*

Yes = 1, no = 0, unable to determine = 0

26. Were losses of patients to follow-up taken into account? *If the numbers of patients lost to follow-up are not reported, the question should be answered as unable to determine. If the proportion lost to follow-up was too small to affect the main findings, the question should be answered yes*

Yes = 1, no = 0, unable to determine = 0

### Power (adapted)

27. Did the article outline a power analysis prior to the results section?

1 = yes, 0 = no

## Appendix 3B. – Quality analysis using the Downs and Black Checklist.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Question**  **Study** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **Total** |
| Bambling et al. (2006) | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | **20** |
| Berg & Stone (1980) | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 14 |
| Borders (1991) | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13 |
| Bradshaw et al. (2007) *T* | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 18 |
| Bradshaw et al. (2007) *P* | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| Burlingame et al. (2007) *T* | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 16 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **Total** |
| Burlingame et al. (2007) *P* | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 15 |
| Crutchfield & Borders (1997) *T* | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 15 |
| Crutchfield & Borders (1997) *P* | 0 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| Fenell et al. (1986) | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 12 |
| Grossl et al. (2014) | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 13 |
| Kivlighan et al. (1991) | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 16 |
| Ladany et al. (1999) | 1 | 1 | 1 | 0 | 2 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 15 |
| Reese et al. (2009) *T* | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 14 |
| Reese et al. (2009) *P* | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 13 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **Total** |
| Sholomskas et al. (2005) | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 18 |
| Singo (1998) | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 22 |
| Tanner et al. (2012) | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 13 |
| Weck et al. (2016) | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 22 |

|  |
| --- |
|  |

## Appendix 4A - Study 1 ethics

From: **Psychology Research Ethics Application Management System** <no\_reply@psychology>  
Date: 4 June 2014 09:43  
Subject: Approval of your research proposal  
To: [G.Waller@sheffield.ac.uk](mailto:G.Waller@sheffield.ac.uk)  
  
  
Your submission to the Department of Psychology Ethics Sub-Committee (DESC) entitled "Do the complexity of clinical cases and the way that psychotherapists present them influence the advice that supervisors give in supervision? " has now been reviewed. The committee believed that your methods and procedures conformed to University and BPS Guidelines.  
  
I am therefore pleased to inform you that the ethics of your research are approved. You may now commence the empirical work.  
  
Yours sincerely,  
  
Prof Richard Crisp  
  
Chair, DESC

## Appendix 4B – Study 1 questionnaire

Thank you for your interest in our study. We are investigating the role that supervisors play in the delivery of CBT by their supervisees. In particular, we would like to know what advice you provide during sessions with your supervisees and which supervisory techniques you use. To take part in this research, you must be a supervisor to CBT clinicians treating patients with depression. All answers are confidential and individual data will only be identifiable during data collection by the researchers involved. No information about individuals will be made available to your managers, employers, supervisors, etc. After data collection is complete all email addresses will be deleted (unless you indicate that you would like a summary of the research findings or are happy to be contacted for future research). If this questionnaire causes any professional concerns, please speak to a colleague. If you have any questions or would like more information about this study, please contact me - Chloe Simpson-Southward ([crsimpson-southward1@sheffield.ac.uk](mailto:crsimpson-southward1@sheffield.ac.uk)). This research has been approved by the University of Sheffield's Department of Psychology Ethics Committee and is supervised by Glenn Waller ([g.waller@sheffield.ac.uk](mailto:g.waller@sheffield.ac.uk)) and Gillian Hardy ([g.hardy@sheffield.ac.uk](mailto:g.hardy@sheffield.ac.uk)).

If you are willing to allow your answers to be used in this study, please indicate consent below. Please note that all answers will be stored anonymously and your ID will not be disclosed to anybody else.

* I agree to my answers being used for research in this project and I understand that I can withdraw consent at any time.

Do you clinically supervise others?

* Yes
* No

**Please tell us a little about yourself:**

Your age:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your gender:

* Male
* Female

What country are you working in?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What country did you do your therapy training in?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your background profession?

* Nurse
* Social Worker
* Occupational Therapist
* Clinical Psychologist
* Counselling Psychologist
* Psychiatrist
* Health Trainer
* IAPT High Intensity Worker
* Psychological Wellbeing Practitioner
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been qualified? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you accredited by your national CBT organisation (e.g., BABCP in the UK)?

* Yes
* No
* Provisionally

How long have you been accredited as a CBT practitioner? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you accredited as a supervisor by your national CBT organisation?

* Yes
* No

How long have you been accredited as a CBT supervisor? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been using CBT to treat patients with depression? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, how big is your CBT caseload at any one time?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, what percentage of your client caseload has a **primary** diagnosis of depression?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, what percentage of your client caseload has a **secondary** diagnosis of depression (alongside another major referring diagnosis)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, how many hours of clinical supervision do you receive **each month**?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many people do you clinically supervise?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you spend clinically supervising **each month**?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use treatment manuals on a regular basis for your work with depression?

* Yes
* No

How many do you use?

* 1-2
* 3-4
* 5+

Please specify the one that you use most commonly (lead author and title):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You will be presented with three clinical cases that your supervisee has brought to you in their supervision sessions. For each case you will be asked a series of questions regarding how the therapist should approach treating the patient.**

Mary is 36 and lives with her two children. She got divorced from her husband two years ago, and currently has a partner of about four months. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still doing her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood.

Midway through Mary's course of therapy, the clinician comes to you and outlines her condition. Using the sliders below, please indicate how likely you are to focus on each of the following techniques when giving the clinician advice during supervision.   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Focus on the development of the therapeutic alliance with the patient |  |
| Focus on evidence-based therapeutic techniques |  |
| Focus on other issues in supervision |  |

To what extent would you focus on the following areas of the **therapeutic relationship**?   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Therapeutic bond (attachment between patient and clinician) |  |
| Agreement on the goals of therapy |  |
| Agreement on the tasks of therapy |  |

Of the **evidence-based therapeutic techniques** available, how much would you focus on each of the following? (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| eviewing depression levels |  |
| Education into the CBT model |  |
| Agenda setting |  |
| Socratic questioning |  |
| Linking cognitions, emotions and behaviour |  |
| Detection and recording of negative automatic thoughts |  |
| Clarify dysfunctional assumptions |  |
| Develop alternative hypotheses about cognitive distortions |  |
| Behavioural activation |  |
| Mindfulness |  |
| Eye Movement Desensitisation and Reprocessing (EMDR) |  |
| Response to feedback from patient |  |
| Discussion of thought records |  |
| Review other homework tasks |  |
| Testing alternative hypotheses via behavioural experiments |  |
| Cognitive rehearsal |  |
| Assertiveness training |  |
| Use of reattribution |  |
| Relapse prevention techniques |  |
| Other (please indicate) |  |

To what extent would you focus on these **other issues** in supervision?  (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Focus on risk (to the patient or others) |  |
| Focus on the patient's capacity to use treatment and benefit from it |  |
| Focus on the patient's week |  |
| Encouragement/motivation of the clinician to remain on task |  |
| Other (please state) |  |

Joanne is 38 and lives with her husband and son. She describes her relationship as “solid”, though she and her husband do not always get on well. She works as a classroom assistant, though she would like to do something more challenging. Her mood has generally been okay, but she reports feeling detached from the world and feeling a lack of direction in her life. She finds herself feeling “down”, though would not harm herself. She sought a referral so that she would have opportunity to talk about where she is going in life.

Midway through Joanne's course of therapy, the clinician comes to you and outlines her condition. Using the sliders below, please indicate how likely you are to focus on each of the following techniques when giving the clinician advice during supervision.   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Focus on the development of the therapeutic alliance with the patient |  |
| Focus on evidence-based therapeutic techniques |  |
| Focus on other issues in supervision |  |

To what extent would you focus on the following areas of the **therapeutic relationship**?   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Therapeutic bond (attachment between patient and clinician) |  |
| Agreement on the goals of therapy |  |
| Agreement on the tasks of therapy |  |

Of the **evidence-based therapeutic techniques** available, how much would you focus on each of the following? (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Reviewing depression levels |  |
| Education into the CBT model |  |
| Agenda setting |  |
| Socratic questioning |  |
| Linking cognitions, emotions and behaviour |  |
| Detection and recording of negative automatic thoughts |  |
| Clarify dysfunctional assumptions |  |
| Develop alternative hypotheses about cognitive distortions |  |
| Behavioural activation |  |
| Mindfulness |  |
| Eye Movement Desensitisation and Reprocessing (EMDR) |  |
| Response to feedback from patient |  |
| Discussion of thought records |  |
| Review other homework tasks |  |
| Testing alternative hypotheses via behavioural experiments |  |
| Cognitive rehearsal |  |
| Assertiveness training |  |
| Use of reattribution |  |
| Relapse prevention techniques |  |
| Other (please indicate) |  |

To what extent would you focus on these **other issues** in supervision?   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Focus on risk (to the patient or others) |  |
| Focus on the patient's capacity to use treatment and benefit from it |  |
| Focus on the patient's week |  |
| Encouragement/motivation of the clinician to remain on task |  |
| Other (please state) |  |

Susan is 35, and is currently in a relationship that she is unhappy with. She is depressed and socially isolated. Her appetite and sleep are poor and she reports feeling slowed down. She is struggling to find things funny or exciting about life. These symptoms are affecting her ability to do her office job. She has had suicidal ideas, but she is unsure whether she will act upon them, She recently took a small overdose, though she described it as to help her “turn off” for a while. That encouraged her to seek a referral for therapy.

Midway through Susan's course of therapy, the clinician comes to you and outlines her condition. Using the sliders below, please indicate how likely you are to focus on each of the following techniques when giving the clinician advice during supervision.   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Focus on the development of the therapeutic alliance with the patient |  |
| Focus on evidence-based therapeutic techniques |  |
| Focus on other issues in supervision |  |

To what extent would you focus on the following areas of the **therapeutic relationship**?   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Therapeutic bond (attachment between patient and clinician) |  |
| Agreement on the goals of therapy |  |
| Agreement on the tasks of therapy |  |

Of the **evidence-based therapeutic techniques** available, how much would you focus on each of the following? (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Reviewing depression levels |  |
| Education into the CBT model |  |
| Agenda setting |  |
| Socratic questioning |  |
| Linking cognitions, emotions and behaviour |  |
| Detection and recording of negative automatic thoughts |  |
| Clarify dysfunctional assumptions |  |
| Develop alternative hypotheses about cognitive distortions |  |
| Behavioural activation |  |
| Mindfulness |  |
| Eye Movement Desensitisation and Reprocessing (EMDR) |  |
| Response to feedback from patient |  |
| Discussion of thought records |  |
| Review other homework tasks |  |
| Testing alternative hypotheses via behavioural experiments |  |
| Cognitive rehearsal |  |
| Assertiveness training |  |
| Use of reattribution |  |
| Relapse prevention techniques |  |
| Other (please indicate) |  |

To what extent would you focus on these **other issues** in supervision?   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Focus on risk (to the patient or others) |  |
| Focus on the patient's capacity to use treatment and benefit from it |  |
| Focus on the patient's week |  |
| Encouragement/motivation of the clinician to remain on task |  |
| Other (please state) |  |

We are interested in whether the techniques that you focus on in supervision are related to you as a person. Please indicate whether the following items apply to you and, if so, to what extent they do.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Strongly Agree | Agree | Disagree | Strongly Disagree |
| I feel that I am a person of worth, at least on an equal plane with others. |  |  |  |  |
| I feel that I have a number of good qualities. |  |  |  |  |
| All in all, I am inclined to feel that I am a failure. |  |  |  |  |
| I am able to do things as well as most other people. |  |  |  |  |
| I feel I do not have much to be proud of. |  |  |  |  |
| I take a positive attitude toward myself. |  |  |  |  |
| On the whole, I am satisfied with myself. |  |  |  |  |
| On the whole, I am satisfied with myself. |  |  |  |  |
| I certainly feel useless at times. |  |  |  |  |
| At times I think I am no good at all. |  |  |  |  |

Finally, please indicate how much these statements apply to you.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1  (Not at all characteristic of me) | 2 | 3 | 4 | 5  (Entirely characteristic of me) |
| Unforeseen events upset me greatly. |  |  |  |  |  |
| It frustrates me not having all the information I need. |  |  |  |  |  |
| One should always look ahead so as to avoid surprises. |  |  |  |  |  |
| A small, unforeseen event can spoil everything, even with the best of planning. |  |  |  |  |  |
| I always want to know what the future has in store for me. |  |  |  |  |  |
| I can’t stand being taken by surprise. |  |  |  |  |  |
| I should be able to organize everything in advance. |  |  |  |  |  |
| Uncertainty keeps me from living a full life. |  |  |  |  |  |
| When it’s time to act, uncertainty paralyses me. |  |  |  |  |  |
| When I am uncertain I can’t function very well. |  |  |  |  |  |
| The smallest doubt can stop me from acting. |  |  |  |  |  |
| I must get away from all uncertain situations. |  |  |  |  |  |

Thank you for completing this questionnaire. If you have any questions or would like more information about this study, please contact me - Chloe Simpson-Southward ([crsimpson-southward1@sheffield.ac.uk](mailto:crsimpson-southward1@sheffield.ac.uk)). This research is supervised by Glenn Waller ([g.waller@sheffield.ac.uk](mailto:g.waller@sheffield.ac.uk)) and Gillian Hardy ([g.hardy@sheffield.ac.uk](mailto:g.hardy@sheffield.ac.uk)).   We will be conducting some similar research in the future, if you are happy to be contacted for this or would like a copy of the findings of this study please indicate below and provide your email address.

* I am happy to be contacted in future for a similar piece of research
* I would like a summary of the findings of this research

My email address is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Appendix 4C. - Case vignettes used in the Study 1

|  |  |
| --- | --- |
| **Case type** | **Vignette** |
| Straightforward | ‘Mary is 36 and lives with her two children. She got divorced from her husband two years ago, and currently has a partner of about four months. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still doing her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood.’ |
| Diffuse | ‘Joanne is 38 and lives with her husband and son. She describes her relationship as “solid”, though she and her husband do not always get on well. She works as a classroom assistant, though she would like to do something more challenging. Her mood has generally been okay, but she reports feeling detached from the world and feeling a lack of direction in her life. She finds herself feeling “down”, though would not harm herself. She sought a referral so that she would have opportunity to talk about where she is going in life.’ |
| **Case type** | **Vignette** |
| Complex | ‘Susan is 35, and is currently in a relationship that she is unhappy with. She is depressed and socially isolated. Her appetite and sleep are poor and she reports feeling slowed down. She is struggling to find things funny or exciting about life. These symptoms are affecting her ability to do her office job. She has had suicidal ideas, but she is unsure whether she will act upon them, She recently took a small overdose, though she described it as to help her “turn off” for a while. That encouraged her to seek a referral for therapy.’ |

## Appendix 5A - Study 2 ethics

From: **Thomas Webb** <[t.webb@sheffield.ac.uk](mailto:t.webb@sheffield.ac.uk)>  
Date: 9 September 2014 16:47  
Subject: Re: A query and a technical thing  
To: Glenn Waller <[g.waller@sheffield.ac.uk](mailto:g.waller@sheffield.ac.uk)>

Hi Glenn,  
  
I'm not sure why you are unable to log in and unfortunately can't investigate as I don't know how the system works. We're planning a move to a new system programmed (and I'm assured supported) by EpiGenesis, to overcome this rather considerable limitation. In the meantime, I'm able to add 'non-staff' if I have their username, so perhaps email me your username and we'll see if that allows you access again.  
  
With regard to your application, if the procedures are the same (broadly defined as having the same potential ethical implications) then I'm happy for you to conduct additional research under the same ethics application, especially as you noted on the original application that it is likely to be a series of studies.  
  
Hope this helps - good luck with the research.  
  
Tom

## Appendix 5B – Study 2 questionnaire

|  |  |
| --- | --- |
| crest | Department Of Psychology.  Clinical Psychology Unit. |
| Chloe Simpson-Southward  PhD Candidate  Department of Psychology  University of Sheffield  Western Bank  Sheffield S10 2TP UK | Telephone: 0114 222 6504  Email: crsimpson-southward1@sheffield.ac.uk |

**Investigation of clinical supervision techniques: Information sheet**

Thank you for your interest in our study. We are investigating the role that supervisors play in the delivery of CBT by their supervisees. In particular, we would like to know what advice you provide during sessions with your supervisees and which supervisory techniques you use.

To take part in this research, you must be a supervisor to CBT clinicians treating patients with depression.

All answers are confidential and individual data will only be identifiable during data collection by the researchers involved. No information about individuals will be made available to your managers, employers, supervisors, etc. After data collection is complete, all email addresses will be deleted (unless you indicate that you would like a summary of the research findings). If this questionnaire causes any professional concerns, please speak to a colleague.

If you have any questions or would like more information about this study, please contact me - Chloe Simpson-Southward (crsimpson-southward1@sheffield.ac.uk).

This research has been approved by the University of Sheffield's Department of Psychology Ethics Committee and is supervised by Glenn Waller (g.waller@sheffield.ac.uk) and Gillian Hardy (g.hardy@sheffield.ac.uk).

|  |  |
| --- | --- |
| crest | Department Of Psychology.  Clinical Psychology Unit. |
| Chloe Simpson-Southward  PhD Candidate  Department of Psychology  University of Sheffield  Western Bank  Sheffield S10 2TP UK | Telephone: 0114 222 6504  Email: crsimpson-southward1@sheffield.ac.uk |

**Investigation of clinical supervision techniques: Consent form**

We would like you to take part in a piece of research investigating clinical supervision techniques. We are interested in the role that supervisors play in the delivery of CBT by their supervisees. In particular, we would like to know what advice you provide during sessions with your supervisees and which supervisory techniques you use.

Attached to this form is a questionnaire. If you are willing to fill it in and allow your answers to be used for our research, please sign below to indicate consent. Please note that all answers will be stored anonymously and your ID will not be disclosed to anybody else.

I agree to my answers being used for research in this project and I understand that I can withdraw consent at any time.

I would like a summary of the findings of this research.

If you have indicated that you would like a summary, please provide your email address (this will not be used for any other purpose): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you clinically supervise others? YES / NO

If **YES**,

How many people do you clinically supervise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours **per month** do you spend clinically supervising others? \_\_\_\_\_\_\_\_\_\_\_\_hours

If **NO**, please do not continue. Thank you for your time but this piece of research is not relevant to you.

1. Do you supervise clinicians treating patients with depression? YES / NO

If **NO**, please do not continue. Thank you for your time but this piece of research is not relevant to you.

**Please tell us a little about yourself:**

1. Your age: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_
2. Your gender: Male/Female
3. What country are you working in? ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What country did you do your therapy training in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. What is your background profession? (Please circle)

Nurse / Social Worker / Occupational Therapist / Clinical Psychologist / Counselling Psychologist / Psychiatrist / Health Trainer / IAPT high intensity worker / Psychological Wellbeing Practitioner / Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How long have you been qualified? ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ years
2. Are you accredited as a therapist by your national CBT organisation (e.g., BABCP in the UK)?

YES / NO / Provisionally

If **YES**, how long have you been accredited? ­­­\_\_\_\_\_\_\_\_\_\_ years

1. Are you accredited as a supervisor by your national CBT organisation?

YES / NO

If **YES**, how long have you been accredited? ­­­\_\_\_\_\_\_\_\_\_\_ years

1. How long have you been using CBT to treat patients with depression? \_\_\_\_\_\_\_\_\_\_\_ years
2. On average, how many patients do you have on your caseload at any given time? \_\_\_\_\_\_\_\_cases
3. On average, what percentage of your client caseload have a **primary** diagnosis of depression? \_\_\_\_\_\_\_\_\_%
4. On average, what percentage of your client caseload have a **secondary** diagnosis of depression (alongside another major referring diagnosis)? \_\_\_\_\_\_\_\_\_%
5. Do you use treatment manuals on a regular basis for your work with depression? YES / NO

If **YES**, how many do you use?

1-2 3-4 5+

Please specify the one that you use most commonly (lead author and title):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over this and the next two pages, you will be presented with three clinical cases that your supervisee has brought to you in their supervision sessions. For each case, please answer the questions that follow regarding the issues that you would focus on in supervision.**

**Case 1**

Your supervisee, James, is 40 and has been a qualified therapist for 15 years. He is quite an anxious individual, and seems to worry about his patients a lot of the time. When discussing his cases, a particular issue comes up about a depressed patient called Lauren, who he has been seeing for eight sessions.

Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has shown no signs of self-harm or any indication that she is a suicide risk.

James has reservations about pushing Lauren to change behaviourally. He is particularly concerned that Lauren will not cope well with the demands of behavioural activation. He fears that she might get worse or stop coming to sessions, if this aspect of therapy is pushed.

**To what extent would you focus on the following techniques when giving the clinician advice during supervision?**

(Please indicate your response by putting an ‘x’ in the appropriate box)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | I would not focus on this |  |  |  | I would focus entirely on this |
| Focus on the development of the therapeutic alliance with the patient |  |  |  |  |  |
| Focus on evidence-based therapeutic techniques |  |  |  |  |  |
| Focus on other issues in supervision (see below to tell us which issues) |  |  |  |  |  |

If focusing on ‘other issues’, please list the major issues that you would be addressing:**Case 2**

Your supervisee, William, is 42 and has been a qualified therapist for 16 years. He is usually quite confident in his abilities as a therapist but he is noticeably anxious in your supervision session today. During your session, it transpires that he is concerned about a depressed patient, Mary, who is halfway through her course of treatment.

Mary is 36 and lives with her two children. She got divorced from her husband two years ago, and currently has a partner of about four months. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still doing her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood.

William explains that he is struggling to push Mary towards behavioural activation. He is concerned that if he pushes Mary to engage in behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether. William is deeply worried about Mary’s welfare if she does decide to end her treatment.

**To what extent would you focus on the following techniques when giving the clinician advice during supervision?**

(Please indicate your response by putting an ‘x’ in the appropriate box)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | I would not focus on this |  |  |  | I would focus entirely on this |
| Focus on the development of the therapeutic alliance with the patient |  |  |  |  |  |
| Focus on evidence-based therapeutic techniques |  |  |  |  |  |
| Focus on other issues in supervision (see below to tell us which issues) |  |  |  |  |  |

If focusing on ‘other issues’, please list the major issues that you would be addressing:

**Case 3**

Your supervisee, Richard, is 45 and has been a qualified therapist for 19 years. He is very relaxed when discussing his cases in supervision and is rarely worried about carrying out therapy. During your supervision session he discusses one of his patients, Emma, who has depression and has just had her ninth treatment session.

Emma is 35 and lives with her daughter and long-term boyfriend of seven years. In recent years she has started feeling that life is pointless, and she is unhappy. Over the past five months she has started showing signs of depression, including poor self-esteem, low mood and self-blame. She is still managing to attend her job as a cashier but has stopped seeing people socially. She currently has no biological signs of depression and has given no indication of suicidal ideas or intent.

Richard is about to commence behavioural activation with Emma, and says he is quite comfortable in doing so. He is currently feeling satisfied with Emma’s progress and has no immediate concerns.

**To what extent would you focus on the following techniques when giving the clinician advice during supervision?**

(Please indicate your response by putting an ‘x’ in the appropriate box)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | I would not focus on this |  |  |  | I would focus entirely on this |
| Focus on the development of the therapeutic alliance with the patient |  |  |  |  |  |
| Focus on evidence-based therapeutic techniques |  |  |  |  |  |
| Focus on other issues in supervision (see below to tell us which issues) |  |  |  |  |  |

If focusing on ‘other issues’, please list the major issues that you would be addressing:

We are interested in whether the techniques that you focus on in supervision are related to you as a person. Please indicate the extent to which the following items apply to you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Statement | Strongly Agree | Agree | Disagree | Strongly Disagree |
| I feel that I am a person of worth, at least on an equal plane with others. |  |  |  |  |
| I feel that I have a number of good qualities. |  |  |  |  |
| All in all, I am inclined to feel that I am a failure. |  |  |  |  |
| I am able to do things as well as most other people. |  |  |  |  |
| I feel I do not have much to be proud of. |  |  |  |  |
| I take a positive attitude toward myself. |  |  |  |  |
| On the whole, I am satisfied with myself. |  |  |  |  |
| I wish I could have more respect for myself. |  |  |  |  |
| I certainly feel useless at times. |  |  |  |  |
| At times I think I am no good at all. |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Item | 1  Not at all characteristic of me | 2 | 3 | 4 | 5  Entirely characteristic of me |
| Unforeseen events upset me greatly. |  |  |  |  |  |
| It frustrates me not having all the information I need. |  |  |  |  |  |
| Uncertainty keeps me from living a full life. |  |  |  |  |  |
| One should always look ahead so as to avoid surprises. |  |  |  |  |  |
| A small unforeseen event can spoil everything, even with the best of planning. |  |  |  |  |  |
| When it’s time to act, uncertainty paralyses me. |  |  |  |  |  |
| When I am uncertain I can’t function very well. |  |  |  |  |  |
| I always want to know what the future has in store for me. |  |  |  |  |  |
| I can’t stand being taken by surprise. |  |  |  |  |  |
| The smallest doubt can stop me from acting. |  |  |  |  |  |
| I should be able to organize everything in advance. |  |  |  |  |  |
| I must get away from all uncertain situations. |  |  |  |  |  |

Thank you for completing this questionnaire. If you have any questions or would like more information about this study, please contact me - Chloe Simpson-Southward (crsimpson-southward1@sheffield.ac.uk).

## Appendix 5C. – Case vignettes used in Study 2.

|  |  |
| --- | --- |
| **Clinician type** | **Vignette** |
| Male trait | ‘Your supervisee, James, is 40 and has been a qualified therapist for 15 years. He is quite an anxious individual, and seems to worry about his patients a lot of the time. When discussing his cases, a particular issue comes up about a depressed patient called Lauren, who he has been seeing for eight sessions.  Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk.  James has reservations about pushing Lauren to change behaviourally. He is particularly concerned that Lauren will not cope well with the demands of behavioural activation, and that, if this aspect of therapy is pushed, she might get worse or stop coming to sessions.’ |
| Male state | ‘Your supervisee, William, is 42 and has been a qualified therapist for 16 years. He is usually quite confident in his abilities as a therapist but he is noticeably anxious in your supervision session today. During your session, it transpires that he is concerned about a depressed patient, Mary, who is halfway through her course of treatment.  Mary is 36 and lives with her two children. She got divorced from her husband two years ago, and currently has a partner of about four months. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still doing her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood.  William explains that he is struggling to push Mary towards behavioural activation. He is concerned that if he pushes Mary to engage in behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether. William is deeply worried about Mary’s welfare if she does decide to end her treatment.’ |

|  |  |
| --- | --- |
| **Clinician type** | **Vignette** |
| Male calm | ‘Your supervisee, Richard, is 45 and has been a qualified therapist for 19 years. He is very relaxed when discussing his cases in supervision and is rarely worried about carrying out therapy. During your supervision session he discusses one of his patients, Emma, who has depression and has just had her ninth treatment session.  Emma is 35 and lives with her daughter and long-term boyfriend of seven years. In recent years she has started feeling that life is pointless and she is unhappy. Over the past five months she has started showing signs of depression, including poor self-esteem, low mood and self-blame. She is still managing to attend her job as a cashier but has stopped seeing people socially. She currently has no biological signs of depression and has given no indication of suicide.  Richard is about to commence behavioural activation with Emma, and says he is quite comfortable in doing so. He is currently feeling satisfied with Emma’s progress and has no immediate concerns.’ |
| Female trait | ‘Your supervisee, Jane, is 40 and has been a qualified therapist for 15 years. She is quite an anxious individual, and seems to worry about her patients a lot of the time. When discussing her cases, a particular issue comes up about a depressed patient called Lauren, who she has been seeing for eight sessions.  Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk.  Jane has reservations about pushing Lauren to change behaviourally. She is particularly concerned that Lauren will not cope well with the demands of behavioural activation, and that, if this aspect of therapy is pushed, she might get worse or stop coming to sessions.’ |

|  |  |
| --- | --- |
| **Clinician type** | **Vignette** |
| Female state | ‘Your supervisee, Wendy, is 42 and has been a qualified therapist for 16 years. She is usually quite confident in her abilities as a therapist but she is noticeably anxious in your supervision session today. During your session, it transpires that she is concerned about a depressed patient, Mary, who is halfway through her course of treatment.  Mary is 36 and lives with her two children. She got divorced from her husband two years ago, and currently has a partner of about four months. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still doing her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood.  Wendy explains that she is struggling to push Mary towards behavioural activation. She is concerned that if she pushes Mary to engage in behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether. Wendy is deeply worried for Mary’s welfare if she does decide to end her treatment.’ |
| Female calm | ‘Your supervisee, Rebecca, is 45 and has been a qualified therapist for 19 years. She is very relaxed when discussing her cases in supervision and is rarely worried about carrying out therapy. During your supervision session she discusses one of her patients, Emma, who has depression and has just had her ninth treatment session.  Emma is 35 and lives with her daughter and long-term boyfriend of seven years. In recent years she has started feeling that life is pointless and she is unhappy. Over the past five months she has started showing signs of depression, including poor self-esteem, low mood and self-blame. She is still managing to attend her job as a cashier but has stopped seeing people socially. She currently has no biological signs of depression and has given no indication of suicide.  Rebecca is about to commence behavioural activation with Emma, and says she is quite comfortable in doing so. She is currently feeling satisfied with Emma’s progress and has no immediate concerns.’ |

## Appendix 6A – Ethics approval for Study 3.

From: **Psychology Research Ethics Application Management System** <no\_reply@psychologyresearchethicsapplicationmanagementsystem>  
Date: 12 May 2015 at 22:18  
Subject: Approval of your research proposal  
To: [G.Waller@sheffield.ac.uk](mailto:G.Waller@sheffield.ac.uk)  
  
  
Your submission to the Department of Psychology Ethics Sub-Committee (DESC) entitled "The role of supervision for depression: Dealing with non-compliance from patients and therapists " has now been reviewed. The committee believed that your methods and procedures conformed to University and BPS Guidelines.  
  
I am therefore pleased to inform you that the ethics of your research are approved. You may now commence the empirical work.  
  
Yours sincerely,  
  
Paul Norman  
Acting Chair, DESC

## Appendix 6B – Study 3 questionnaire

Thank you for your interest in our study. We are investigating the role that supervisors play in the delivery of CBT by their supervisees. In particular, we would like to know what advice you provide during sessions with your supervisees and which supervisory techniques you use.  
 To take part in this research, you must be a supervisor to CBT clinicians treating patients with depression.

All answers are confidential and individual data will only be identifiable during data collection by the researchers involved. No information about individuals will be made available to your managers, employers, supervisors, etc. After data collection is complete, all email addresses will be deleted (unless you indicate that you would like a summary of the research findings). If this questionnaire causes any professional concerns, please speak to a colleague.  
   
 If you have any questions or would like more information about this study, please contact me - Chloe Simpson-Southward ([crsimpson-southward1@sheffield.ac.uk](mailto:crsimpson-southward1@sheffield.ac.uk)).  
   
 This research has been approved by the University of Sheffield's Department of Psychology Ethics Committee and is supervised by Glenn Waller ([g.waller@sheffield.ac.uk](mailto:g.waller@sheffield.ac.uk)) and Gillian Hardy ([g.hardy@sheffield.ac.uk](mailto:g.hardy@sheffield.ac.uk)).

If you are willing for your answers to be used in this study, please indicate consent below. Please note that all answers will be stored anonymously and your ID will not be disclosed to anybody else.

* I agree to my answers being used for research in this project and I understand that I can withdraw consent at any time

Please indicate whether you would like a summary of the research findings

* Yes, I would like a summary
* No, I would not like a summary

My email address is (this will only be used to send you a summary of the findings):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you clinically supervise others?

* Yes
* No

How many people do you clinically supervise?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many **hours per month** do you spend clinically supervising others?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you supervise clinicians treating patients with depression?

* Yes
* No

**Please tell us a little about yourself:**

Your age: (years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your gender:

* Male
* Female

What country are you working in?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What country did you do your therapy training in?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your background profession?

* Nurse
* Social Worker
* Occupational Therapist
* Clinical Psychologist
* Counselling Psychologist
* Psychiatrist
* Health Trainer
* IAPT high intensity worker
* Psychological Wellbeing Practitioner
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been qualified? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you accredited as a therapist by your national CBT organisation (e.g. BABCP in the UK)?

* Yes
* No
* Provisionally

How long have you been accredited? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you accredited as a supervisor by your national CBT organisation?

* Yes
* No
* Provisionally

How long have you been accredited? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Most of the following set of questions will address your practice when working with depression:**

How long have you been using CBT to treat patients with depression? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, how many patients, **regardless of diagnosis**, do you have on your caseload at any given time? (please give your answer as the number of cases)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, what percentage of your client caseload have a **primary** diagnosis of depression?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, what percentage of your client caseload have a **secondary** diagnosis of depression (alongside another major referring diagnosis)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use treatment manuals on a regular basis for your work with depression?

* Yes
* No

How many do you use?

* 1-2
* 3-4
* 5+

Please specify the one that you use most commonly (lead author and title):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We would like you to imagine that a supervisee is bringing to you a case of a patient with depression. We are interested in the guidance that you would give this supervisee in a supervision session.  
   
 Over the next few pages, you will be presented with three clinical cases. For each case, please answer the questions that follow regarding the issues that you would focus on in supervision.**

Your supervisee, William, is 42. He has been a qualified therapist for 15 years. He is usually quite confident in his abilities as a therapist but he is noticeably anxious in your supervision session today. During your session, it transpires that he is concerned about a depressed patient, Mary, who is halfway through her course of treatment.

Mary is 36 and lives with her partner of about eight months. She has two children from a previous relationship which ended in divorce two years ago. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including low mood and poor self-esteem, though there are no biological signs. Although she is still showing up for work in a local shop, she is becoming increasingly socially isolated outside of work. She was referred because of her low mood and has given no indication that she is suicidal.

You had previously suggested to William that he should focus on behavioural activation with Mary, but this approach is not working. The problem appears to be that Mary is not engaging in the behavioural exercises that have been suggested. William is concerned that if he pushes Mary to engage in these behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether. William is deeply worried about Mary’s welfare if she does decide to end her treatment.

**When advising William of how to proceed in therapy with Mary, to what extent would you focus them on each of the following aspects of therapy?**   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Focus on risk (to the patient or others) |  |
| Focus on the patient's capacity to use treatment and benefit from it |  |
| Focus on the patient's week |  |
| Encouragement/motivation of the clinician to remain on task |  |
| Motivation work with the patient |  |
| Focus on the therapeutic bond (attachment between patient and clinician) |  |
| Agreement on the goals of therapy |  |
| Agreement on the tasks of therapy |  |
| Reviewing depression levels |  |
| Education into the CBT model |  |
| Detection and recording of negative automatic thoughts |  |
| Clarify dysfunctional assumptions |  |
| Develop alternative hypotheses about cognitive distortions |  |
| Return to behavioural activation |  |
| Mindfulness |  |
| Eye Movement Desensitisation and Reprocessing (EMDR) |  |
| Review homework tasks |  |
| Testing alternative hypotheses via behavioural experiments |  |
| Cognitive reheasal |  |
| Assertiveness training |  |
| Use of reattribution |  |
| Other (please state) |  |

Your supervisee, Richard, is 39. He has been a qualified therapist for six months. In your supervision session today he discusses a patient, Joanne, who has depression. Richard has been seeing her for six sessions out of a planned 12.

Joanne is 38 and lives with her husband of two years and their son. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still attending her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood.

You had previously suggested to Richard that he should focus on behavioural activation with Joanne. Unfortunately, Joanne is failing to engage in this aspect of therapy. She says that she doesn’t feel comfortable or motivated to do such exercises and cannot see how they will help her in the long-term.

**When advising Richard of how to proceed in therapy with Joanne, to what extent would you focus them on each of the following aspects of therapy?**   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Focus on risk (to the patient or others) |  |
| Focus on the patient's capacity to use treatment and benefit from it |  |
| Focus on the patient's week |  |
| Encouragement/motivation of the clinician to remain on task |  |
| Motivation work with the patient |  |
| Focus on the therapeutic bond (attachment between patient and clinician) |  |
| Agreement on the goals of therapy |  |
| Agreement on the tasks of therapy |  |
| Reviewing depression levels |  |
| Education into the CBT model |  |
| Detection and recording of negative automatic thoughts |  |
| Clarify dysfunctional assumptions |  |
| Develop alternative hypotheses about cognitive distortions |  |
| Return to behavioural activation |  |
| Mindfulness |  |
| Eye Movement Desensitisation and Reprocessing (EMDR) |  |
| Review homework tasks |  |
| Testing alternative hypotheses via behavioural experiments |  |
| Cognitive reheasal |  |
| Assertiveness training |  |
| Use of reattribution |  |
| Other (please state) |  |

Your supervisee, James, is 40. He has been a qualified therapist for 15 years. He seems anxious in your supervision session today. This is surprising as he’s usually a relaxed clinician who’s confident in his abilities. It transpires that he is concerned about a patient called Lauren who has depression. James has been seeing her for six sessions out of a planned 12.

Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk.

In previous supervision sessions you had advised James that he should be pushing Lauren to engage in behavioural activation. Although he had agreed with you that behavioural activation was the appropriate course of action, he has failed to deliver on this. He had reservations about pushing Lauren to change behaviourally and so had focused on developing a strong therapeutic alliance with her, rather than on the therapeutic techniques that you had discussed. He is particularly concerned that the demands of behavioural activation may cause Lauren to stop coming to sessions and drop out of therapy.

**When advising James of how to proceed in therapy with Lauren, to what extent would you focus them on each of the following aspects of therapy?**   (Where 0 is 'I would not focus on this' and 100 is 'I would focus entirely on this')

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

|  |  |
| --- | --- |
| Focus on risk (to the patient or others) |  |
| Focus on the patient's capacity to use treatment and benefit from it |  |
| Focus on the patient's week |  |
| Encouragement/motivation of the clinician to remain on task |  |
| Motivation work with the patient |  |
| Focus on the therapeutic bond (attachment between patient and clinician) |  |
| Agreement on the goals of therapy |  |
| Agreement on the tasks of therapy |  |
| Reviewing depression levels |  |
| Education into the CBT model |  |
| Detection and recording of negative automatic thoughts |  |
| Clarify dysfunctional assumptions |  |
| Develop alternative hypotheses about cognitive distortions |  |
| Return to behavioural activation |  |
| Mindfulness |  |
| Eye Movement Desensitisation and Reprocessing (EMDR) |  |
| Review homework tasks |  |
| Testing alternative hypotheses via behavioural experiments |  |
| Cognitive reheasal |  |
| Assertiveness training |  |
| Use of reattribution |  |
| Other (please state) |  |

**We are interested in whether the techniques that you focus on in supervision are related to you as a person. Please indicate the extent to which the following items apply to you.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Strongly Agree | Agree | Disagree | Strongly Disagree |
| I feel that I am a person of worth, at least on an equal plane with others. |  |  |  |  |
| I feel that I have a number of good qualities. |  |  |  |  |
| All in all, I am inclined to feel that I am a failure. |  |  |  |  |
| I am able to do things as well as most other people. |  |  |  |  |
| I feel I do not have much to be proud of. |  |  |  |  |
| I take a positive attitude toward myself. |  |  |  |  |
| On the whole, I am satisfied with myself. |  |  |  |  |
| I wish I could have more respect for myself. |  |  |  |  |
| I certainly feel useless at times. |  |  |  |  |
| At times I think I am no good at all. |  |  |  |  |

**Finally, please indicate how much these statements apply to you.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1  Not at all characteristic of me | 2 | 3 | 4 | 5  Entirely characteristic of me |
| Unforeseen events upset me greatly. |  |  |  |  |  |
| It frustrates me not having all the information I need. |  |  |  |  |  |
| Uncertainty keeps me from living a full life. |  |  |  |  |  |
| One should always look ahead so as to avoid surprises. |  |  |  |  |  |
| A small unforeseen event can spoil everything, even with the best of planning. |  |  |  |  |  |
| When it’s time to act, uncertainty paralyses me. |  |  |  |  |  |
| When I am uncertain I can’t function very well. |  |  |  |  |  |
| I always want to know what the future has in store for me. |  |  |  |  |  |
| I can’t stand being taken by surprise. |  |  |  |  |  |
| The smallest doubt can stop me from acting. |  |  |  |  |  |
| I should be able to organize everything in advance. |  |  |  |  |  |
| I must get away from all uncertain situations. |  |  |  |  |  |

Thank you for completing this questionnaire. If you have any questions or would like more information about this study, please contact me - Chloe Simpson-Southward (crsimpson-southward1@sheffield.ac.uk).

## Appendix 6C – Study 3a vignettes

|  |  |
| --- | --- |
| **Clinician type** | **Vignette** |
| State anxious clinician, male | ‘Your supervisee, William, is 42. He has been a qualified therapist for 15 years. He is usually quite confident in his abilities as a therapist but he is noticeably anxious in your supervision session today. During your session, it transpires that he is concerned about a depressed patient, Mary, who is halfway through her course of treatment.  Mary is 36 and lives with her partner of about eight months. She has two children from a previous relationship which ended in divorce two years ago. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including low mood and poor self-esteem, though there are no biological signs. Although she is still showing up for work in a local shop, she is becoming increasingly socially isolated outside of work. She was referred because of her low mood and has given no indication that she is suicidal.  You had previously suggested to William that he should focus on behavioural activation with Mary, but this approach is not working. The problem appears to be that Mary is not engaging in the behavioural exercises that have been suggested. William is concerned that if he pushes Mary to engage in these behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether. William is deeply worried about Mary’s welfare if she does decide to end her treatment.’ |

|  |  |
| --- | --- |
| **Clinician type** | **Vignette** |
| State anxious clinician, female | ‘Your supervisee, Wendy, is 42. She has been a qualified therapist for 15 years. She is usually quite confident in her abilities as a therapist but she is noticeably anxious in your supervision session today. During your session, it transpires that she is concerned about a depressed patient, Mary, who is halfway through her course of treatment.  Mary is 36 and lives with her partner of about eight months. She has two children from a previous relationship which ended in divorce two years ago. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including low mood and poor self-esteem, though there are no biological signs. Although she is still showing up for work in a local shop, she is becoming increasingly socially isolated outside of work. She was referred because of her low mood and has given no indication that she is suicidal.  You had previously suggested to Wendy that she should focus on behavioural activation with Mary, but this approach is not working. The problem appears to be that Mary is not engaging in the behavioural exercises that have been suggested. Wendy is concerned that if she pushes Mary to engage in these behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether. Wendy is deeply worried about Mary’s welfare if she does decide to end her treatment.’ |

|  |  |
| --- | --- |
| **Clinician type** | **Vignette** |
| Trait anxious clinician, male | ‘Your supervisee, William, is 42. He has been a qualified therapist for 15 years. He is quite an anxious individual, and seems to worry about his patients a lot of the time. When discussing his cases, a particular issue comes up about a depressed patient called Mary, who is halfway through her course of treatment.  Mary is 36 and lives with her partner of about eight months. She has two children from a previous relationship which ended in divorce two years ago. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including low mood and poor self-esteem, though there are no biological signs. Although she is still showing up for work in a local shop, she is becoming increasingly socially isolated outside of work. She was referred because of her low mood and has given no indication that she is suicidal.  You had previously suggested to William that he should focus on behavioural activation with Mary, but this approach is not working. The problem appears to be that Mary is not engaging in the behavioural exercises that have been suggested. William is particularly concerned that Mary is not coping well with the demands of behavioural activation, and that, if this aspect of therapy is pushed, she might get worse or stop coming to sessions.’ |

|  |  |
| --- | --- |
| **Clinician type** | **Vignette** |
| Trait anxious clinician, female | ‘Your supervisee, Wendy, is 42. She has been a qualified therapist for 15 years. She is quite an anxious individual, and seems to worry about her patients a lot of the time. When discussing her cases, a particular issue comes up about a depressed patient called Mary, who is halfway through her course of treatment.  Mary is 36 and lives with her partner of about eight months. She has two children from a previous relationship which ended in divorce two years ago. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including low mood and poor self-esteem, though there are no biological signs. Although she is still showing up for work in a local shop, she is becoming increasingly socially isolated outside of work. She was referred because of her low mood and has given no indication that she is suicidal.  You had previously suggested to Wendy that she should focus on behavioural activation with Mary, but this approach is not working. The problem appears to be that Mary is not engaging in the behavioural exercises that have been suggested. Wendy is particularly concerned that Mary is not coping well with the demands of behavioural activation, and that, if this aspect of therapy is pushed, she might get worse or stop coming to sessions.’ |

|  |  |
| --- | --- |
| **Clinician type** | **Vignette** |
| Calm clinician, male | ‘Your supervisee, William, is 42. He has been a qualified therapist for 15 years. He is very relaxed when discussing his cases in supervision and is rarely worried about carrying out therapy. During your supervision session he discusses one of his patients, Mary, who has depression and is halfway through her course of treatment.  Mary is 36 and lives with her partner of about eight months. She has two children from a previous relationship which ended in divorce two years ago. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including low mood and poor self-esteem, though there are no biological signs. Although she is still showing up for work in a local shop, she is becoming increasingly socially isolated outside of work. She was referred because of her low mood and has given no indication that she is suicidal.  You had previously suggested to William that he should focus on behavioural activation with Mary. Although he said that he was comfortable in doing so, this approach is not working. The problem appears to be that Mary is not engaging in the behavioural exercises that have been suggested. Apart from this glitch in therapy, William is currently feeling satisfied with Mary’s progress and has no immediate concerns.’ |

|  |  |
| --- | --- |
| **Clinician type** | **Vignette** |
| Calm clinician, female | ‘Your supervisee, Wendy, is 42. She has been a qualified therapist for 15 years. She is very relaxed when discussing her cases in supervision and is rarely worried about carrying out therapy. During your supervision session she discusses one of her patients, Mary, who has depression and is halfway through her course of treatment.  Mary is 36 and lives with her partner of about eight months. She has two children from a previous relationship which ended in divorce two years ago. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including low mood and poor self-esteem, though there are no biological signs. Although she is still showing up for work in a local shop, she is becoming increasingly socially isolated outside of work. She was referred because of her low mood and has given no indication that she is suicidal.  You had previously suggested to Wendy that he should focus on behavioural activation with Mary. Although she said that she was comfortable in doing so, this approach is not working. The problem appears to be that Mary is not engaging in the behavioural exercises that have been suggested. Apart from this glitch in therapy, Wendy is currently feeling satisfied with Mary’s progress and has no immediate concerns.’ |

## Appendix 6D – Vignettes from study 3b

|  |  |
| --- | --- |
| **Clinician/ patient type** | **Vignette** |
| Clinician inexperienced, patient straightforward | ‘Your supervisee, Richard, is 39. He has been a therapist for six months. In your supervision session today he discusses a patient, Joanne, who has depression. Richard has been seeing her for six sessions out of a planned 12.  Joanne is 38 and lives with her husband of two years and their son. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still attending her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood.  You had previously suggested to Richard that he should focus on behavioural activation with Joanne. Unfortunately, Joanne is failing to engage in this aspect of therapy. She says that she doesn’t feel comfortable or motivated to do such exercises and cannot see how they will help her in the long-term.’ |

|  |  |
| --- | --- |
| **Clinician/ patient type** | **Vignette** |
| Clinician inexperienced, patient diffuse | ‘Your supervisee, Richard, is 39. He has been a therapist for six months. In your supervision session today he discusses a patient, Joanne, who has depression. Richard has been seeing her for six sessions out of a planned 12.  Joanne is 38 and lives with her husband and son. She describes her relationship as “solid”, though she and her husband do not always get on well. She works as a classroom assistant, though she would like to do something more challenging. Her mood has generally been okay, but she reports feeling detached from the world and feeling a lack of direction in her life. She finds herself feeling “down”, though would not harm herself. She sought a referral so that she would have opportunity to talk about where she is going in life.  You had previously suggested to Richard that he should focus on behavioural activation with Joanne. Unfortunately, Joanne is failing to engage in this aspect of therapy. She says that she doesn’t feel comfortable or motivated to do such exercises and cannot see how they will help her in the long-term.’ |
| Clinician inexperienced, patient complex | ‘Your supervisee, Richard, is 39 and has been a therapist for six months. In your supervision session today he discusses a patient, Joanne, who has depression. Richard has been seeing her for six sessions out of a planned 12.  Joanne is 38 and lives with her husband and son but is unhappy in her marriage. She is depressed and socially isolated. Her appetite and sleep are poor and she reports feeling slowed down. She is struggling to find things funny or exciting about life. These symptoms are affecting her ability to do her office job. She has had suicidal ideas, but she is unsure whether she will act upon them. She recently took a small overdose, though she described it as to help her “turn off” for a while. That encouraged her to seek a referral for therapy.  You had previously suggested to Richard that he should focus on behavioural activation with Joanne. Unfortunately, Joanne is failing to engage in this aspect of therapy. She says that she doesn’t feel comfortable or motivated to do such exercises and cannot see how they will help her in the long-term.’ |

|  |  |
| --- | --- |
| **Clinician/ patient type** | **Vignette** |
| Clinician experienced, patient straightforward | ‘Your supervisee, Richard, is 39 and has been a qualified therapist for 15 years. In your supervision session today he discusses a patient, Joanne, who has depression. Richard has been seeing her for six sessions out of a planned 12.  Joanne is 38 and lives with her husband of two years and their son. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still attending her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood.  You had previously suggested to Richard that he should focus on behavioural activation with Joanne. Unfortunately, Joanne is failing to engage in this aspect of therapy. She says that she doesn’t feel comfortable or motivated to do such exercises and cannot see how they will help her in the long-term.’ |
| Clinician experienced, patient diffuse | ‘Your supervisee, Richard, is 39. He has been a qualified therapist for 15 years. In your supervision session today he discusses a patient, Joanne, who has depression. Richard has been seeing her for six sessions out of a planned 12.  Joanne is 38 and lives with her husband and son. She describes her relationship as “solid”, though she and her husband do not always get on well. She works as a classroom assistant, though she would like to do something more challenging. Her mood has generally been okay, but she reports feeling detached from the world and feeling a lack of direction in her life. She finds herself feeling “down”, though would not harm herself. She sought a referral so that she would have opportunity to talk about where she is going in life.  You had previously suggested to Richard that he should focus on behavioural activation with Joanne. Unfortunately, Joanne is failing to engage in this aspect of therapy. She says that she doesn’t feel comfortable or motivated to do such exercises and cannot see how they will help her in the long-term.’ |

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| **Clinician/ patient type** | **Vignette** |
| Clinician experienced, patient complex | ‘Your supervisee, Richard, is 39. He has been a qualified therapist for 15 years. In your supervision session today he discusses a patient, Joanne, who has depression. Richard has been seeing her for six sessions out of a planned 12.  Joanne is 38 and lives with her husband and son but is unhappy in her marriage. She is depressed and socially isolated. Her appetite and sleep are poor and she reports feeling slowed down. She is struggling to find things funny or exciting about life. These symptoms are affecting her ability to do her office job. She has had suicidal ideas, but she is unsure whether she will act upon them. She recently took a small overdose, though she described it as to help her “turn off” for a while. That encouraged her to seek a referral for therapy.  You had previously suggested to Richard that he should focus on behavioural activation with Joanne. Unfortunately, Joanne is failing to engage in this aspect of therapy. She says that she doesn’t feel comfortable or motivated to do such exercises and cannot see how they will help her in the long-term.’ |

## Appendix 6E – Vignettes from study 3c

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| **Clinician type** | **Vignette** |
| State anxious clinician, male | ‘Your supervisee, James, is 40. He has been a qualified therapist for 15 years. He seems anxious in your supervision session today. This is surprising as he’s usually a relaxed clinician who’s confident in his abilities. It transpires that he is concerned about a patient called Lauren who has depression. James has been seeing her for six sessions out of a planned 12.  Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk.  In previous supervision sessions you had advised James that he should be pushing Lauren to engage in behavioural activation. Although he had agreed with you that behavioural activation was the appropriate course of action, he has failed to deliver on this. He had reservations about pushing Lauren to change behaviourally and so had focused on developing a strong therapeutic alliance with her, rather than on the therapeutic techniques that you had discussed. He is particularly concerned that the demands of behavioural activation may cause Lauren to stop coming to sessions and drop out of therapy.’ |

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| **Clinician type** | **Vignette** |
| State anxious clinician, female | ‘Your supervisee, Jane, is 40. She has been a qualified therapist for 15 years. She seems anxious in your supervision session today. This is surprising as she’s usually a relaxed clinician who’s confident in her abilities. It transpires that she concerned about a patient called Lauren who has depression. Jane has been seeing her for six sessions out of a planned 12.  Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk.  In previous supervision sessions you had advised Jane that she should be pushing Lauren to engage in behavioural activation. Although Jane had agreed with you that behavioural activation was the appropriate course of action, she has failed to deliver on this. Jane has reservations about pushing Lauren to change behaviourally and so had focused on developing a strong therapeutic alliance with her, rather than on the therapeutic techniques that you had discussed. She is particularly concerned that the demands of behavioural activation may cause Lauren to stop coming to sessions and drop out of therapy.’ |

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| **Clinician type** | **Vignette** |
| Trait anxious clinician, male | ‘Your supervisee, James, is 40. He has been a qualified therapist for 15 years. . He has concerns about his patients much of the time and is quite an anxious individual in general. In your session with him today, a particular concern comes up about a patient called Lauren who has depression. James has been seeing her for six sessions out of a planned 12.  Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk.  In previous supervision sessions you had advised James that he should be pushing Lauren to engage in behavioural activation. Although he had agreed with you that behavioural activation was the appropriate course of action, he has failed to deliver on this. He had reservations about pushing Lauren to change behaviourally and so had focused on developing a strong therapeutic alliance with her, rather than on the therapeutic techniques that you had discussed. He is concerned that if he pushes Lauren to engage in behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether.’ |

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| **Clinician type** | **Vignette** |
| Trait anxious clinician, female | ‘Your supervisee, Jane, is 40. She has been a qualified therapist for 15 years. She has concerns about her patients much of the time and is quite an anxious individual in general. In your session with her today, a particular concern comes up about a patient called Lauren who has depression. Jane has been seeing her for six sessions out of a planned 12.  Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk.  In previous supervision sessions you had advised Jane that she should be pushing Lauren to engage in behavioural activation. Although Jane had agreed with you that behavioural activation was the appropriate course of action, she has failed to deliver on this. Jane has reservations about pushing Lauren to change behaviourally and so had focused on developing a strong therapeutic alliance with her, rather than on the therapeutic techniques that you had discussed. She is concerned that if she pushes Lauren to engage in behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether.’ |

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| **Clinician type** | **Vignette** |
| Calm clinician, male | ‘Your supervisee, James, is 40. He has been a qualified therapist for 15 years. He is very relaxed individual and is rarely worried about carrying out therapy. In your session with him today, a particular issue comes up about a patient called Lauren who has depression. James has been seeing her for six sessions out of a planned 12.  Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk.  In previous supervision sessions you had advised James that he should be pushing Lauren to engage in behavioural activation. Although he had agreed with you that behavioural activation was the appropriate course of action, he has failed to deliver on this. He has focused on developing a strong therapeutic alliance rather than on the therapeutic techniques that you had discussed.’ |
| Calm clinician, female | ‘Your supervisee, Jane, is 40. She has been a qualified therapist for 15 years. She is very relaxed individual and is rarely worried about carrying out therapy. In your session with her today, a particular issue comes up about a patient called Lauren who has depression. Jane has been seeing her for six sessions out of a planned 12.  Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk.  In previous supervision sessions you had advised Jane that she should be pushing Lauren to engage in behavioural activation. Although Jane had agreed with you that behavioural activation was the appropriate course of action, she has failed to deliver on this. Jane has focused on developing a strong therapeutic alliance rather than on the therapeutic techniques that you had discussed.’ |