

**Investigating the Core Skills of Clinical
Supervision :
A Qualitative Analysis**

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“The candidate confirms that the work submitted is his own and that the appropriate credit has been given where reference has been made to the work of others.”

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ABSTRACT

This study used self-reports of the experience of Clinical Psychology trainees on the Doctor of Clinical Psychology course at the University of Leeds as the basis for developing a model of effective clinical supervision from the users' perspective. Three sources of data were used: 100 critical incident reports of episodes which trainees had experienced as particularly helpful during supervision; seven extended commentaries by trainees on video-tape recordings of supervision sessions in which they had been involved (following the principles of inter-personal process recall); and two focus group discussions in which final year trainees reflected on their worst experiences in clinical supervision during their time on the training course. This data was analysed using the grounded theory approach to qualitative research. The study contains procedures for assessing the reliability of the codings used in the study and attempting to validate the theoretical model developed. The study identified five factors that contributed to a successful outcome in supervision (from the trainees' viewpoint): promoting experiential learning; developing a strong supervisory alliance; accepting the sapiential authority of the supervisor; timing interventions in supervision appropriately; and working in a personal and professional context that facilitates good practice. The model of effective supervision developed is dynamic and recognises the mutual influence of supervisor and supervisee on each other and the fluid interaction of the five factors described. The findings of the study are compared with the extensive psychological literature on clinical supervision. Finally the practical implications of the study's findings for training clinical supervisors are considered.

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Chapter 1

Introduction and Literature Review

Clinical supervision is an integral part of the basic professional training of clinical psychologists. Its primary focus is the development of therapeutic competence.

"Supervision is that part of the overall training of mental health professionals that deals with modifying their actual in-therapy behaviours. It excludes the parts of training that are primarily didactic, such as classroom teaching, and likewise excludes the parts of training that are particularly personal e.g. experiential groups and the personal therapy experience." (Lambert M.J & Arnold R.C., 1987)

Clinical supervision is therefore driven by educational and therapeutic priorities rather than managerial or organisational concerns (Howard F.M. 1997). An experienced clinician meets regularly with a trainee practitioner throughout the duration of a defined training placement in a manner somewhat akin to an apprentice serving time with a master craftsman.

" The primary goal of supervision is the establishment of a relationship in which the supervisor designs specific learning tasks and teaching strategies related to the supervisee's development as a professional. In addition the supervisor empowers the supervisee to enter the profession by understanding the attitudes, skills, and knowledge, demanded of the professional and by guiding the relationship strategically to facilitate the trainee's achievement of a professional standard." (Holloway E.L. 1987)

The supervisor also has a duty to ensure that trainee practitioners practice safely and meet performance criteria expected of responsible therapists. The evaluative component of many supervisory relationships cannot therefore be ignored. Bernard and Goodyear (Bernard J.M & Goodyear R.K., 1992) in a widely quoted (Watkins C.E, 1997) definition of clinical supervision describe the activity as:

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

Clinical supervision is regarded as an essential aspect of the professional socialisation of trainee clinical psychologists. Anyone seeking eligibility for chartered clinical psychologist status with the British Psychological Society must provide evidence that their therapeutic work has been supervised for a minimum period of three years. Furthermore professional guidelines for qualified clinical psychologists (DCP., 1995) place an obligation on all practitioners to make arrangements for continued supervision of their work throughout their careers. This strong emphasis on the importance of clinical supervision in establishing and maintaining high standards of professional performance is echoed in recent publications in allied professions such as social work (C.C.E.T.S.W. 1996)

Unsurprisingly such a well established, highly regarded, and widely practised activity as clinical supervision, has generated a formidably large literature (Robiner W.N & Schofield W, 1990). However the scientific basis on which so much supervisory effort is based remains distinctly limited (Ellis M.V et al., 1996).

A number of reasons can be posited for this perceived mismatch between the quantity and quality of empirical research conducted in the field of clinical supervision.

A great deal of investigatory effort has been expended in evaluating the efficacy of psychological therapies. Do they work? How do they work? For whom do they work best?. In contrast minimal research attention has been devoted to exploring how well our traditional training programmes in psychotherapy prepare clinicians to deliver effective psychological treatments. Researchers have concentrated on evaluating the product and somewhat ignored the means of production (Binder J.L. 1993). As a result clinical psychology, a profession that has gained its status by marketing its scientific credentials, is open to the pertinent criticism that it has not applied a sufficiently rigorous approach towards its own educational methods (Stein D.M & Lambert M.J., 1995). In consequence the expectation that health-care practice should be evidence-based is exerting a pressure on those training health-care professionals to provide an empirical justification for their programmes (Sechrest L & Chatel D.M., 1987). However, although the argument that clinical psychology trainers should take a dose of their own medicine and subject the courses they run to scientific scrutiny is hard to refute in principle, few educators have thus far volunteered in practice (Peterson D.K. 1995).

It is not however fair to criticise supervisors for failing to reflect on their work and publish their ideas in professional journals and books. Theoretical models, anecdotal examples and empirical studies abound. There is a wealth of literature to be consulted, but the bulk of this work has been subjected to such serious criticism on methodological grounds, that it would be unwise to draw many major conclusions about everyday good practice in supervision from the existing literature (Ellis M.V & Ladany N., 1997; Ellis M.V et al., 1996).

It seems that a pragmatic wish to use available data sources and produce practically useful results has led researchers into sometimes failing to pay due regard to central design issues such as explicit hypothesis-testing, appropriate sampling procedures, and suitable statistical analyses. More sophisticated research standards have been recommended if the knowledge base on which our training strategies are founded is to advance (Alberts G. & Edelstein B., 1990).

One of the fundamental tests of effective clinical supervision is - do the supervisee's clients benefit from the treatment provided? The point of the whole venture is to improve therapeutic outcome for the patient. Unfortunately there are so many factors that might influence therapeutic outcome (supervisor variables, supervisee variables, patient variables, treatment variables etc.,) that it is very hard to trace a clear cause and effect path between a particular supervisory approach and a demonstrable improvement in any given client's functioning (Holloway E.L. & Neufeldt S.A., 1995). In a recent literature review Neufeldt and colleagues baldly concluded that:

“no empirical studies have shown a link between specific supervisor behaviour and client outcome.” (Neufeldt S.A., et al., 1997).

Much research in supervision has therefore tapped the perspectives of the supervisor and supervisee and made the optimistic assumption that what's good for the psychologist is also good for his or her patients in the long run.

Supervision must be conducted by qualified clinical psychologists of an appropriate level of seniority. This is a surprisingly under-researched population. While a veritable industry has built up examining the professional development of psychologists in training, there has been a widespread failure to track the careers of clinicians after they qualify (Skovholt T.M. & Ronnestad M. H., 1995).

In particular there is very little extant research on how supervisors might best be trained to improve their effectiveness in their educational role (Watkins C.E., 1995). In effect the mysterious world of the supervisor remains relatively virgin territory.

Major Themes in Supervisory Research.

1. Therapy - based approaches.

Much early writing on clinical supervision emphasised the transfer of established therapeutic models of change to the educational field. So, for example, supervisors in the client-centred tradition (Patterson C.H. 1983) emphasised the importance of establishing an optimal inter-personal climate in the relationship between supervisor and supervisee. Those adopting a personal construct perspective advocated the use of supervision to explore alternative understandings of events (Feixas G. 1992). Workers with a background in systemic therapy put a focus on appreciating the organisational context in which supervision takes place (Scaife J. 1993). Psycho-analytic writers proposed that the dynamics of the therapist/patient relationship are replayed in the supervisor/supervisee relationship and that this "parallel process" can be fruitfully analysed during supervision (Friedlander M.L. et al., 1989).

This school approach to supervision remains influential in everyday practice so that the same case material presented to supervisors of differing theoretical persuasions may be treated in characteristically different ways (Jacobs M. 1996). While there is something wholesome about supervisors reflexively applying the psychological models of change they use to help their patients, when promoting the development of their colleagues, the evidential output of these therapy-based approaches to supervision has been disappointing.

For example the assumptions of the parallel process paradigm have been largely untested by empirical research (Jacobs M. 1996).

Furthermore micro-analytic studies have demonstrated that clinicians hold significantly different conversations with their supervisees from those they have with their patients (Holloway E.L. 1995). This suggests that the participants in clinical supervision discussions are engaging in a different sort of learning conversation from that employed in psychotherapeutic discourse.

2. Developmental Stage Models.

A second substantial body of research in clinical supervision has investigated the common-sense thesis that the stage of a trainee therapist's development will be a reliable indicator of the style of supervision from which she/he will most benefit. For example a complete novice may need very active direction and encouragement from a clinical supervisor, while an individual nearing completion of their basic professional training would prefer to function at a more autonomous level and hence appreciate a less structured form of supervision. A number of similar stage theories purporting to describe the experience of therapists and counsellors in training have been published which draw on both the historical structures of the medieval artisan's progress from apprentice to master craftsman, and psychological models of identity development such as those proposed by Erikson (Hawkins P. & Shohet R., 1989).

While there is some experimental support for this development framework, for example the prediction that beginners prefer highly structured supervision (Worthington E.L. 1987) research in the field has been generally criticised as top-heavy with theory and surprisingly light on the empirical testing of predictions from theory (Watkins C.E, 1995).

Crucially the "matching" hypothesis which argues that maximum learning will result from the supervisor consciously adjusting his or her supervisory style to the developmental status of the supervisee remains unproven (Swanson J.L & O'Saben C.L., 1993).

3. The Search for generic skills in supervision.

A third strand of research into clinical supervision has attempted to identify the core skills of effective supervisory practice. This strategy adopts a generic approach to the understanding of the supervisory process and aims to establish what might be the fundamental competences of all good clinical supervisors. Parallels can be drawn with the search for essential psychotherapeutic skills (Horwath A. & Greenberg L., 1994). Rather than pursue ideas generated from a particular therapeutic or theoretical standpoint this approach employs a range of research methodologies to identify the common factors associated with effective clinical supervision. The research to be described follows this tradition.

Investigating Professional Competence.

Professions have a reputation for being somewhat inexplicit about the special skills their members supposedly possess (Shaw G.B. 1906). While this inexactitude might promote a useful mystique, it also frustrates efforts at devising training programmes intended to promote the development of specific skills. If the expense of an extended professional education is to be justified, it is increasingly important that ways are found to pin down just what abilities a competent doctor, lawyer, teacher, clinical psychologist etc., needs to be able to demonstrate.

A range of research methodologies have been devised with which this investigation of professional competence might be conducted (Caves R. 1988) Critical Incident Technique (Flanagan J. 1954; Dunn W.R. & Hamilton D.D., 1986) was devised in the Second World War to try and ensure that aircraft crews were effectively prepared to undertake their duties in the heat of battle. If air-crew were inadequately trained their lives and those of their colleagues were put at risk. Flanagan therefore, asked experienced pilots to provide a fund of actual examples of tasks they needed aircrew to be able to perform in specific circumstances. From this extensive "real life" data-base he was able to construct a model of occupational competence on which subsequent training programmes were founded. The critical incidents approach has been used to explore on-the-job competence in a range of health-related professions including medicine (Dunn W.R et al., 1985) and clinical psychology (Green D.R. et al., 1994).

Alternative approaches to identifying core professional competence include sampling the opinions of a large number of competent judges and providing each with feedback on the views of their fellow panel members in an iterative cycle designed to promote group consensus. This Delphi Panel methodology tends to result in a more abstract definition of the skill profile of a particular occupation than that produced by the critical incidents approach (Green D.R. & Gledhill K., 1993).

A more detailed analysis of expert performance can be achieved by in-depth interviews of a limited number of practitioners who are invited to reflect at length on a particular aspect of their work. Systematic coding of recurrent themes emerging from these extended interviews allows researchers to construct a theoretical model of competence that is "grounded" in the reported experience of respondents (Pidgeon N. et al., 1991).

Pidgeon et al's work is also noteworthy for its investigation of examples of human error in failing organizations (in this instance the provision of ill-informed engineering advice) as a way of shedding light on the skills needed to perform a task effectively.

Quantitative Investigations into Supervisory Competence

A number of broadly quantitative approaches to investigating what works in supervision have been employed by researchers in the field:

N.B. This introductory stage of the literature review concentrates on the different methodologies that have been employed in investigating supervisory competence and so only limited details of the studies' conclusions are provided. Greater emphasis on the findings of researchers in the field will be found in the discussion of results section of the thesis. (see Chapter 6)

1. Questionnaire Studies

A small number of self-report questionnaires tapping the perspective of both the supervisor and supervisee have been developed. Holloway (Holloway E.L. 1995) particularly commends the established psychometric qualities of the Supervisory Styles Inventory (Friedlander M.L. & Ward L., 1984). A more recent addition to the limited range of questionnaires specifically designed to investigate the supervisory relationship is the Supervisory Working Alliance Inventory (Efstation J. et al., 1990) which uses two parallel forms (for supervisor and trainee) to examine participants' perceptions of the inter-personal dynamics of the supervisory pairing.

An example of research in this tradition is Schact and colleagues' creation of a relationship inventory specific to the clinical supervision pairing.(Schact A et al., 1988).

Their careful revision of an established relationship inventory (the Barrett-Leonard) and attention to the psychometric qualities of their new measure mark this instrument as one of only two questionnaires recommended in a recent comprehensive review of self-report forms used in clinical supervision research (Ellis M.V & Ladany N., 1997). The relationship inventory constructed for use in the clinical supervision setting successfully discriminated between supervisees' rankings of past supervisors who they considered had contributed the **least** and the **most** to their clinical effectiveness.

2. Micro-Analytic Studies

The micro-analytic approach to investigating the nature of effective supervisory relationships involves the detailed dissection of recordings of actual supervisory discussions to map out how particular categories of discourse follow each other in minute-to-minute conversation. This content analysis methodology has been used both for in-depth investigation of a particular supervisory dyad (Martin J. et al., 1987) and in a multiple case-study format (Holloway E. et al., 1989).

Published research in this tradition has confirmed predictions that the essentially hierarchical characteristics of the supervisory relationship parallel those observed in other teacher/student exchanges (Holloway E.L. 1995). For example counsellors seem to be significantly more likely to provide direct instructions and offer authoritative opinions when talking to their trainees in supervision than when holding therapeutic discussions with their clients.

3. Direct Observational Studies

Empirical descriptive studies of supervision which have taken a broader focus than micro-analytic research have also subjected recordings of actual supervision sessions to detailed quantitative analysis.

For example Shanfield and his colleagues (Shanfield S.B et al., 1992) asked independent judges to rate 53 videotapes of psychotherapy supervision sessions using the predetermined categories of the Psychotherapy Supervision Inventory and compared the scores on each sub-scale to a global assessment of the perceived excellence of each supervisor made by the same raters. A step-wise regression analysis confirmed predictions that judgments regarding a supervisor's empathy accounted for the bulk of the covariance in raters' perceptions of excellence. In terms of technique the most highly rated supervisors tended to focus on trainees' immediate experience and offer comments that allowed them to integrate different aspects of a case.

Using a somewhat different design Heppner and his co-researchers (Heppner P. et al., 1994) videotaped interventions made by supervisors during 'live' supervision sessions (i.e. trainee and client are directly observed by the supervisor from behind a one-way screen; when the supervisor considers it appropriate, for example if the discussion has become unproductively stuck, he or she enters the clinic room and makes a direct contribution to the therapeutic process). Each intervention was transcribed, and a large pool of independent judges asked to group together what they perceived as essentially similar exchanges. The authors subjected their data to multi-dimensional scaling and produced six separate dimensions which were needed to capture the variability of supervisor behaviour they had observed. The authors describe these scales as a) Directing-Instructing Versus Deepening b) Cognitive Clarification Versus Emotional Encouragement c) Confronting Versus Encouraging the Client d) Didactic-Distant Versus Emotionally Involved e) Joining With Versus Challenging the Trainee and f) Providing Direction Versus Resignation. Importantly the explicit goal of this study was not to test a prediction emerging from any existing theoretical model of supervision but to describe in detail the underlying patterns in observed supervisor practice. These "grounded observations" were then compared with the extant literature on clinical supervision.

4. Simulation Studies

In addition to investigating real-life supervisory episodes using quantitative methodologies, it is possible to construct simulated experiments to test hypotheses emerging from theoretical models of supervision. An elegant example of research in this tradition is a study by Tracey and his colleagues (Tracey T.J. et al., 1989) who produced four 'made-up' videotapes of supervision sessions demonstrating a highly structured as opposed to a looser approach when discussing two different cases one of which featured a run-of-the-mill clinical problem and the other of which concerned a potentially suicidal client. Subjects were asked to rate their preferred supervisory style as if they were the trainee in each circumstance. The experiment's results supported the prediction that more senior as opposed to novice trainees preferred the less structured supervision format. However preference for style of supervision was also significantly influenced by the special content of the case under discussion and the particular personality characteristics of the trainee (a distaste for being told what to do delicately described as "reactance" by the researchers).

Limitations of the quantitative approach in supervision research

While particular examples of well-conducted, original, quantitative research into clinical supervision can be cited, the bulk of work in this category has been subjected to repeated criticism (Russell R et al., 1984; Ellis M.V & Ladany N., 1997; Ellis M.V et al., 1996) on fundamental methodological grounds. Ellis and his colleagues reviewed twelve years of published empirical studies in clinical supervision (1981 to 1993) and evaluated each paper against a series of established criteria which might threaten the validity of conclusions drawn from the experiment's results. They concluded that the vast majority of published research which they analysed failed to meet these rigorous scientific standards (e.g. inexplicit hypothesis-testing, inappropriate statistical analysis etc.).

The paper concludes with a series of recommendations that might be followed to ensure future researchers can conduct “a feasible and well-designed supervision study”.

An alternative or addition to this strategy is to supplement the quantitative approach to understanding what works in supervision with qualitative studies that focus on the meaning participants ascribe to their different experiences within supervision (Holloway E.L. & Carroll M., 1996).

Issues in Qualitative Research

Qualitative research is a generic term that encompasses a range of related methods e.g. discourse analysis, ethnography, grounded theory (Richardson J.T.E. 1996). All the approaches have a common aim of understanding the phenomenon under investigation by the analysis of words (in the form of interview transcripts, case-notes, newspaper articles etc.). rather than numbers. They are all broadly interpretive in nature and hence concerned with the construction of meaning, and in particular the importance of understanding experiences and events as described by those most directly involved. Qualitative research is therefore a powerful tool for promoting psychological theorizing founded on participants' accounts of their own first-hand experiences (Henwood K. & Pidgeon N., 1992).

A recent commentary by Rennie (Rennie D.L, 1996)) in the journal *Psychotherapy Research* on an article written by Levy and colleagues in the same edition (Levy J.A. et al., 1996) illustrates well the different approaches qualitative and quantitative researchers adopt to similar material. Levy et al. report an analysis of comments collected from participants in a large-scale study of psychological and pharmacological therapies for depression about experiences (within therapy) that patients considered had adversely affected their progress.

The authors devised a method of content analysis derived from existing literature in the field and demonstrated that suitably tutored research assistants could use the categorization system reliably. Rennie contrasts the hypothesis-testing “hard science” approach adopted by Levy and his co-authors with the way a qualitative researcher might have tackled the same issue. Rennie identifies three key themes that set the qualitative and quantitative traditions apart.

The first concerns the data itself. Levy et al. analysed over 150 brief written commentaries completed well after the date of the experience they described. Rennie contrasts this broad but relatively superficial investigation of the subjects’ experience with the smaller number of in-depth interviews which typically forms the basis of qualitative research. This intensive case-study style of enquiry, he suggests is more likely to do justice to the uniqueness of individual experience, and will often include extended verbatim quotations of what particular participants actually wrote or said.

In Levy and colleagues’ work these short accounts were further sub-divided into standard units and subjected to a content analysis whose categories had been predetermined by the researchers on theoretical grounds. Where a minority of participants’ responses could not be sensibly allocated to a category in this system they were coded as “unclassifiable”. Rennie’s second comparison is between this fixed system of data analysis that is devised to test a particular hypothesis and the more flexible “discovery-orientated” categories that qualitative researchers use to explore patterns in their data.

Typically this involves a first level coding strategy that stays very close to the participants’ own words. A more theoretically complex model is then constructed by the researcher to try and account for the variety of experiences described while still staying true to specifics of the evidence provided by participants.

Inevitably this exploratory approach relies somewhat on the creative contribution of the researcher him or herself and the qualitative approach tends to eschew the notion that any single authoritative interpretation of any given data set is possible or indeed desirable. Rennie's final point is that this emphasis on the personal and provisional nature of research findings characterizes the way in which qualitative researchers describe their work. In contrast studies in the quantitative tradition such as Levy and Co's prefer the more absolutist rhetoric of the natural sciences. The difference, Rennie argues, is between aiming to demonstrate that a given hypothesis has been "proved" (or more properly "not disproved") and providing a "plausible" account of why and how a particular set of conclusions have been drawn from a particular data set.

However because qualitative studies neither convert their data to numbers which can be subjected to conventional methods of statistical analysis nor are generally conducted with large-scale representative groups of subjects, concerns have been raised within the scientific community about the "trustworthiness" of results emerging from this non-traditional paradigm (Morgan M. 1996). In particular critics have been concerned about the potential replicability of findings and asked questions about how the key quality issues of reliability and validity in research can be addressed within the qualitative approach (Mays N. & Pope C., 1995).

These pertinent challenges have resulted in an emerging consensus about appropriate standards of scholarship to which qualitative researchers should adhere (Turpin G. et al., 1997; Silverman D. 1997; Sherrard C. 1997; Greenhalgh T. & Taylor R., 1997; Fitzpatrick R. & Boulton M., 1996; Elliot R. et al., 1997; Smith J. 1996; Stiles W, 1993)

Hence those planning qualitative research studies can incorporate strategies for maximizing the reliability (King N. 1994) and generalizability (Schofield J.W. 1990) of their findings into their project designs. These developments have led to an increasing acceptance that systematically conducted qualitative research can prove a useful addition to the methodological repertoire available to investigate process and outcome in psychological therapies (Polkinghorne D.E. 1994) Furthermore within clinical psychology it has been argued (Orford J. 1995) that qualitative methods are particularly well-suited to the development of theory in areas of the discipline where theoretical models require greater specification if hypothesis-driven empirical research is to be more profitably pursued. The area of clinical supervision could fairly be described in those terms.

Qualitative Research in Clinical Supervision

Qualitative research is generally concerned with the “inside story” and early qualitative investigations have sought to tap the participants’ subjective interpretations of what matters in effective clinical supervision.

The Supervisor’s Experience

Two recent British studies in counselling supervision illustrate the way in which qualitative research methods have been employed to investigate supervisors’ views of their role. Clarkson and Aviram (Clarkson P. & Aviram O., 1995) asked 11 counselling supervisors from a broadly humanistic/existential psychotherapy background, to write down what they considered “being a supervisor” meant for them. This exercise generated some 270 statements which were subjected to a two-stage coding process by two independent judges. The first stage clustered statements by grouping evidently similar items.

This produced a list of 37 descriptive categories. In the second stage these clusters were further reduced to 6 broader, more abstract categories that sought to fairly represent the underlying structure that the researchers had inferred from the supervisors' comments. The authors define these superordinate constructs as a) Structuring b) Teaching c) Nurturing d) Supervisor as Person e) Supervisor as Colleague and f) the Triangle Client-Therapist-Supervisor. Inter-rater agreement measures were taken throughout this process of hierarchical coding. The authors compare the core components of clinical supervision that emerged from this phenomenological investigation with the existing literature on supervisory competence in counselling.

As part of his doctoral thesis Carroll (Carroll M. 1994) interviewed a group of 23 British Association for Counselling accredited supervisors to illuminate their understanding of supervision and in particular their views on the tasks of supervision.

The supervisors were asked a) to explain their understanding of supervision b) to indicate what they considered were the key tasks of supervision and c) to explain how they undertook 7 named tasks of supervision which Carroll had culled from an extensive literature search (viz .the relationship task, the teaching task, the counselling task, monitoring the ethical/professional aspects of supervision, the evaluation task, the consultation task, and the administrative task). Carroll subjected the data from these interviews to a systematic content analysis. The model of supervision that emerged from this consultative exercise was compared with the view of the generic tasks of counselling supervision produced by two other pertinent sources of evidence: viz the results of a longitudinal study of counselling trainees' reports of their expectations of supervision and ratings of which supervisory tasks they construed as most important at different stages of their training; and observational coding of actual videotapes of supervision sessions.

This 'triangulated' research strategy produced a limited consensus on the relative importance of seven key tasks of supervision identified in the counselling literature, but some tasks were viewed as more important than others (for example the consultancy task consistently received highest ratings and the administrative task got the lowest scores). Furthermore the every day practice of counselling supervisors seemed more influenced by the way they adapted their preferred model of therapy to the allied task of supervision than by applying any generic educational model from which all effective supervisors might benefit.

The Supervisee's Experience

Research into the effective components of psychotherapy has been significantly enriched by research that has tapped the consumer's perspective on which moments during the free-flow of therapeutic conversation have impressed patients as being the most helpful (Elliott R. 1979; Llewelyn S.P et al., 1988). Clients tend to identify different significant experiences from those reported by their therapists (Llewelyn S.P, 1988). These consumers' accounts have formed the basis for constructing a model of both what helps and what hinders in psychotherapy that is grounded in the subjective experience of patients (Watson J.C & Rennie D.L., 1994)

A similar rationale has been proposed for exploring the elements of effective clinical supervision from the recipient's point of view. Worthen and McNeil (Worthen V. & McNeil B.W., 1996) interviewed 8 trainee counselling psychologists all at an intermediate or advanced stage of their basic training. Each subject was asked to describe a "recent good supervision experience". In-depth interviews averaging 45-50 minutes in length were tape-recorded and transcribed 'in toto'. Phenomenological analysis of individual transcripts proceeded through a series of seven explicit steps:

1. Obtaining a sense of the whole.
2. Identifying meaning units.
3. Defining relevant and psychologically explicit meaning.
4. Integration of meaning units.
5. Articulating the meaning units.
6. The situated meaning structure.
7. The essence of the experience of good supervision.

Finally commonalities across all 8 interviews were examined through an explicit four stage process of analysis:

1. Individual events of good supervision.
2. Common events of good supervision.
3. Collective events of good supervision.
4. General meaning structure for the experience of good supervision.

Through this systematic process of abstraction the authors were able to produce a provisional model of effective counselling supervision from the consumers' perspective, illustrated by verbatim quotes which grounded an increasingly elaborated theory in the accounts provided by the supervisees themselves. This model gives high priority to the central importance of the supervisory relationship noting how particular supervisor behaviours (such as disclosing to trainees their own struggles to understand) can contribute to the establishment of an atmosphere in which experimentation is encouraged and both parties consider it normal and healthy for beginners to make mistakes.

Most of the research cited in this literature review has been conducted in the United States usually with participants such as trainee counsellors who are not clinical psychologists.

It is important that the local cultural and professional context in which clinical supervision occurs is recognized to reduce the likelihood of inappropriately enthusiastic transfer of findings across significantly different settings. There are major differences between professional training programmes in the U.S. and U.K. which may limit the applicability of American findings concerning clinical supervision in a British context (Carrol M. 1988). It is also recognised that the basic training of counsellors and clinical psychologists in the U.K. is typified by recognisably different emphases on the role of scientific research and personal experience in developing professional competence (Davidson C. & Davidson J., 1997)

Hence it would be unwise to assume that counsellors and clinical psychologists in training will have common constructions of what helps in supervision. The last studies to be described in this section therefore concentrate on qualitative research using critical incidents methodology into clinical supervision which has been undertaken in a British context and include analysis of the few published articles which have explored the supervisory experiences of British trainee clinical clinical psychologists.

Williams and Webb (Williams P. & Webb C., 1994) noted the dearth of research into good practice in healthcare supervision in Britain for members of the professions allied to medicine and could find no published material that was specific to the education of junior radiographers in particular. They therefore designed a two-phase research project which combined a Delphi survey of 24 experts in radiography education with an analysis of 448 critical incidents provided by trainee radiographers describing both their helpful and unhelpful experiences with clinical supervisors. The initial Delphi consultation required that participants identify key components of the supervisor's role in radiography.

After a three-round cycle in which panel members were informed of the views of their fellow judges in an iterative fashion characteristic of the Delphi approach, Williams and Webb selected six items that were unanimously judged to be central to the supervisor's job which could be used to structure the analysis of the pool of critical incidents. They were a) Supervised Practice; b) Real Radiography; c) Active Participation; d) Observation of Expert Practitioner; e) Encouragement and Support; and f) Link-in with Practice. These broad role descriptions formed the basis of a top-down coding system for analysing the critical incidents in which the researchers developed an elaborated network of sub-categories to accommodate the specific supervisor behaviours cited in the critical incident accounts

In an overview of their results Williams and Webb noted that more than 80% of their pool of critical incidents were coded under two titles - 1) the supervisor's interpersonal style and 2) the teaching skill of the supervisor. The interpersonal style coding included sub-categories entitled relationships and attitudes. The teaching code included the sub-categories of skill and technique; preparation and planning; evaluation; and provision of an atmosphere that facilitates learning. The authors concluded that competent radiography supervisors establish working relationships with their trainees that maximize opportunities for experiential learning.

Within clinical psychology in the UK three studies have reported the use of the critical incidents approach to try and define the competences required of effective clinical supervisors. McCrea and Milsom (McCrea C. & Milsom J., 1996) used a critical incidents analysis to conduct a Quality Delivery audit of the effectiveness of clinical supervisors previously developed in a study of supervision across a range of healthcare disciplines including clinical psychology (McCrea C. & Rogers S., 1995).

The Quality Delivery process requires that the desired outputs of a given service are determined by its primary customers and the performance of the suppliers is judged against these pre-defined output criteria. McCrea and Milsom analysed the guidance provided for the clinical supervisors on the Leicester clinical psychology training course with which they are associated and produced a list of 11 outputs that their supervisors were expected to provide eg a statement of learning objectives for the placement, referrals that cover a range of problems, directed reading concerning the speciality etc. A consultation exercise conducted with the trainee group on the Leicester course indicated that supervisees placed most importance on 3 particular supervisor outputs viz 1) advice on how to assess, formulate, intervene, record and report; 2) role model on how to assess, formulate, intervene, record and report; and 3) feedback on trainee's endeavours to assess, formulate, intervene, record, and report.

Accordingly the researchers emphasised these supervisor competences in the next stage of their study. 177 critical incidents were collected from a sample consisting of second and third year trainees, recently qualified clinical psychologists and supervisors. Approximately half the pool of incidents was provided by the trainee population. Participants were asked to provide examples of notably effective and ineffective supervisory behaviour. Overall 92 effective and 85 ineffective incidents were collected. McRea and Milsom analysed the pool of critical incidents in a "top-down" manner first establishing four broad categories viz 1) issues surrounding supervision meetings; 2) issues surrounding meetings with other professionals; 3) issues surrounding supervisor's monitoring and awareness of trainee's professional performance, and 4) issues surrounding supervisor's general conduct. Behaviours placed within these superordinate categories were then sub-divided into subordinate categories as many times as possible. The minimum requirement for the construction of a new sub-category was that it contained at least three behaviours that could not be adequately subsumed under any existing code.

The authors note that the unit of analysis they used in classifying the critical incidents was not the whole account but the specific behaviours described therein. They suggest that this “dismantling” of the critical incident reports also served to reassure participants that the material they provided would remain anonymous. It is also arguable that this deliberate decontextualizing of supervisor behaviour lost some valuable clues about its meaning from the reporter’s point of view. McCrea and Milsom conclude their paper by listing the categories of “customer requirements” for clinical supervision produced by their analysis and provide some illustrative examples of specific supervisor behaviours cited in the critical incident reports. The broad category “issues surrounding supervision meetings” is the most articulated of the four superordinate codes and includes six sub-categories which are themselves further sub-divided.

The first level subordinate categories are 1) trainee’s personal well-being, 2) meeting composition, 3) stimulation of trainee to think for self, 4) provision of feedback, 5) provision of role model or example to follow, and 6) provision of advice instruction or theoretical grounding. The authors describe their analysis as the beginning of a process which might ultimately lead to “a functional description of the activity of supervision in terms of specific behaviours.”

Hitchen and her colleagues (Hitchen H. et al., 1997) collected a sample of 200 critical incidents from their fellow trainees on the Oxford training course which represented an impressive 80% response rate. Like McCrea and Milsom (op cit) they asked participants to provide examples of markedly helpful and unhelpful supervisor behaviour and sought evidence under four predetermined categories - 1) meetings, 2) supervisor’s monitoring and awareness of trainee’s professional performance, 3) supervisor’s general conduct, and 4) the interface between the placement and the course.

The first three of these categories were taken from McCrea and Milsom's model and the fourth was added because it reflected the researchers' interest in communication issues between trainees, supervisors and course staff.

The authors provide limited details on how this substantial pool of critical incidents was analysed but they seem to have followed closely McCrea and Milsom's methodology in both "dismantling" reports and employing a top-down system of classification in which supervisor behaviours were allocated to one of the four broad superordinate categories and then further sub-divided into a complex network of sub-categories. The authors present their results in the form of a list of four broad headings each with a number of subsidiary categories:

a) Practicalities:

1. Boundaries
2. Atmosphere
3. Organizational
4. Systems/Politics

b) Monitoring/Teaching:

1. Observation
2. Trainee's stage of learning.
3. Guided discovery.
4. Supervisor's knowledge.

c) Supervision Relationship:

1. Support.
2. Confidence.
3. Respect and valuing.
4. Dialogue and supervision

d) Trainee, supervisor and course system.

1. Awareness.
2. Openness and confidentiality.
3. Power.

The authors used their findings as part of a training workshop for supervisors on the Oxford course which was run by the trainees under the title "Perspectives on supervision. Opening the dialogue." The feedback from the supervisors attending the event apparently confirmed that the supervisory competences identified by the trainee clinical psychologists in the critical incident reports were similar to those they themselves had discovered in a group exercise conducted as part of the workshop. Hence the consultation component of the training day provided some validation for the trustworthiness of the results of the survey of trainees' views on supervision.

The most detailed extant description of the collection and analysis of real-life helpful and unhelpful events in the supervision of clinical psychologist trainees in the UK has been provided by Hirons (Hirons A. & Velleman R., 1993; Hirons A. 1991). In her thesis research Hirons conducted an exploratory study with 6 first-year clinical psychology trainees all undertaking supervised clinical placements in the adult mental health specialty. Both supervisors and supervisees were interviewed on completion of the placement and asked to reflect on experiences within supervision that impressed them as having been notably helpful or notably unhelpful. Hirons employed a variation on Llewellyn's "Helpful Aspects of Therapy (HAT)" form which she unsurprisingly dubbed the "Helpful Aspects of Supervision (HAS)" questionnaire. The trainees were also asked to rate their overall satisfaction with the supervision they had received. Hirons reports a 73% completion rate on the part of the trainees and a 65% completion rate from the supervisor participants. A total of 201 helpful and unhelpful events were identified from the 89 questionnaires that were returned of which 117 were provided by the trainee participants.

The helpful and unhelpful events were analysed separately. The author and her supervisor both conducted an initial sorting exercise independently. They then compared results and resolved any differences of opinion to generate an agreed list of appropriate categories for the classification of both the unhelpful and helpful events.

Although Hiron described this process as “content analysis” she clearly did not structure her handling of the data by employing any predetermined theoretically driven model of classification. Rather her categories are very closely grounded in the descriptions of events provided by her research participants. Overall supervisors and trainees tended to identify the same competences and incompetences. Finally trainees and supervisors involved in the study were given the list of event categories identified in the qualitative analysis and asked to rate their relative importance to effective supervision in general. Again with the notable exception of events in the category labelled ‘feedback’ (which supervisors consistently reported as being more important than trainees did). Hiron’s work portrayed a reassuring consensus between supervisor and supervisee perspectives on what had, and had not, proved useful during these particular supervisory relationships. Interestingly Hiron reports that there was no evident relationship between the number of episodes of supervisor behaviour classified in a particular category and its perceived importance in participants’ implicit theories of what matters in clinical supervision. This finding held for both the helpful and unhelpful events.

The “headline findings” of the thesis were that the four most strongly endorsed helpful supervisor behaviours were 1) Direct guidance on clinical work, 2) Joint problem-solving typified by a co-operative approach between supervisor and trainee, 3) Reassurance, and 4) Theory-practice linking. The three most readily identifiable unhelpful supervisor behaviours were 1) Supervisor telling the trainee what to do, 2) Lack of direction, and 3) Trainee being talked to as if s/he were a client.

The apparent contradiction between actions 1) and 2) is explained by the trainees' preference for being given explicit guidance by their supervisors but only after an appropriate period of discussion had taken place in supervision during which their own views have been sought. Unfortunately Hiron, perhaps mindful of the limited data base from which she is operating, falls short of making any substantial attempt at theoretical integration of the various supervisor behaviours identified as helpful or unhelpful in her study.

Summary

The preceding literature review has:

- Defined the central role of clinical supervision in the training of clinical psychologists.
- Described the limited empirical base on which current professional practice is founded.
- Provided a brief historical review of therapy-based and developmental stage models of effective supervision.
- Described a number of research methods that have been developed to determine the specific competences of individual professions, including the critical incident technique.
- Offered a critical review of the various quantitative research approaches that have been employed to investigate the process and outcome of clinical supervision.
- Compared qualitative research methods to this traditional quantitative science paradigm.
- Described selected studies illustrating the qualitative approach to exploring the experience of clinical supervision from the perspectives of both the supervisor and the supervisee.
- Given a detailed résumé of the three studies that have used a critical incidents approach (or variant thereof) to investigate the supervision experience of British clinical psychology trainees.

While these final three articles (McCrea C. & Milsom J., 1996; Hitchen H. et al., 1997; Hirons A. 1991) are highly pertinent to the current study, each also has a number of shortcomings when measured against recently published canons of good practice in qualitative research (Turpin G. et al., 1997; Boulton M. et al., 1996).

The sample of participants is either very small and potentially unrepresentative (in Hirons' case) or are not described at a level of detail (eg gender mix, placement speciality) which allows the reader to make an informed judgement on the generalizability of the authors' findings. Critical Incident reports (or helpful aspects of supervision questionnaires in Hirons' work) are the only source of evidence collected. The modes of analysis used are not described tightly enough for fellow researchers to replicate the methodology easily or trace the trail from original data to summarized results in a straightforward fashion. Variable efforts are made to establish the reliability of the codings developed during the research and the validity of its findings with no study meeting both criteria of recommended practice. Finally the conclusions of each of the studies are presented in a list form which might best be described as a basic taxonomy of reported effective practice in clinical supervision (Henwood K. & Pidgeon N., 1995) There is no concerted attempt to use qualitative research methods to generate a coherent and comprehensive theoretical model of supervision.

The research to be described now has been informed by these criticisms.

The Current Study

The aims of the current study are:

- a) to collect a pool of critical incidents consisting of real-life examples of helpful episodes in clinical supervision experienced by trainee clinical psychologists at different stages of their professional training.

- b) to analyse these incidents using the “grounded theory” approach to qualitative research in the Social Sciences (Strauss A. & Corrin J., 1990; Pidgeon N. et al., 1996) with the intention of developing a provisional theoretical model of clinical supervision that takes account of the experiences of the research participants.
- c) to further test and develop this preliminary model by the analysis of two further sources of evidence employing what has been termed a “triangulated” research design (Flick U. 1992). The other data to be analysed are 1) trainees’ reflections on helpful moments in supervision prompted by systematic review of a videotaped supervision session in which they have been involved using the methodology of Interpersonal Process Recall (McQuellon R.P. 1982), and 2) “focus group” discussions (Kitzinger J, 1995) in which final year trainee clinical psychology trainees reflect on their worst experiences in supervision over the course of their training with the assistance of a facilitator.
- d) to construct a coherent empirically grounded model of effective supervisory practice in clinical psychology that can be validated both by comparison with the extant published research in the field and the “expert” views of practitioners with a close professional involvement in clinical supervision.
- e) mindful of the serious methodological criticisms made of much published research in the field of supervision to conduct this study according to the emerging canons of good practice in qualitative research. Specifically:
 - 1. to declare details of the researcher’s own attitudes and background that might have coloured the way he chose to interpret the data.

2. to provide detailed information on all research participants and their specific roles in the research so that readers can make informed judgements on whether the study's findings might be reasonably generalized to other supervisory settings.
3. to employ more than one data source (see the triangulation strategy above)
4. to give a full and transparent account of how all stages of the process of data analysis were conducted.
5. to incorporate into the analysis a measure of inter-judge agreement to enhance the perceived "trustworthiness" of the coding system employed.
6. to test the validity of the study's findings by presenting the results to "expert" groups for comment and consultation.
7. to compare the conclusions of the research with those of other studies in the field.
8. to consider the practical implications of the study's findings for the future training of clinical supervisors.

CHAPTER 2

Forestructure

Qualitative research is centrally concerned with personal meaning. Its focus is the sense research participants make of a particular experience and its product is the interpretative framework adopted by the individual researcher to 'pull together' the various accounts he or she has analysed. We expect research participants to tell unique stories, even if they have confronted some common challenge such as serious illness, because they construct their experience in diverse ways. The same reflexive logic applies to the way researchers tell their tales. The originators of the Grounded Theory approach (Glaser B. & Strauss A., 1968) anticipated that, provided researchers stuck to the procedural guidelines they proposed, the analysis of any given data set would result in essentially the same explanatory model being "discovered". Like palaeontologists piecing together the bones of a dinosaur, careful analysis would eventually reveal the correct skeletal structure that linked the parts to the whole. However Charmaz (Charmaz K. 1990) has criticized this 'discovery' metaphor. She argues that there are many potential interpretations that a researcher can place on the accounts provided by subjects. Researchers construct their stories much as their research participants do. Just as the sense an individual makes of being diagnosed with cancer may depend on their religious beliefs, understanding of the specific disease, or prior experience of ill-health, so the interpretations researchers make of the evidence before them, no matter how assiduously they seek to "ground" their ideas in the accounts of their participants, will likely be influenced by the personal and professional constructs with which they approach the study in the first place.

Stiles (Stiles W, 1993) in an influential review paper entitled 'Quality Control in Qualitative Research' recommends therefore that researchers provide what he calls a "forestructure" to their writing in which they disclose key details of their orientation (eg prior experience in the field, theoretical commitment). Stiles considers this form of openness would be good practice for those writing up traditional quantitative research papers, but is particularly helpful for readers of qualitative studies seeking to gauge the trustworthiness of the analysis described. An awareness of the researcher's orientation allows the reader to make a judgement as to whether the researchers found what they were primed to find or whether the study shows evidence of "permeability" (Stiles' term) in their theorizing (ie new and unexpected ideas were developed in the course of the study).

There are, to my knowledge, no established rules about how researchers might best provide a forestructure for a doctoral thesis. A lengthy autobiographical piece seems inappropriate and however candid and comprehensive my disclosures I would probably omit details of personal biases of which I am only barely aware myself. Nonetheless the important thing is to 'have a go'!

I have been qualified as a clinical psychologist for 20 years. I have been closely involved in the supervision of trainee clinical psychologists for the last 18 of those years initially as a supervisor myself and for the last decade as Clinical Tutor on the Clinical Psychology training programme at the University of Leeds. One of my primary responsibilities as Clinical Tutor is the organization of the clinical placement component of the training scheme. I therefore co-ordinate the placement timetable; run supervisor training workshops; prepare trainees for clinical placements; visit supervisors and trainees for mid-placement reviews; hold post-placement de-briefing discussions with trainees; and have a senior role in developing course policy regarding clinical placements.

I have therefore read some (I now discover an embarrassingly small fraction) of the substantial literature in the field, and have published a few articles on the topic of supervision myself (Green D.R. 1997; Green D.R. 1995; Green D.R. & Wang M., 1997).

It would therefore be naïve to imagine that I could approach the evidence provided by the trainees in this study without my analysis being influenced by any pre-conceived notions about the role of the clinical supervisor in the professional training of clinical psychologists. I think supervised clinical practice is the single most important component of our training programme. It would also be a bad job if I did not, by now, have a number of reasonably articulated views about what makes an effective supervisor, for example in acting as an ethical role-model with whom trainees can identify.

As regards theoretical commitment I have no established association with any particular model of clinical supervision though I do have a history of affiliation to two therapeutic schools of thought which might well colour my views on how supervisory discussions promote change (see the section in the introductory literature review on the ways supervision has been understood within different psychotherapeutic traditions).

I am sympathetic to the ideas of Personal Construct Theory (Kelly G, 1955) and have written on the application on Kelly's ideas to therapeutic work with young people (Butler R & Green D.R., 1998; Green D.R. 1997) and the education of clinical psychologists (Green D.R. 1989). I have also undertaken some limited professional training in family therapy and been exposed to the basic tenets of systems theory. An article co-written with a colleague on the same training programme (Green D.R. & Kirby-Turner N., 1990) describes my reflections on the struggle to incorporate these new ideas into an established therapeutic ideology.

Stiles (op. cit.) also suggests that readers will find it easier to evaluate the findings of a qualitative study if they appreciate the social context in which the research was conducted. The clinical psychology training course at the University of Leeds is one of the longest established in the UK. It is currently a three-year programme with an annual intake of 12-14 trainees. During the first two years of study, all trainees undertake four core clinical placements of 3 days per week each lasting 6 months. All students therefore have supervised clinical experience with four distinct client populations - adult mental health, child and adolescent, elderly, and people with learning difficulties. Trainees are allocated to these core placements by the clinical tutors. In the final year of the programme trainees undertake an elective placement in a speciality and with a supervisor of their own choice. All clinical placements have the status of examinations in the University's eyes and are evaluated on a pass/fail basis. Supervisors' assessments of trainees' performance on placements are returned to me as Clinical Tutor and I present their recommendations to the Examination and Assessment sub-committee of the course for ratification.

Hence there exists a complex, established, hierarchical relationship between me, as researcher, and the trainees on the course, as research participants. The nature of this relationship between researcher and participants may well influence the way supervisees choose to describe their experiences in supervision. The responses provided may depend on who's asking the questions. Is it a fellow student (Hirons A. 1991), or a senior staff member on the training course (McCrea C. & Milsom J., 1996), or a researcher with no prior involvement in the training programme (Allen et al., 1986)?

The reader should therefore understand the "small world" in which this research was conducted. I knew all the research participants well. I knew all the clinical settings in which their supervision had taken place. I knew all the supervisors whose activities were reported as part of the project. And the research participants knew I knew.

CHAPTER 3

The Critical Incidents Reports

As described in the introductory literature review the Critical Incidents approach seeks to collect detailed descriptions of individuals' 'on the job' behaviour from which the researcher builds up a cumulative picture of the skills required to perform competently in a given occupational role. The invitation to clinical psychology trainees to report their positive experiences in supervision was framed in the following terms:

“As part of a research project to try and identify the component skills of effective supervision I am seeking to collect real-life examples of particularly helpful practice. I am therefore asking all trainees to record **at the time** descriptions of episodes in which they feel they have definitely benefited from the process of clinical supervision. Please describe

1. The context ie the nature of the problem you were seeking help to resolve, any pertinent history.
2. What the supervisor actually did, said, conveyed etc.
3. How this was related to a beneficial outcome for the trainee and/or the client concerned.”

Research participants were also asked to identify themselves, their year of training, and the placement speciality in which they were being supervised at the time of the incident (see appendix 1).

This request was made to trainees on all three years of the clinical psychology training course at the University of Leeds over a 3 year period. I gave regular 'pep talks' to all year groups and made plenty of critical incident blanks available to all potential participants in the project.

Participation

A total of 49 trainees were invited to contribute critical incident reports over the three years of the project. 32 of the 49 potential contributors returned completed forms. This represents a 65% response rate which compares favourably with reports of some other critical incident studies that have relied on postal questionnaire returns (Andersson B. & Nilsson S., 1964) but falls significantly short of the 80% participation rate described by Hitchen et al (op cit) when making a comparable request of their fellow trainees on the Oxford training course. However when contributions to the other two components of the research design (the focus groups and commentaries on video-tapes of supervision sessions) are included, 85% of the potential pool of supervisees provided some evidence for the project.

The number of incidents reported by individual trainees varied considerably with a range of 1-12 forms returned. The mean number of incidents reported per trainee was 3.125. However the three most active research participants contributed 28% of the total pool of critical incidents. Although there is some anthropological evidence that 'expert' informants on local cultures (as these committed participants could be construed) express views that are typical of the communities they represent (D'Andrade R. 1987), there is evidently a risk that the theory of effective supervision built from this data will rely heavily on the testimony of a small sub-group of supervisees. I will return to this point in the conclusion section of the thesis (Chapter 10).

12 of the 49 possible participants were male. This 25/75% male/female ratio is characteristic of current intake patterns into clinical psychology training programmes in the UK (Evans R, 1997). However only 16% of the critical incidents were reported by male trainees as opposed to an expected 25%.

It may be that males are less comfortable than females with invitations to self-disclose (Dindia K. & Allen M., 1992) or more inclined to let others take responsibility for completion of group tasks, a delegation of duty delightfully described as the phenomenon of “social loafing” (Karau S. & Williams K., 1993). Whatever the cause the supervision experiences of male clinical psychology trainees, themselves a minority, are under-reported in the critical incidents section of this research.

In other ways the pool of incidents collected is broadly typical of the range of supervision experiences provided on a UK clinical psychology training course in that they are reasonably evenly spread across the three years of the course (see figure 1) and the five placement categories (see figure 2). Hence it can be argued that the model of effective supervision developed from this data base is unlikely to be dominated by patterns of supervisor behaviour that are especially valued by trainees who are at a particular developmental stage, or working therapeutically with a specific client group.

Total Sample of Critical Incidents

A total of 100 critical incidents were reported over the three years of the data collection phase of the study. The precise number of incidents collected using this methodology varies considerably from study to study (Williams P. & Webb C., 1994) and is probably best construed as an arbitrary decision made in the context of a particular set of research aims and constraints. Nonetheless the pool of 100 incidents analysed in this project is ‘on the low side’ of published guidelines (Dunn W.R et al., 1985). The sample size can be justified on three grounds:

1. The pool of critical incidents is being employed to explore one particular competence of clinical psychologists, their supervision skills, rather than seeking to define the full range of abilities needed to practice professionally in that role (Doran A & Carr A., 1996).

Figure 1: Stage of Training

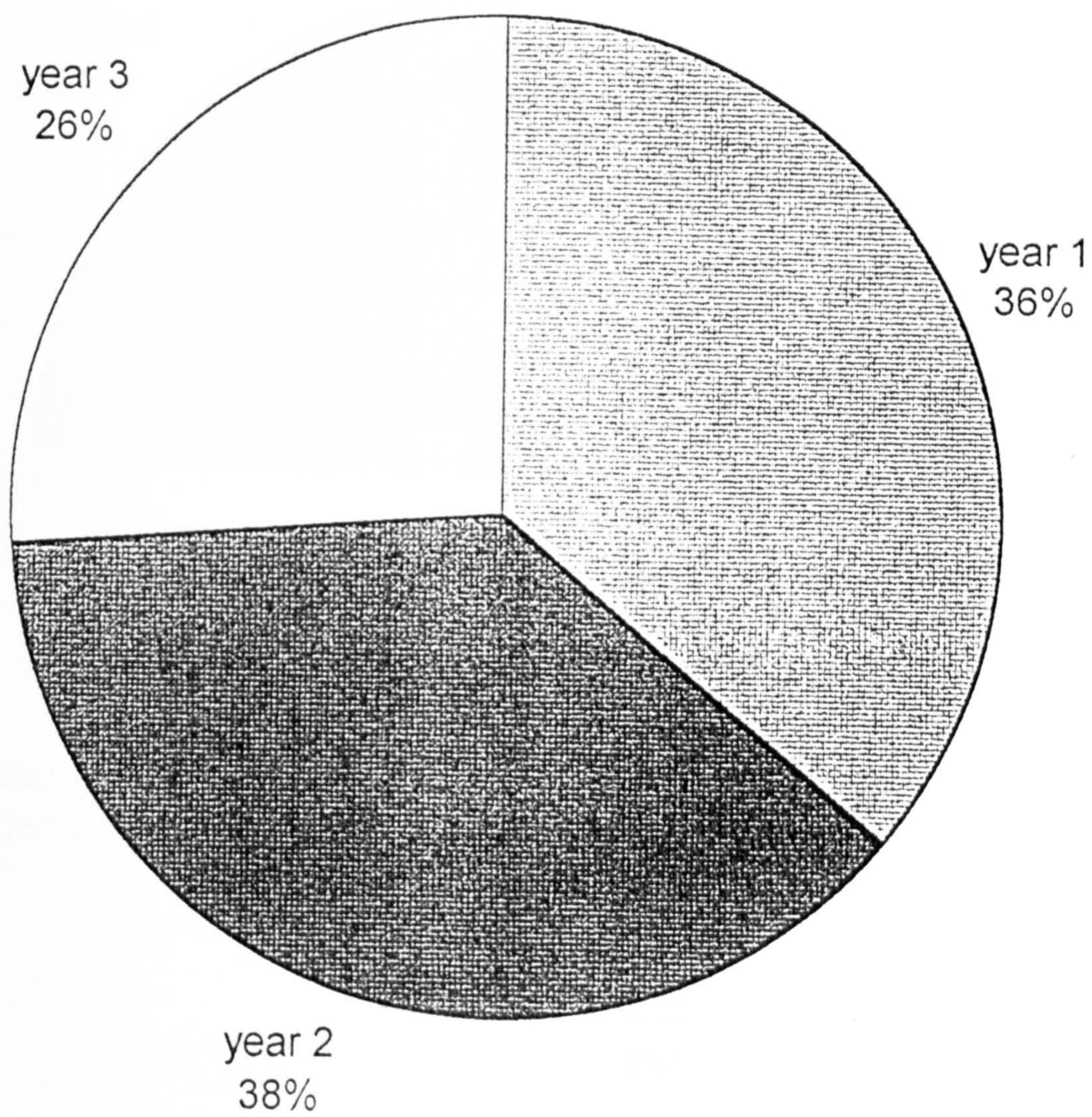
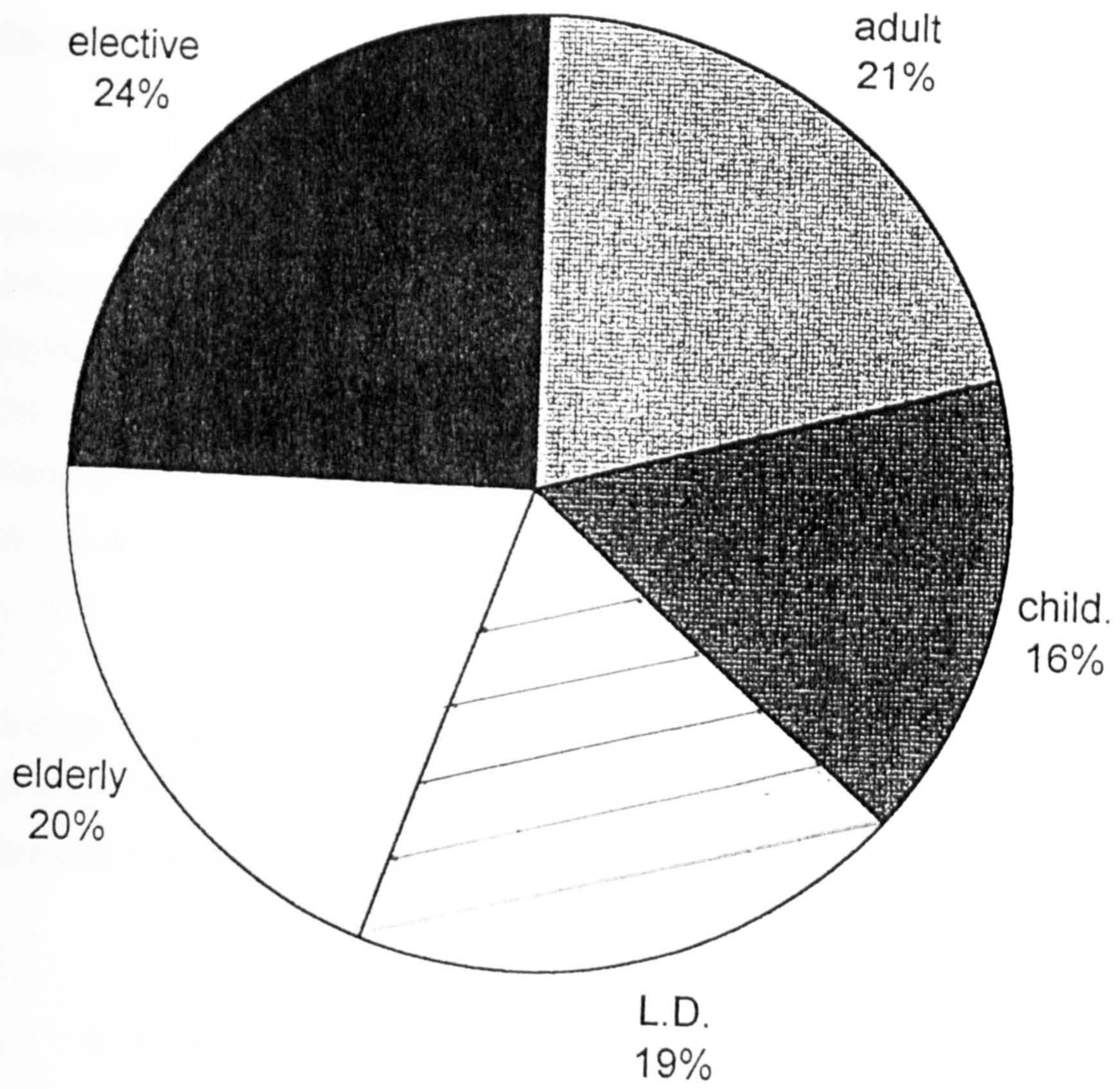


Figure 2: Nature of Placement



2. The study uses two further sources of evidence - the focus groups and commentaries on video-tape recordings - to test and develop theoretical ideas derived from the critical incidents analysis (Flick U. 1992).
3. Most behaviour categories identified in critical incidents research are classified in the early stages of studies (Anderson B. Nilsson S., 1964).

Analysis

Although grounded theory is one of the most methodologically explicit of the procedures employed in qualitative research, it is best understood as a strategic approach to data analysis than a single prescribed technique. The originators of grounded theory (Glaser B & Strauss A., 1968) anticipated that their ideas would be adapted and developed by fellow researchers and their “discovery” has indeed generated a diverse body of studies which vary both in the topics investigated and the analytic methods employed (Strauss A. & Corbin J., 1994).

Although the grounded theory approach has been used with an impressive flexibility at its core remain a few fundamental data handling strategies identified by Henwood and Pidgeon (Henwood K. & Pidgeon N., 1995) as:

1. the generation of low level descriptive categories which closely ‘fit’ the data collected
2. creating definitions of categories and making linkages between them at different levels of abstraction
3. continuously exploring and re-configuring the data available to the researcher using the method of constant comparisons

4. Seeking out fresh data which has been strategically selected because of the light it might shed on the developing account of the phenomenon under investigation, a tactic termed theoretical sampling.

This systematic sequence of describing, classifying, and connecting pieces of evidence en route to the construction of a grounded theoretical account puts a premium on the organizational skills of the researcher. The demanding task of recording 'what goes where' can be managed by using one of a number of computer software packages developed to support qualitative data analysis (Weitzman E.A. & Miles M.B., 1995). The C.A.Q.D.A.S project at the University of Surrey advised me both that a number of computer programmes were available which were compatible with the grounded theory approach (Lonkila M. 1995) and that the NUD*IST package would match the design of this project (Lewins A. & Trapp A., 1997).

Although I have endeavoured to follow published guidelines for the practice of grounded theory research (Pidgeon N. & Henwood K., 1996) I do not intend asking the reader to take my word that I have employed appropriate analytic procedures. Rather I will try to give a chronological account of what, how, when, and why I did what I did, and let you judge for yourself.

Stage One

Descriptive Coding

To begin at the beginning. I received critical incident reports on an irregular basis over a period of three years. On receipt of a report form I read through the account of the incident described, and hand-wrote a complete copy (including identifying details) onto a file-card.

I then completed a second file-card on which I noted what struck me as the key themes expressed in the incident. At this stage I made no attempt to collate or organize the themes I noted emerging from the incidents, but restricted myself to a close and careful reading of each report.

Once the complete pool of incidents had been collected and individually recorded in this way, all the reports were typed out and imported into the NUD*IST computer programme; I then began the formal coding exercise.

The report format

The critical incident reports took the form of the example below (See Appendix for a series of further examples).

2/95

INCIDENT NO 011

SUPERVISEE NO 13 YR I SPECIALITY: ADULT

Nature of Problem Seeing a client with psychosexual problems I had a clearly structured first interview plan but found it very difficult to tackle the very personal intimate details. I concentrated on more general details and other pertinent issues and put off intimate discussion until discussion with my supervisor.

Supervisor

- 1) Listened to my account and how I felt in myself.
- 2) Asked what the client was displaying/saying.
- 3) Gave positive feedback on what I had succeeded in doing in terms of empathy, building the relationship etc.

- 4) Gave me clear examples of how to ask intimate questions, both in terms of what to say and how to say it by 'modelling' such.

Outcome

The next session I 'took the bull by the horns', ensured the client felt comfortable and followed the protocol given me by my supervisor, particularly tips on how to broach difficult subjects. I felt much more confident in my own competence and my client visibly relaxed during the session as I 'modelled' how to discuss intimate problems in a reassuring but matter-of-fact way.

Overall this supervision:

- 1) was practical in its approach
- 2) emphasised my strengths
- 3) increased my knowledge base
- 4) helped strengthen my confidence
- 5) enabled a beneficial progress for the client.

At the beginning stage of the analysis I concentrated on the middle section of the report using the problem and outcome sections as contextual information to help me make sense of the exchange described.

In this example the descriptive codes I created to classify the supervisor's behaviour were:

1. **LISTEN:** 'Supervisor listened closely to what trainee had to say'.
2. **INFORMATION SEEKING:** 'Supervisor elicited relevant information from the trainee'.
3. **POSITIVE FEEDBACK:** 'Supervisor provided positive feedback to the trainee on what they had been doing right'.
4. **DEMO:** 'Supervisor modelled an interaction for the trainee to copy'.

NB A full list of the operational definitions of all the codes used in this study can be found in the appendix.

This incident is typical of those provided by the research participants in that it provides a rich and detailed account of a sequence of supervisory behaviours that cannot be adequately captured in a single descriptive category (cf McCrea and Milsom op cit). As a result I had developed more than 60 codes after analysing the first 50 critical incident reports. It had been my intention to generate these 'low level' descriptive categories for all 100 incidents before proceeding to a more abstract theoretical analysis. However an unstructured list of more than 60 categories was becoming cumbersome so I decided to attempt to classify the codes I had thus far developed into more manageable clusters

Hierarchical coding

Exponents of critical incident analysis have described the process of analysis through which a substantial batch of behavioural reports is transformed into a comprehensive set of occupational competences as an "art not a science" (Flanagan J. 1954). The distinction implies that there is something subjective and uncommunicable about artistic creativity such that it cannot be operationalized in specific enough terms for another person to replicate the procedure. A doctoral thesis, as opposed to a journal article, allows the researcher to describe the experience of data analysis in close detail, and so I intend providing a full account both of the several stages of coding and theory-building which I undertook in the course of this project and of the private musings that informed my decision-taking.

The initial stages of conducting a qualitative research analysis have been compared with the first phases of trying to solve a jig-saw puzzle (Dey I, 1998). Certainly as I scattered over 60 file cards across the carpet and scanned their contents for similarities the analogy seemed eminently apt to me!

Just as the jig-saw enthusiastic might start by 'putting the blue bits' together in the expectation that they will be part of a larger unit called "sky", so I formed small clusters of codes that struck me as evidently holding some quality in common. For example I linked the **DEMO** code with the similar behavioural code of **ROLE-PLAY** defined as "supervisor role-played a scenario with the trainee". This process of low-level analysis re-arranged the 60 or so codes into a smaller, but still somewhat bewildering, series of small piles of file cards still randomly spread across the floor.

It is at this point that the parallel between solving a jigsaw puzzle and undertaking qualitative research breaks down. There is only one correct way to re-construct a jigsaw puzzle and testing a hypothesis about 'what fits where' is a straightforward business. The qualitative researcher is not cleverly re-discovering some pre-existing unity but creating anew his or her own theoretical picture, and that picture can legitimately be painted in many ways (Charmaz K. 1990). That is not to argue that qualitative accounts do not have to 'fit' their data closely, but to acknowledge that researchers, unlike jig-saw enthusiasts, do not have the luxury of knowing for sure that they are making the right connections between the bits of their particular puzzles.

The first 'pattern' I saw to connect some of the piles of cards strewn across the living-room carpet I chose to describe as 'an experiential learning cycle'. (See figure 3). As the 'memo' (See memo 1) I wrote at the time explains, it is evident that this conceptualization has its intellectual origins in Kolb's work on experiential learning (Kolb D, 1982). Nonetheless I did not seek out or expect to find evidence to support its relevance to the process of clinical supervision.

Memo 1:

MEMO ABOUT EXPERIENTIAL LEARNING

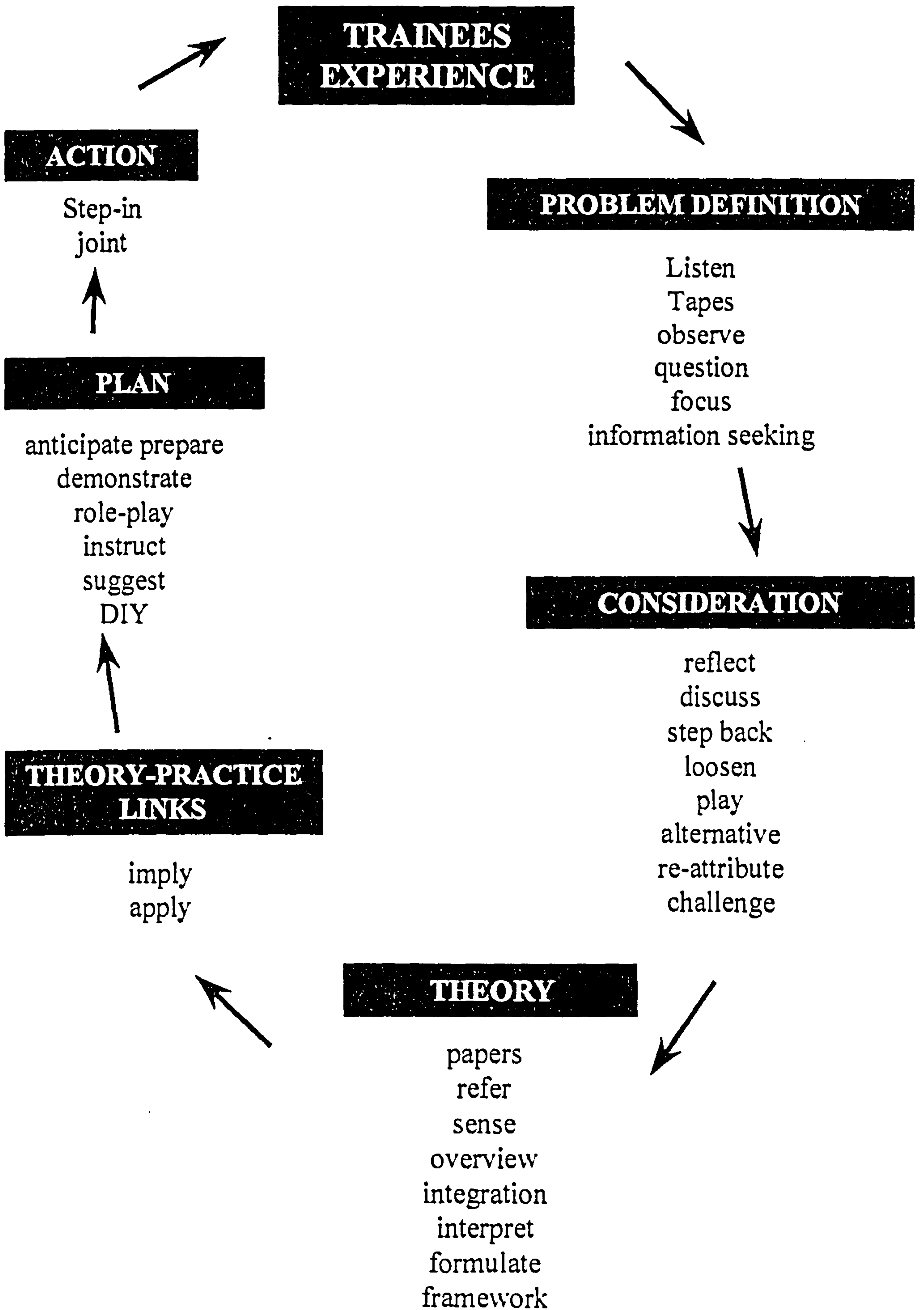
After creating 60+ descriptive codes for the first 50 critical incidents, a majority can be subsumed as distinguishable parts of an experiential learning cycle. The broad sequential stages of problem definition, consideration of possible meanings, conducting a more or less formal theoretical analysis, translating theory into a practical plan of action, and finally basically getting on with it, are very similar to Kolb's experiential learning cycle. I think my prior knowledge of this model (and respect for its potential usefulness in training supervisors) has undoubtedly influenced these initial explanatory ideas. However the higher order coding is still closely grounded in the details of the incidents themselves. I did not code with Kolb's model in mind at all. Rather, a bit like a jigsaw enthusiast I did the equivalent of "putting all the blue bits together". It was only as I sought for some broader pattern that the "fit" with an experiential learning cycle struck me. It wasn't exactly an "aha" moment but I felt a convincing and apt summary of some emerging pattern in the data.

Once I had classified the various phases of the learning cycle under the super-ordinate codes of problem definition, consideration, theory, theory-practice links, action plan, and action, I found that more than half of the basic descriptive codes I had generated had been subsumed into this first theoretical framework.

Relationship Factors

The next set of connections that I made between the remaining codes concerned those behaviours that I considered contributed positively to the quality of the working relationship developed between the supervisor and the supervisee.

Experiential Learning Cycle



I created four super-ordinate categories under the broad heading of relationship factors: supervisor's attitude (eg showing respect for the trainee); supervisor's emotional sensitivity (eg picking up cues that the trainee is distressed in some way); the structure of the supervisory sessions (eg clear sense of organization); and the nature of the inter-personal climate established in supervision (eg it feels safe for the supervisee to disclose some area of difficulty). The full classification system is reproduced in figure 4.

In establishing these theoretical categories I was aware that the ideas I was formulating were consistent with research demonstrating that the quality of the therapeutic alliance is a powerful predictor of treatment outcome in psychotherapy (Horwath A. & Greenberg L., 1994). However I was not familiar with research investigating the importance of the allied concept of the "supervisory alliance". As the memo I wrote at the time illustrates I also anticipated that problems arising in the working relationship between supervisor and supervisee would feature prominently in the complaints voiced by trainees when recalling their experiences in supervision in the focus group phase of the research (see Memo 2).

Memo 2:

MEMO ABOUT RELATIONSHIP FACTORS

This is a variant on the "facilitative conditions" notion common in psychotherapy research. Two key components are a supportive interpersonal climate and a strong sense of a supervisory alliance. The effective supervisor seems to be able to foster the conditions in which a supervisee can learn eg feels safe to take risks, knows what to expect, feels valued. I suspect the opposite side of this particular coin will come out from the focus groups on unhelpful experiences in supervision. A good test.

Figure 4:

RELATIONSHIP FACTORS

SUPERVISOR'S ATTITUDE

Non-judgmental
Seriously
Respect
Apologise

STRUCTURE

Organised
Access
Prompt

EMOTIONAL SENSITIVITY

Cues
Feelings
Express
Disclosure
Counter-transference

INTERPERSONAL CLIMATE

Containment
Safety
Protect
Support

Sapiential Authority

The third substantial grouping of codings I constructed I chose to title "Sapiential Authority" because it struck me that the various behaviours described all relied on the trainee recognizing the seniority and experience of the supervisor. Whether the supervisor was offering feedback on the trainee's performance, or sharing some expert knowledge he or she possessed, or speaking with the authority of long experience, these self-evidently hierarchical exchanges depended for their effectiveness not on the supervisor's power in relation to the trainee but on the respect they were accorded by the supervisee in recognition of their prior learning. The trainees appreciated that in certain useful respects their supervisors knew more or better than they did (see figure 5). Again the memo recorded at the time finds me wondering whether this analysis implies that only wholly competent supervisors will be construed as having enough perceived wisdom to comment authoritatively on their trainee's conduct (see Memo 3).

Memo 3:

MEMO ABOUT SAPIENTIAL AUTHORITY

This group of descriptive codes is linked by the hierarchical nature of the exchanges described. The success of the supervisors' interventions relies on their being recognised by the trainee as having sapiential authority that is commensurate with their supervisory status. The provision of helpful feedback requires that the supervisor's opinion is respected. The special knowledge of the supervisor may take various forms such as being expert in a particular form of psychotherapy or knowing the local professional network well. Being able to offer authoritative comment such that the supervisee experiences a convincing sense that their analysis of a problem is reasonable, or the anxiety they are experiencing is normal, or that their therapeutic expectations of a particular case are unrealistic, all depend on the trainee's acceptance of the supervisor's legitimate seniority. What if the supervisee does not see their supervisor in this respectful light? Not all of us can be revered elder statesmen and women!

Figure 5:

SAPIENTIAL AUTHORITY

FEEDBACK

Positive
Reassure
Constructive criticism

SPECIAL KNOWLEDGE

Local knowledge
Expert
Experience

CREDIBILITY THROUGH SENIORITY

Validation
Normalise
Realist

Stragglers!

The three broad theoretical groupings that I had created took account of all but three of the small piles of coding cards I had assembled. The three remaining clusters I dubbed 'development' (when a supervisor's intervention was reported as being appropriately pitched for a particular stage of the supervisee's training); 'ethics' (where an ethical dilemma was raised in supervision); and 'prompt' (when a trainee reported appreciating how quickly a supervisor had made herself available at a time of crisis). I could see no theoretical linkages between these codings and the broader groupings of codes I had created and decided to return to the business of analysing more data rather than attempt any further integration of my provisional classification system at this stage.

The final 50 Critical Incidents

The hierarchical 'tree' structure into which I had organized the codes generated by the first 50 critical incidents, made the task of analysing the remaining reports considerably more manageable. I therefore proceeded to code the supervisor behaviours reported into existing codes where appropriate or create new codes where no fitting definition adequately captured the exchange described. The table below lists the new codes I introduced and where I chose to place each code in the emerging theoretical model (see appendix for operational definitions of individual codes).

Revised codings after 100 incidents analysed

Experimental Learning Cycle

probdef -

debrief

consider -

compare

shoes (empathy)

identify

self-appraisal

recall

talk through

own view

theory -

links

process

revise

theo-prac -

strategy

plan -

describe

decide

flexible

advice

Relationship Factors

attitude -

candour

structure -

goals

Sapiential Authority

responsible

Timing

prompt

The bulk of the fresh codings augment the experiential learning cycle sub-grouping, confirming my impression that much effective clinical supervision consisted of systematic reflection on practice, followed by theoretical formulation, leading to a plan of action that was subsequently put into practice. Several critical incident reports described more than one phase of this sequence or commended a supervisor's intervention that had 'unstuck' the trainee and allowed him or her to think through a problem successfully.

Incident No 79 perhaps offers the most telling endorsement of a cyclical model of experiential learning in supervision.

****Problem***

In the early stages of trying to put a form of therapeutic endeavour into practice - brief short-term dynamic psychotherapy. Not quite sure if/that I'm getting the hang of this: reading books and talking about what I might/could do is jarring with what I seem to be doing (which is very person-centred and "looks like it could be long-term dynamic psychotherapy").

****Supervisor***

Taped one of the early sessions which C listened to and commented on. Next did a process recall of the next session after that and talked this through with C. The talking through (the meta-problem recall) with my supervisor was extremely productive. It set me more surely on track and married with what I had been reading and talking about prior to clinical activity. There really is no better way to learn than through experience (informed by reading/theory and reflected on in supervision with a skilled practitioner!).

****Outcome***

Much more focused in next sessions. Was able to address important issues in the "transference" with the client which benefited from the greater sense of focus (and alliance with this person).

Two further codes ('candour' and 'goals') have been added to the relationship factors sub-group. The code 'responsible' has been added to the sapiential authority grouping but I have not yet decided how it might best be incorporated into its sub-structure.

Finally I have provisionally linked the categories of 'prompt' and 'development' under the broader notion of 'timing' as I consider they share the sense of a supervisor having been able to say the right thing at the right time. However I considered that this aspect of the theoretical model was under-developed and needed testing against fresh data.

Reliability Issues

At this point in the research programme I was feeling encouraged that I might indeed be able to produce a reasonably coherent theoretical account of effective clinical supervision. However the validity of the various abstract connections I was beginning to make between the codes, rested on the assumption that I had legitimately defined the supervisor behaviours described in the critical incident reports in the first place. I elected therefore to conduct an inter-judge agreement exercise to demonstrate (to myself as much as to any outside observer) that another person could reliably employ the coding system I had developed on a random sample of critical incident reports.

So, according to recommended good practice (Fitzpatrick R. & Boulton M., 1996) my supervisor and I undertook two linked analyses:

a) Dialogic Intersubjectivity (Kvale S. 1996)

In the first exercise I briefed my supervisor (CS) fully on the 'tree' of codes I had thus far constructed using a wall poster (produced for a conference presentation) and a file-card system listing all the code definitions. Once CS felt she had been adequately introduced to the model she independently coded the supervisor behaviour section of 10 randomly selected critical incidents. I then compared these results with the codes I had registered in the NUD*IST programme. For each pair of reports I noted:

- a) Those codes where both judges agreed at all three levels of abstraction (ie subgroup - **SAPIENTIAL AUTHORITY**; category - **FEEDBACK**; code - **POSITIVE**). See appendix for a worked copy of the marking sheet employed.
- b) Those codes on which the two judges disagreed.
- c) My thoughts on how those disagreements might have come about, and how they might reasonably be resolved.

These notes formed the basis of a detailed discussion between my supervisor and myself in which we reviewed our respective codings on each critical incident report in the sample and came to an agreed judgement on how best to resolve our differences of opinion.

As I noted in a memo written at the time, although the general tenor of our discussions confirmed my conviction that the basic codes I had developed were securely grounded in the data provided on the critical incident reports, this exercise also revealed two unanticipated sources of disagreement between the two coders:

1. CS made her judgements on the basis of a completed coding system, whereas I had built up the coding system in the process of sequentially analysing each incident in turn.
2. When CS assumed from the code title she knew when a code was appropriate, without checking the formal definition in the file card system, there was a clear risk of misunderstanding. For example the code **CANDOUR** is defined as "supervisor and trainee openly air a difference of opinion" whereas CS had employed **CANDOUR** in the broader sense of the supervisor conveying a sense of frankness in their communication with the trainee.

We corrected these two anomalies in our approaches to the coding task and repeated the inter-judge agreement exercise with a further 10 randomly selected critical incidents.

b) Arithmetic Intersubjectivity (Kvale S. 1996)

A stricter test of the reliability of codings used in qualitative research has been suggested by King (King N. 1994). He recommends that the judgements of independent raters are charted against each other on a "confusion matrix" on which the axes of the graph list, in order, all the possible codes that might be used to classify a unit of text. The line of perfect agreement between judges is the major diagonal of the matrix. The degree of consensus can then be calculated using the Kappa statistic which, unlike a % figure, takes into account the level of inter-judge agreement that might have occurred by chance.

The confusion matrix I drew to chart two sets of codings derived from this second random sample of critical incident reports identified 79 possible codes that could be employed within the classificatory 'tree'. The probability of chance inter-judge agreement is therefore very low in this instance. The confusion matrix showed where both judges agreed or disagreed on the appropriateness of particular coding. However there were a number of instances when one judge had coded a unit of text which the second rater had not classified at all. In these cases the disagreement was about the unit of text to be analysed rather than about which code best captured the supervisor behaviour described. See for example in Incident 011, the supervisor behaviour section starts:

"Listened to my account and how I felt in myself", CS classified the whole of this sentence under the code FEELINGS defined as "Supervisor demonstrated sensitivity to the trainee's emotional state". I used the same code for the second half of the sentence but coded the first phrase as LISTEN defined as "Supervisor listened closely to what trainee had to say".

There are two ways of dealing statistically with these "sins of omission". You either count them in with the disagreement score, or disregard them completely when computing the Kappa score. I tried both strategies with the following outcomes:

a) Without omissions KAPPA = .79

b) With omissions KAPPA = .59

It has reasonably been suggested (Bakeman R. & Gottman J., 1986) that strategy a) probably overestimates and strategy b) probably underestimates, the actual level of inter-judge agreement. Therefore I am inclined to argue that a mid-point between the two figures be adopted and assume a working estimate of KAPPA at approximately .7.

This figure is substantially above the .4 minimum recommended for qualitative research by King (King N. 1994) and is ranked a "good" level of inter-judge reliability on the Fleiss scale quoted by Bakeman and Gottman (Bakeman R. & Gottman J., 1986) Hence the exploration of inter-judge agreement (which involved detailed analysis of 20% of the data coded at this stage of the research programme) provides a sound basis for claiming that the basic codes which form the building blocks for my more abstract theoretical formulations are adequately "grounded" and operationalized. That is not to argue that this is the right and only way to describe supervisory behaviour, but rather to recognize the sense of reassurance (recorded in my research memo at the time) that "my ideas are not so vague and idiosyncratic that I cannot convey them to another person".

It is perhaps worth noting at this stage that the level of evidence on inter-judge agreement presented in this thesis meets the standards recommended for doctoral research in clinical psychology (Turpin G. et al., 1997) and indeed exceeds the acceptance criteria adopted by some journals for the publication of qualitative studies (Boulton M. et al., 1996).

However the analyses described still fall short of the 'gold standard' recommended by Stiles (Stiles W, 1993) in not using more than one other judge; not employing naïve independent raters with no other role in the research project; and not repeating reliability checks at several stages in the data analysis (for example in coding transcripts of the focus group discussions). This is however the only evidence on reliability issues I intend providing to underpin the theoretical considerations that constitute much of the remainder of this study.

Analysis of the remaining sections of the Critical Incident Report forms.

As explained in the introduction to this chapter, the descriptions of helpful supervisor behaviour that formed the meat of the critical incident reports were sandwiched between relevant 'before' and 'after' information to provide a context within which the supervisory exchange could be better understood. However having got thoroughly immersed in this material I felt there were theoretically interesting patterns in the 'problem' and 'outcome' sections of the critical incident accounts that warranted systematic analysis in their own right.

Problems presented in supervision

Although trainees occasionally (7% of all reports) described themselves as not having raised any particular problem in the supervision session during which a critical incident occurred, the substantial majority of accounts began with the supervisee seeking assistance with what they felt was a pressing difficulty. After undertaking a closely grounded description of the problems presented (see full operational definitions in appendix) I organized the basic codes into six broad categories (see figure 6):

1. Problems related to the trainee's emotional state such as feeling highly anxious about a case.
2. A feeling that the case work in which the trainee was engaged had reached a critical point such as a therapeutic impasse.

3. The trainee being acutely aware of their own ignorance and struggling to make sense of therapeutic material.
4. The trainee being uncertain about the course events were taking in their clinical work and for example, seeking direction for future therapy.
5. Problems primarily concerned with the difficult content of particular therapeutic sessions such as the awareness of an ethical dilemma that needs to be resolved.
6. Problems that do not relate directly to the client the trainee is treating but to another interested party such as a family member or health professional.

I did not attempt a more substantive theoretical analysis of the problems with which the supervisees in this study sought help, as this was not the primary focus of the research. However I did undertake a literature search to try and discover if any comparable survey of "what psychologists choose to bring to clinical supervision" had been undertaken. I could find no published studies concerning trainee clinical psychologists but Davis and colleagues (Davis J. et al., 1987) report a provisional taxonomy of therapist difficulties based on the problems a small group of experienced qualified clinical psychologists confronted in their own practice. Of the 9 categories that Davis and his colleagues identified 5 have recognizable overlaps with the classification system I constructed viz

1. Therapist feels incompetent (comparable with trainee's understanding).
2. Therapist feels puzzled about how best to proceed (comparable to trainee uncertainty).

3. Therapist's personal issues (overlaps with trainee's emotional state particularly a sense of over-involvement in a case).
4. Therapist faces an ethical dilemma (direct equivalence).
5. Therapist stuck in a therapeutic impasse (direct equivalence).

Although there appears to be very little extant research on the difficulties for which clinical psychologists seek external help, the consistencies between Davis' findings and my own codings suggest that the trainees in this study were bringing problems to their supervisors that are inherent in the professional practice of psychological therapy, and are hence perhaps typical of the range of the issues clinicians at all levels of experience might raise in supervision.

One of the reflections with which Davis and his colleagues conclude their research account, also has potential relevance to the current study. When comparing their experiences the 7 investigators in the study noted they all seemed to have idiosyncratic but apparently stable biases about what categories of therapist difficulty they were each most likely to report. If experienced psychologists find themselves habitually getting into the same sort of trouble, novice therapists may also find themselves repeatedly confronted with the same recurrent difficulties during their training. Since there is suggestive evidence (Tracey et al., 1989) that some styles of supervision are better suited than others to the resolution of particular difficulties, (for example direct advice is valued when urgent action by the therapist is needed), it may be important for the generalizability of investigations into supervisor competences that data describing problems presented by supervisees are incorporated in research reports.

PROBLEM BROUGHT TO SUPERVISION

TRAINEE'S EMOTIONAL STATE

Anxiety
Fed-up
Too close

TRAINEE'S UNDERSTANDING

Don't know
Struggle

CONTENT

Ethical dilemma
Supervision
Child abuse

CRITICAL POINT IN THERAPY

Crisis
Stuck

UNCERTAINTY

Past
Future

INTERESTED PARTIES

Other professions
Wider family
Other

NO PROBLEM

Outcome

Evaluating the outcome of supervisory interventions is a complex business. The most convincing evidence available to support the adoption of a particular 'modus operandi' in supervision would be the demonstration that specific supervisor behaviours towards the supervisee were associated with improved clinical outcomes for the supervisee's clients. No such body of evidence currently exists (Neufeldt S.A. et al., 1997), primarily because there are so many other intervening variables - trainee characteristics, patient characteristics, efficacy of therapy employed to name but three - between the supervisory exchange and the anticipated therapeutic benefit that a clear causal link is hard to establish (Holloway E.L. 1984).

However there is an acknowledgement in the supervision literature that supervisors have a responsibility to protect their supervisees' clients from avoidable harm (Holloway E.L. & Neufeldt S.A., 1995).

The focus of evaluation in this study has been the conduct of the supervisor as judged by the person being supervised. It could hence be reasonably characterized as a survey of "consumer satisfaction". There is an implicit, and suspect, logic in the choice of this outcome measure which runs along the following lines: "a contented trainee will learn better and become a more skilful clinician with resultant therapeutic benefits for his or her clients". Of course beginners may well not have the experience to differentiate between what they need and what they like from supervisors (Holloway E.L. & Neufeldt S.A., 1995). Maybe "feel good" factors in supervision have a significant influence on how trainees construe their supervisors but do not have a recognizable impact on the trainee's performance in his or her therapeutic role?

In order to explore this issue further I conducted a simple classification of the 'Outcome' section of each of the critical incident reports by asking the question "Who was identified as the primary beneficiary of the supervisory episode described?" I constructed four categories of outcome:

1. **The trainee benefited.** For example in incident 070 the trainee described a timely opportunity to de-brief after a personally harrowing consultation with a bereaved client.

"Thanks to my supervisor making time and considering the effects that this session might have on me, I was able to spend 10 to 15 minutes talking about what had happened and how I felt. Following this I felt 'unburdened' and much happier."

2. **The trainee and their client benefited.** For example in incident 011 (see earlier in this chapter) the trainee explained how a detailed demonstration by her supervisor of how she might discuss intimate sexual material with a client, resulted in "a beneficial progress for the client".

"The next session I took the 'bull by the horns', ensured the client felt comfortable and followed the protocol given me by my supervisor, particularly tips on how to broach difficult subjects. I felt much more confident in my own competence and my client visibly relaxed during the session as I 'modelled' how to discuss intimate problems in a reassuring but matter-of-fact way."

- 3 **The client benefited.** For example in incident 097 the trainee reported the consequences of using supervision to work out a complex formulation of why a diabetic client regularly became unwell at times of personal crisis.

“Able to present the revised procedural model to patient incorporating responses to crises. Actions/procedures described make sense and had meaning to patient. Next crisis - the patient did not stop insulin injections.”

4. **Someone other than the trainee or their client benefited.** For example in incident 023 the trainee related how the supervisor’s endorsement of a particular piece of therapeutic work conducted by the trainee, allowed him to face the criticism of a client’s relative.

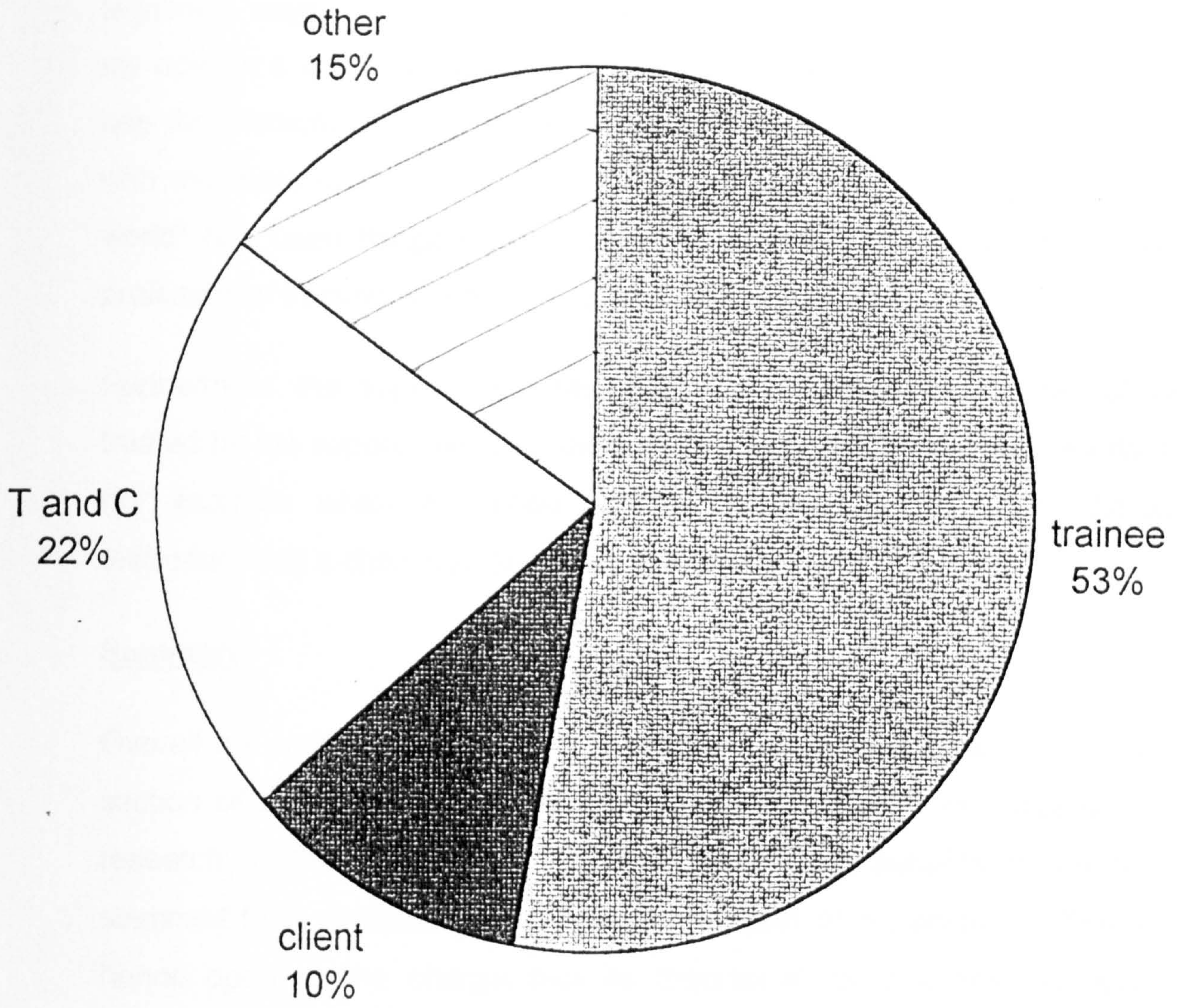
“This led to a very constructive discussion with the sister which hopefully was of benefit to my client and the sister and allowed me to leave the placement without a cloud.”

Other beneficiaries of supervision identified in this category were fellow healthcare professionals and the supervisor him/herself.

Rather than attempt an in-depth qualitative analysis of the information provided in the outcome section of the critical incident reports, I have decided to summarize my findings quantitatively (See figure 7) and illustrate how frequently I allocated each of the four codes viz ‘trainee’, ‘trainee and client (T and C)’, ‘client’, and ‘other’.

As the pie chart makes clear over half the critical incidents had a reported outcome in which the trainees themselves were the primary beneficiaries of the supervision episode described. In these instances there was no explicit mention of the mechanism by which the advantage felt by the supervisee was passed on to their clients, indeed in one report (Incident No 65) the trainee candidly confessed that while he had found the supervisor’s ideas very helpful they had done no good whatsoever for his client!

Figure 7: Beneficiaries of Supervision



However if the 'client' and 'T and C' categories are combined a third of all the incidents reported made mention of some specific benefit that the client derived from the cited supervisory episode. This suggests that in a significant proportion of cases trainees chose to report experiences in supervision that not only helped them but also helped them to help their clients.

The 11% of reports in which someone other than the trainee or his/her client has been identified as being the primary beneficiary is a reminder of the many legitimate ways in which the outcomes of supervision might be measured. In my opinion it is entirely appropriate that a trainee clinical psychologist should use the medium of supervision to consider tensions in working relationships with members of other disciplines. Indeed successful coping with the "staff world" has been flagged as a core competence to be targeted during their professional training (Green D.R. et al., 1994).

Furthermore the supervisor's responsibility to ensure the safety of clients treated by the supervisee, also extends to other members of the clients' family (for example when a trainee reports concerns arising from therapeutic disclosure that a child may be at risk of abuse).

Summary

Overall the somewhat superficial analysis of the data provided in the outcome section of the critical incident reports has, in common with nearly all other research in the field, failed to trace therapeutic benefits to patients that stemmed from particular behaviours on the part of supervisors. The study is hence open to the charge that its theoretical formulations are essentially founded on a survey of supervisee satisfaction. However a significant minority of reports described occasions when what happened in supervision had led ultimately to an improved therapeutic consequence for clients.

Finally the 'other' category constructed in the analysis suggested that outcome measures in supervision research should not focus exclusively on the supervisee and his/her client but also include a range of other possible beneficiaries of good supervisory practice.

Chapter 4

Interpersonal Process Recall

Interpersonal Process Recall (IPR) is a vehicle for systematically reflecting on private experience using the prompt of video-tape (or sometimes audiotape) recordings of events in which an individual has participated. The method was serendipitously discovered by Kagan (Kagan H & Kagan N., 1997) when as a junior university staff member he had the responsibility of making recordings of lectures delivered by visiting “star” speakers. Kagan noted that when reviewing the video-tape recordings of their talks, lecturers would spontaneously remark on the inner dialogue that had associated their public performance, for example, when commenting that they had experienced a sense of elation if a joke had gone down well with the audience. Kagan developed this insight into a systematic training procedure that has been employed in a wide range of educational settings from counselling courses to the US army (McQuellon R.P. 1982). It has been argued that while the use of audiotape in clinical supervision is well-established (Aveline M. 1997), the structured use of videotape review and prescribed role of the facilitator recommended by Kagan, offer an especially fruitful route for exploring the trainee’s experience of therapy within clinical supervision (Clarke P. 1997). Kagan’s ideas have also been employed by psychotherapy researchers wanting to find a quick and effective way of prompting clients’ recall of particularly helpful episodes in their treatment (Elliott R. & Shapiro D.A., 1988).

I chose to use a variant on the IPR approach in this research project for two primary reasons:

1. The method has an established research pedigree and pertinence to the field of clinical supervision.

2. The moment-by-moment analysis of interactions between supervisor and supervisee provided by the IPR technique complements the critical incident approach which invited trainees to report remarkable incidents that had “stood out” in their experience of a whole clinical placement. This microscopic study of supervisory exchanges might provide evidence on the minutiae of effective practice that the critical incident vignettes could not capture. This rationale would be termed “theoretical sampling” by the originators of grounded theory (Glaser B. & Strauss A., 1968).

Method

After two pilot interviews in which I experimented with alternative instructions and recording methods, I decided upon the following procedure for this phase of the research programme:

1. Trainee and supervisor were invited to make a video-tape recording of one of their supervision sessions (see participants section).
2. A second copy of this tape was made displaying a running timer on the screen.
3. The supervisee was invited to replay the tape and stop the action at any point at which they recalled their supervisor’s behaviour as having been helpful.
4. Having stopped the tape, the trainee was asked to comment on their experience at that moment and explain what they had appreciated about the supervisor’s conduct. Each comment was prefaced by a “time-check”, and recorded on a hand-held dictaphone.
5. I was present throughout this exercise but played a less active part as facilitator than that described in usual IPR practice (Clarke P. 1997), restricting myself to occasional prompts when I could not clearly grasp what the trainee was getting at.

A full transcript of one of the IPR commentaries can be found in the appendix.

Participants

I wrote to ask all trainee/supervisor pairings over a six month period if they would be prepared to record one of their supervision sessions for use in this aspect of the research programme. One pair politely refused - some evidence at least that informed consent had been obtained from other potential participants. From the available subjects I selected seven supervisory pairings who would actually make and review recordings.

See the following table:

Table 1:

No	Year of Training	Gender		Speciality	Length of Tape	Number of Comments
		Trainee	Supervisor			
1	1	F	M	ADULT	60 mins	26
2	1	F	F	CHILD	80 mins	22
3	3	M	F	CHILD	60 mins	19
4	2	M	F	ELDERLY	90 mins	22
5	3	F	F	ADULT	30 mins	24
6	2	M	F	LEARNING DIFFICULTIES	63 mins	20
7	3	M	F	NEURO- PSYCHOLOGY	65 mins	19

The period of tape reviewed ranged from recorded ranged from 19 to 26 with an average of 21.7 remarks per participant. Although local availability evidently played a part in my choice of subjects 30 to 90 minutes with a mean duration of 64 minutes. The number of comments, the pairings selected follow a "purposive sampling" strategy (Cohen L. & Mannion L., 1994) in that:

1. All three years of training are represented.
2. All core placement specialities plus neuropsychology are included.

3. 4 of the 7 trainees who participated were male, thus compensating somewhat for the under-representation of the experience of male supervisees reported in the critical incidents survey.

As data is also available on the gender of the supervisor for this component of the project, I have inserted that information in table 1 to aid readers' interpretation of the results to be presented. Though a number of studies have tested predictions concerning the different dynamics in matched or unmatched gender pairings in supervision no convincing conclusions can be drawn from the research literature (Ellis M.V & Ladany N., 1997). Overall the findings suggest that gender differences exist in supervision but that "they are subtle and highly complex" (Nelson M. & Holloway E., 1990). It seems fitting therefore to let the reader make up his or her own mind as to how much weight to allocate to the information provided on the gender of supervisor and supervisee in their understanding of the IPR analysis.

Analysis

The coding of the commentary given by the 7 trainees when reviewing the videotapes went through the following stages:

1. The audiotapes used in the dictaphone were professionally transcribed.
2. I reviewed each videotape and stopped it at the appropriate moment to listen to the linked commentary provided by the supervisee.
3. I checked the transcript for accuracy and wrote provisional codings and notes on the printed copy from which I was working.
4. On completion of the analysis of the series of videotapes I imported the transcripts into the NUD*IST programme and coded all the text, creating new codes where appropriate.

5. I wrote a memo summarizing my reflections on each videotape and commentary which was attached to the relevant document in the NUD*IST index system (see full example in appendix).
6. On completion of all the analyses I wrote a further memo reflecting on the evidence provided by the IPR exercise as a whole.

Results

In analysing the data provided in the trainees' commentaries on the videotapes I found the theoretical model I had constructed from coding the critical incident reports was both confirmed and extended in significant ways.

Experiential Learning Cycle

During the supervision discussions portrayed on the tape there were several clear examples (VTRs 1, 3, and 6) where the sequences of the experiential learning cycle (problem definition, consideration, theory, action plan) were played out in conversations about individual clients. My memo concerning VTR 1 (see appendix) contains the observation that:

"there are clear indications of all phases of the learning cycle being employed within the discussion of a single case. Also the supervisor is commended for offering a summary of his/her understanding on several occasions."

An example of a timely summary is noted 17 minutes into the tape at which point the trainee remarks:

“G is summarizing our joint understanding of the client following the completion of the second round of questionnaires and again helping me think more objectively and coming out of the detail of the questionnaires and thinking more globally about what overall that means for her and how she’s changed.”

Although in this instance the supervisor’s summary has prompted the trainee to step-back and reflect on some pertinent clinical information, in another tape (VTR 3) the supervisor’s summary precedes an important theoretical realization that “you can’t win them all”, and in a third tape (VTR 6) the supervisor reviews the course that the supervisory discussion has taken before advising the trainee takes a specific course of action viz. breaking client confidentiality. The function served by summarizing hence seems to be to set the scene for a timely shift to another phase of the learning cycle, rather than belonging under a particular category such as consideration.

However I did create three new codes which I was able to subsume within the existing structure of the experiential learning cycle. “Clarify” falls straightforwardly within the problem definition category. Two new codes “history” and “diagnosis” were developed in the analysis of VTR 7. This supervisory session took place on a neuropsychology placement and includes the discussion of a client who may be suffering from a form of dementia. So although matters of health history and diagnosis of disease are usually considered characteristic of a medical model of understanding individuals in distress, in this instance they play a significant part in the theoretical formulations of a clinical psychologist.

Sapiential Authority

The trainees who observed tapes of their supervisors in action commented appreciatively on behaviours identified under the sapiential authority grouping of codes. They noted for example when a supervisor shared useful local knowledge about the professional network, or demonstrated technical competence, or was able to convincingly endorse a course of action the trainee had followed.

I also created three further codes that I incorporated under the sapiential authority category. Two tapes (VTRs 4 and 5) prompted the trainees to remark how much they valued their supervisors applying their therapeutic skills to the task of supervision. Since there are ethical and practical dangers of confusing the roles of supervisor and therapist (Russell R.K & Petrie T., 1994) and “being treated like a patient” is a frequently reported complaint of supervisees’ training in the mental health field (Rosenblatt A & Mayeer J.E., 1975) it is important to understand how the supervisors in these two tapes managed to use their clinical skills to their trainees’ evident advantage. In VTR 4 supervision focuses on the treatment of an elderly man, and the supervisor enquires of the trainee whether working with clients of this age has got him thinking about time passing in his own life. The supervisee comments at 28-29 minutes into the tape:

“ It was good that S was able to raise that issue, just a personal feeling. It was there or thereabouts and I wasn’t sure whether it was even appropriate or whatever to be talking about it at that time and she made that possible.”

Five minutes further into the tape the supervisory discussion has led to the recognition that the client the trainee is seeing is the same age as his own father. The trainee’s comment is self-explanatory:

“Bingo! in terms of what was underlying here. One of the issues and it was good to be able to talk.”

As part of an overall reflection on VTR 5 the trainee comments how she considers it has been entirely appropriate and helpful to be challenged about her assumptions by a supervisor applying the principles of cognitive therapy.

“using therapy techniques but not being theraped, not being treated like a school child or anything but like a supervisee. Good!”

This evidence persuaded me to add “therapist” to the “Special Knowledge” sub-group in the Sapiential Authority cluster of codes.

The two other extra codes I created classified supervisor behaviours as displaying “concern for client welfare” (as in taking detailed notes to ensure continuity of care when taking over a case from the trainee at the end of the placement in VTR 1) and showing “concern for trainee welfare” (as in enquiring how the trainee is progressing with other course work in VTR 5). I chose to group these 2 new codes along with the code “responsibility” identified in the critical incidents analysis under a new sub-category entitled “integrity”, to indicate how these behaviours enhance the supervisors’ moral authority.

Relationship Factors

As a result of analysing the 7 trainee commentaries on the supervision they reviewed on videotape, I developed a total of 10 new codes within the relationship factors category.

This greater articulation of the importance of the supervisory alliance stemmed from the way videotape recording revealed the quality of the interplay between the two parties and, in particular, the potency of the supervisor’s non-verbal behaviour in establishing an emotional climate that was conducive to learning.

Two of the new codes – “encourage” and “collaborate” – were classified under the attitude heading as they characterized the approach the supervisor adopted towards the supervisee. I placed two other new codes – “negotiate” and “expectations” in the structure sub-category as I considered they described organizational components of the supervisory relationship. “Wavelength” – when the supervisor was commended for being astutely ‘tuned into’ the trainee’s concerns – belonged with the sensitivity group of codes. The final five new codes – “relaxed”, “fun”, “careful”, “business”, and “permission” – I subsumed under the sub-category describing the interpersonal climate established within supervision. The videotapes regularly displayed humorous and enjoyable exchanges between supervisor and supervisee for example in VTR 3 from a child placement a plastic gun in the playroom was used as a stage prop by the supervisor who reminded the trainee:

“Ve have vays of making you talk. Ve have vays of making you vork!”

The funny side of supervision was explicitly mentioned by 4 of the 7 trainees who reviewed videotapes. Each however portrayed humour as making a positive contribution to the work of supervision rather than as a playful distraction from the task at hand. For example in VTR 6 some 18 minutes into the tape the trainee remarked:

“P has a particularly dry sense of humour. And I know she gets some of her points over very effectively with her humour, and I know it not only lends an enjoyment to the sessions but I actually found it very useful.”

In reviewing VTR 4 the trainee recalled how “jokes were shared throughout supervision” and contributed towards the easy confidence he had in his supervisor:

"I guess in the relationship between supervisor and supervisee I, certainly in supervision with K, always felt able to say what I wanted to say. I guess humour is part of developing that relationship."

The fun element of successful supervisory relationships was balanced in the exchanges portrayed in these videotapes by a professionalism and attention to detail that was respected by the trainees. For example in VTR 5 the trainee appreciated the business-like and thorough attitude her supervisor adopted towards the completion of her placement appraisal:

"That bit of conversation was about her being able to fill in the form on time today and having time to go through it with me. It wasn't just handing it straight back to my tray."

In making a general comment after having reviewed VTR 2 the trainee explicitly described how important it had been to balance the "business and pleasure" aspects of the supervisory relationship.

" A sort of common theme throughout supervision and throughout the relationship with J was the ability to keep boundaries ie could be friends and supervisor/trainee as well and I think that kind of oiled the wheels really quite a bit."

The last new code introduced into the climate sub-category at this stage in the data analysis was "permission" and described the circumstances under which the trainee felt enabled to take risks in supervision.

For example my memo concerning VTR 4 in which the trainee discussed the personal feelings triggered by working with an elderly client noted:

"...the supervisor is clearly well tuned into the trainee's emotional reactions and the trainee feels both given permission to explore these more personal areas and that it is safe to do so. Again much of the quality of the relationship is conveyed in non-verbal terms – acknowledgement, encouragement etc."

Timing

Prior to the analysis of the IPR data I had developed a rudimentary notion that effective supervisors had the capacity to "say the right thing at the right time" by matching their interventions to the particular characteristics and level of training of individual supervisees. The minute-to-minute commentary provided by the trainees as they reviewed the videotapes demonstrated what precise and sophisticated skill this requires in the free-flow of supervisory discussion. For example in VTR 1, within the space of less than 5 minutes the trainee commends her supervisor for first interrupting, then not interrupting, her

2.12 "G interrupted my flow to ask questions which is useful because otherwise I would tend to just talk and talk."

5.52 "I've been talking for some time about a session that happened that morning. G's not interrupting he's just letting me recount what happened, which I think I find helpful because by talking through what happened it's reminding me of the key things that I want to pick out..."

My comment in the memo written concerning VTR 6 also describes a sequence of events when two apparently incompatible supervisor behaviours are both endorsed in close succession:

"....the importance of saying the right thing at the right time is elegantly illustrated when the supervisor is commended at 19.20 for not taking an inappropriate "you should do this, you should do that" approach but when at 51.20 she gives the trainee unambiguous directions on how to proceed he says "this made my day". In context this is not at all contradictory. Problem resolution needed to be preceded by opportunity to reflect and theoretically analyse".

Evidently the judgement exercised by supervisors in these two discussions is not informed by a simple "beginners need structure" developmental model of the needs of supervisees. All three of the supervisees in the final year of their training (VTR 3, 5, and 7) reviewed sections of videotape where they expressly appreciated being given instructions by their supervisor. In contrast in VTR 2 a first year trainee applauded her supervisor for

"....not sort of pre-empting me and sort of moving in there and saying well I think you ought to do such and such."

During the course of a single supervision session supervisors made minutely timed adjustments to their educative style, as the trainee looking back on VTR 4 explained:

"....it's non-directive flavour at certain points on the tape where it was needed just to be able to explore the detail in a particular case. Other times it was that the support, the supervision was quite prescriptive, and again it was in a particular context with a particular case and was very much appreciated by me at the time."

The subtlety and almost instantaneous judgement displayed by supervisors in deciding when to make their interventions in these videotapes led me to construct a new sub-category within the TIMING tree that I entitled MOMENT and within which I created the new codes of “interrupt”, “wait”, and “pace”. I also elected to place the newly developed code of “summarize” in this sub-category as I became convinced that when supervisors helpfully summed-up on these videotapes they delivered their interventions in a timely manner that promoted learning. Overall the IPR exercise underlined the importance of conditional knowledge (Alexander P & Judy J., 1988), that is to say an awareness of when to intervene in a particular way, in the skilled performance of clinical supervisors.

Summary

A synopsis of the results of this component of the research programme is provided by the a) memo 4 which I wrote on completion of this phase of the data analysis; and b) a list of the new codes (figure 8) introduced to the initial theoretical model described in Chapter 3.

Memo 4:

MEMO ON IPR/VTR EXERCISE

The analysis of trainees' commentaries on their own supervision sessions both confirmed and extended the theoretical model developed on the basis of the Critical Incident data. All segments of the **experiential learning** cycle are coded and several sequences depict a discussion proceeding through separate stages in the manner predicted by the model. Supervisors' **authority** is recognized in several forms (local knowledge, and technical competence for example). New codings are used to describe the skilled application of therapist's skills in supervision, and the respect that is engendered when supervisors display moral integrity in their concern for both their clients and their trainees.

The **relationship** codes are very frequently used and 10 new codes developed. The video-recording allows the observer to appreciate the importance of non-verbal communication in conveying particular attitudes (eg encourage) and establishing a facilitative climate (eg relaxed). Also an optimal balance between cordiality and business-like attention to task is noted.

The moment-by-moment analysis afforded by video replay captures the subtlety of the **timing** of effective interventions in supervision. Within a matter of minutes a supervisor is commended for interrupting then waiting; or for not telling the trainee what to do then giving unambiguous directions. In context these sequences are not in the least contradictory. Again the pattern of communication can be seen as consistent with the experiential learning cycle. Another new code "summarize" is included under the heading of timing because timely summarizing by supervisors seems to occur at different stages of the learning cycle and form the basis for further reflection or a transition to the next problem-solving stage.

It seems knowing when to is as important as knowing how to.

Additions to the Coding System after the IPR Analysis

a) Experiential Learning

probdef -

clarify

theory -

history

diagnosis

b) Relationship Factors

attitude –

encourage

collaborate

sensitivity -

wavelength

structure –

negotiate

expectations

climate –

relaxed

fun

careful

business

permission

c) Sapiential Authority

feedback –

monitor

specknow –

therapist

integrity -

client welfare

trainee welfare

d) Timing

interrupt

wait

pace

summarize

Chapter 5

Focus Groups

Focus Group Interviews

The final sets of qualitative data collected in this research programme came from two Focus Group discussions in which clinical psychology students nearing the completion of their professional training were asked to reflect on their worst experiences in supervision.

Focus Groups

The Focus Group approach was initially developed in the field of communication studies as a way of conducting market research into viewers' perceptions of films and TV programmes. The method has subsequently been employed to research subjective attitudes and experiences within educational and health service settings (Kitzinger J, 1995).

The essence of the Focus Group is that a small group of individuals (perhaps up to a maximum of 10) are selected on the basis of some common experience of the phenomenon under investigation, and invited to participate in a free-flowing discussion. A facilitator, or "moderator" as the role is sometimes termed (Krueger R. 1988), keeps the group broadly to task (ie retains its focus) but does not seek to control the flow of conversation as the method aims to stimulate the sort of informal discussion that occurs when people get together to exchange experiences with each other. So unlike the considered reflective views tapped by a method like critical incidents analysis, the data from Focus Groups is more spontaneously produced and might include jokes, stories and disagreements.

The arguments in favour of Focus Groups are firstly pragmatic. This is a cheap, quick way of collecting qualitative data from several research participants all in one go. However the method also benefits from the different dynamic that operates when individuals talk in groups as opposed to pairs. In particular it has been suggested that membership of a group empowers individuals to assert themselves (Hagan T & Smail D., 1997) and hence be more likely to voice critical comments than if interviewed alone (Kitzinger J, 1995). The "light touch" approach of the group facilitator means both that discussion can rapidly take unanticipated and interesting turns but also that the researcher can probe and seek clarification from group members to ensure that he or she understands the points being made.

I decided to use Focus Group discussions concerning trainees' unhelpful experiences in supervision as the third leg in a triangulated strategy of data collection because:

1. A large-scale survey of pressures experienced by British clinical psychologist trainees identified difficulties experienced in supervision as "the single most frequent stressor" reported (Cushway D. 1992). A subsequent survey of trainee clinical psychologists in the UK (Kuyken W. 1997) has suggested that as a group these students do not suffer unusually high levels of distress and that supervisors can function as sources of support as well as stress in trainees' professional lives. Nonetheless there was enough research and anecdotal evidence to convince me that a significant minority of trainees at Leeds were likely to have encountered some problems in their relationships with clinical supervisors at some time over a three year period.
2. Focus Groups have been successfully employed as a vehicle for post-hoc evaluation of educational programmes (Krueger R. 1988).

3. The “elaboration of complaint” is an excellent clinical interviewing tool for eliciting important personal constructs (Kelly G, 1955).
4. Although tape-recordings of spontaneous group discussions are more difficult to transcribe accurately than the dictated commentaries provided by individual trainees in the IPR exercise, their reliability and validity have been reasonably established in published research (Perakyla A. 1997).
5. The Focus Group interviews complemented the other two sources of data tapped in the research programme (Critical Incidents reports and IPR commentaries on videotapes of supervision sessions) in their emphasis on experiences of ineffective supervision, and the different social context in which discussions took place (ie large group, face-to-face discussion).

I was nonetheless aware that the approach has its limitations (Krueger R. 1988) and anticipated that the trainees would participate unequally in the group discussion which might become dominated by the views of an expressive minority. I was also concerned that important experiences might not be related in the group unless an appropriate conversational opening allowed a topic to be raised. Participants might find it hard to highlight an issue that did not “go with the flow” of the prevailing discussion.

Participants

I held two Focus Group discussions, one a year after the other. In the last month of their training the whole group of year 3 finalists were invited to take part in a free-ranging group discussion of their worst experiences in clinical supervision. I explained the purpose of the group, and its place in the research programme, and gave assurances about the confidentiality with which the data would be treated. All trainees in the final year group were invited to join the Focus Group discussion: Participation rates were:

Group 1	10 out of a possible 12 attended	83%
Group 2	8 out of a possible 12 attended	66%

Interestingly male trainees contributed more willingly to this component of the research programme than they had in the critical incident reporting phase. 3 out of the 10 participants in Focus Group 1 were male as were 3 of the participants in Focus Group 2. Hence a third of the participants in the Focus Groups were male while men represented only a quarter of the trainee sample overall. All participants spoke in the group they attended but, as anticipated, the range of contributions to the discussion varied considerably. A section of the transcript of Focus Group 1 is reproduced in the appendix to give the reader a sample of both the conversational pattern of the group and the role played by the facilitator. Sometimes participants recalled specific episodes in detail, while on other occasions they commented on the general characteristics of supervisors and supervision they considered to have been unsatisfactory.

Analysis

The process of analysis used to interpret the Focus Group data closely followed that employed in the two earlier stages of the research. First the discussion was audiotaped. Next an audio-typist transcribed the conversation. This task was very demanding as there were up to 11 different voices recorded frequently speaking across each other. I therefore closely checked the written typescript against the audiotape recordings to create as accurate a record as possible. Nonetheless, occasional conversational snatches were lost to the analysis.

I then coded the written text by hand and finally introduced the analysed data set into the NUD*IST computer programme:

Results

I found that the majority of supervisor behaviours cited as unhelpful during the Focus Group discussions could be linked with the categories of good practice constructed earlier in the study. This experience matches the reports of researchers who analysed reports of critical incidents describing good and bad episodes in supervision (Williams P. Webb C., 1994; Hitchen H. et al., 1997).

I chose therefore to code the majority of the critical remarks from the Focus Groups as “threats” to one of the four major theoretical categories of effective supervisor behaviour previously identified in the research programme.

Threats to Experiential Learning

Trainees in both Focus Groups remarked on the frustration they felt at not having been able to reflect on their clinical work in supervision so as to maximize their learning. In Focus Group 1 a trainee described his experience on one placement as “you just get case management” explaining that discussions with his supervisor never went beyond “this is what’s happened since we last met” reporting back.

When a supervisor failed to take a lead in helping the trainee make sense of their experiences in therapy, the supervisee in turn tended not to open up much so that potentially fruitful routes of exploration were blocked off. For example a trainee in Focus Group 2 referring to her attempts to use supervision to understand and use her own emotional reactions in therapy said:

“Its very tricky when you are exploring this way of working it can be very difficult to talk about various issues if you are not getting any feedback from your supervisor.”

The complaint that some supervisors had failed to provide useful feedback in response to trainees’ description of their work was echoed in both Focus Groups. From Focus Group 1:

"I don't like the sort of supervision where you go and talk about your case and the supervisor says 'Yeah, that sounds great!' "

This remark prompted a loud outburst of laughter from other group members implying not only that the speaker told a good tale but that she also was describing a common experience.

Although the provision of feedback, both positive and critical, falls under the sapiential authority rubric of the theoretical model, I have coded these behaviours as threats to experiential learning as opportunities to increase understanding have been lost because of the supervisor's failure to respond in what the trainee experienced as a facilitative manner. On another occasion a trainee reported that she felt she had been "overloaded with interesting cases" but had not had the chance to gain maximum benefit from her experience because of limited discussion opportunity in supervision. Under such circumstances even the most intriguing therapeutic casework is probably more appropriately construed as exposure rather than experience.

Threats to the Supervisory Relationship

Discussions in the Focus Group illustrated ways in which all four categories of relationship factors identified in the theoretical model of effective supervision could be undermined.

In terms of supervisor's attitude one trainee considered her concerns "were not taken seriously" by her supervisor. Another reported having started a placement "but when I got there it was made very clear....in a way I hadn't been wanted."

In Focus Group 1 another trainee recalled how when her own energy levels were low, she would have welcomed an encouraging stimulus from her supervisor - which she had not received:

"I think when you're training, if you're struggling a bit and it's all getting a bit much for you, you need enthusiasm."

I found reports of unhelpful self-disclosure by supervisors the most unexpected examples of insensitivity in the supervisory relationship. In both the critical incident reports and the IPR commentaries trainees had endorsed self-disclosure by their supervisors as very helpful in for example normalizing their own experience or providing case-material to illustrate a particular educational point. In contrast a trainee in Focus Group 2 recalled a first conversation with a supervisor when:

"within half-an-hour I knew about problems in their marital status, where they were coming from, previous life-events, and siblings' careers."

She described this initiation as "getting off on the wrong foot." Another trainee in the group further explained how this form of intimate disclosure on the part of the supervisor could have an adverse effect on the developing relationship with the trainee:

"She was quite open about herself personally, partly because she's had to be, but then it's sometimes made me a bit protective. Thought I don't know if I want to discuss this case with her because that would be taping right into her own issues...."

The implication of these views is that when a supervisor's motive for revealing personal information to a trainee is essentially for their own benefit, for example, as an act of emotional ventilation, the trainee may experience the disclosure as insensitive and unhelpful. In contrast if, as in successful therapist self-disclosure in long-term psychotherapy (Knox S. et al., 1997), the trainee discerns from the timing and nature of the supervisor's revelations that their purpose is to be helpful to their supervisee, the experience is likely to be evaluated positively.

A comparison can be made with research into adolescents' experience of self-disclosure by their parents (Dolgin K. & Berndt N., 1997). While most parental confessions tend to be relationship-enhancing, it appears that adolescents are likely to feel overwhelmed when a parent emotionally "unloads" on them, and at a loss as to how to respond appropriately.

The complaints about inadequate organization on the supervisor's part mapped straightforwardly onto the categories of good practice classified under the "structure" codes of the relationship factors "tree" in the theoretical model. Where preparation and focus on the task of supervision had been commended in the critical incident reports and IPR commentaries, trainees in the Focus Group recalled occasions when supervisors failed to organize supervision sessions effectively. For example in Focus Group 2 a trainee remarked in response to another group member's recollections:

"Yes, the last minute cancellation, or the last minute overlooking - that's happened and that.....said something about not being taken seriously."

In both groups trainees discussed how they might themselves take pre-emptive action to fill the organizational void if supervisors did not themselves provide the necessary structure on a placement. An example in focus group 1:

"I've had supervision where, you know, I'm more or less responsible for what's on the agenda and you learn to use that, you know."

The recurrent message about the inter-personal climate of supervision expressed in both groups was how destructive a sense of insecurity in the relationship was to trainees' learning. In Focus Group 1 a trainee recalled a specific incident when she felt she had acted in good faith on a supervisor's instructions, only to be told subsequently "what on earth are you doing that for." Her immediate reaction was:

“I just felt utterly...really felt that my trust had been betrayed.”

This painful misunderstanding subsequently soured the whole placement leading the trainee to reflect:

“I think that really brought home to me the issue of needing to trust your supervisor, because I didn’t then and that was very early on and after that it was very, very hard because I didn’t feel I could take things to her.”

Two trainees in Focus Group 1 linked not feeling safe in supervision with an uncomfortable awareness of the power their supervisors could exercise over their future through their evaluative role. As one remarked:

“A lot of supervisors don’t really realize how much power they have.”

This awareness of the potential misuse of supervisors’ power over their supervisees has been echoed in a recent BPS survey of trainee clinical psychologists in the UK (Lewis N. 1997).

A trainee in Focus Group 2 attempted to sum up some of the difficulties she and her colleagues had sometimes experienced in relating to their supervisors as follows:

“Just sounds like there’s a general theme throughout by just not being able to communicate with the supervisor, either the supervisor can’t communicate to you what they want or can’t argue and there’s no discussion either way. So there’s no relationship where people discuss their ideas and come to an agreement. There’s no space for that.”

Threats to the Sapiential Authority

The two main threats to the supervisors' authority I identified from analysis of the Focus Group data stemmed from the trainees' lack of respect for the particular supervisor's competence or professional integrity.

Comments concerning a supervisor's competence were focused on both their clinical and supervisory abilities. For example in Focus Group 1 a trainee expressed her doubts about a supervisor's clinical skills:

"...I felt that she sometimes made it up with patients basically."

Another trainee in the same group recalled his concern that a supervisor was not monitoring his caseload appropriately

"My supervisor didn't know I had discharged some of my patients."

The discussion in this group led to consideration of whether ineffective supervisors were less likely to be active in pursuing their own continued professional development

"I think I've had more problems with supervisors who are not in supervision of some kind themselves, than I have with supervisors who are."

In Focus Group 2 two contrasting remarks from different trainees illustrated how special knowledge possessed by the supervisor can fail to be usefully conveyed to the supervisee.

The first trainee expressed disappointment that a supervisor had "backed down too easily" after suggesting an amendment to a letter he'd written:

"I felt either you've got a really good point and I've not understood it or you're not really sure about what you're meaning."

And either way erm, I'd rather you say very clearly this is what I think, and...and we had a discussion about it."

Taking an entirely different tack, a second trainee reflected:

"I think one thing that I haven't found that helpful with a good supervisor was, and I know that I would contribute to that by feeling very unconfident, but a supervisor taking on a kind of expert role."

Reading these seemingly contradictory accounts it is hard not to sympathize with the well-meaning supervisors and conclude that "the trainer's road to hell is paved with good intentions" (Main T, 1967). On reflection these instances could also be construed as examples of supervisory mismatches (see later discussion in this chapter).

A graphic illustration of the way in which a trainee's appraisal of a supervisor's professional integrity can undermine the placement entirely was provided later in Focus Group 2: -

"I think I needed someone to tell me what to do on the first placement but I didn't actually respect the person who was doing the telling...it was a weird placement in that he used to be very personal about things and always commenting on things like my appearance and quite sort of sexual connotations quite often and also with clients....so that I didn't respect what he was trying to get me to do in sessions."

When a supervisor's moral and sapiential authority has been compromised to this extent, their capacity to deliver convincing feedback on the trainee's performance and credibility as an expert therapist are completely undermined.

Problems of Timing

In common with other reports of unhelpful experiences in supervision (Hirons A. 1991) trainees in both Focus Groups recalled moments of frustration at not feeling there was enough time available for what needed to be discussed.

This might be simply because the supervisor was not available, as one trainee reminisced in Focus Group 1:

“I had a supervisor very similar...he used to get into supervision sessions and he was, very much like you talked about, reviewing cases etc and half-way through a sentence he’d say ‘Got to go’, and I used to say ‘Alright then, bye’.”

This story prompted an outburst of explosive laughter which I attributed partly to the raconteur’s skill and partly to the way this slightly comical vignette encapsulated trainee’s concerns that other people sometimes seemed to take precedence in their demands on their supervisors’ time.

Another source of frustration described in Focus Group 1 was the misuse of the time that was available in supervision:

For example:

“I’ve also found it difficult when...if the supervisor wants to talk about all their cases and I’ve had cases that I’ve really wanted to talk about.”

I classified these complaints under a heading of “mistiming” to describe episodes when the behaviour of the supervisor and the needs of the trainee have not complemented each other well.

In Focus Group 2 one trainee recalled vividly an example of a supervisor misreading her needs:

“I remember times when I’ve needed supervision and its been suggested that ‘why don’t we go shopping or have lunch?’ and....literally we went to have a look at a few shops in a nice place and...I found that quite unhelpful really.”

Earlier in the discussion another trainee considered the sort of supervision she had needed at different stages of her training:

“It would feel very wrong to sort of be given too much freedom at the beginning. I’d have felt very threatened by that. I needed somebody to tell me what to do ‘cos I hadn’t got a clue. And whereas, yeah, to be told what to do now, it would feel very disempowering.”

This general statement that supervisees in the final year of their professional training will prefer a non-directive style of supervision is interestingly at odds with the evidence provided in the IPR commentaries where, on several occasions, third year trainees much appreciated explicit advice from their supervisors. Again the most parsimonious explanation for this apparent inconsistency is that effective supervisors seem to have acquired the conditional knowledge (of both the process of supervision and the individual trainee with whom they are working) to enable them to say the right thing to the right person at the right time.

A brief synopsis of the points raised in the Focus Groups which I coded under the four headings “Threats to experiential learning”, “Threats to the supervisory relationship”, “Threats to sapiential authority” and “Problems of timing” is filed in the appendix.

Contextual Factors

During the Focus Groups trainees often made reference to the context in which difficulties had arisen on their clinical placements.

Since these details provided much more than background colour but constituted a significant part of the speakers' explanations of what had gone wrong between them and their supervisors, I decided to classify these remarks under a new category of "contextual factors". Within this new category I created four sub-grouping:

1. "Supervisor" defined as *"factors in the supervisor's life affecting supervision."* An example of a remark classified under the "supervisor" code was a recollection from a trainee during Focus Group 1 who related the difficulties he was experiencing on placement to the fact that his supervisor *"had a lot of family problems and was being threatened with loss of job."*
2. "Trainee" defined as *"factors in the trainee's life affecting supervision."* In Focus Group 1 a trainee explained how she imported expectations into a placement that jeopardized her capacity to make the most of the supervision available *"I think I grew up in the situation of going to a new supervisor having had a bad experience previously, or just taking in memories of a previous placement about how you were made to feel about your abilities and taking that into a subsequent relationship with a supervisor."*
3. "Department" defined as *"organizational factors in the host department"*. An illustration of a comment coded under "department" came from a trainee in Focus Group 1 who thought her supervisor's conduct was influenced by the organizational climate in which she was working *"politics in the department were pretty nasty at the time....what is going on in the department can actually affect you and your training role, and you need your supervisor to protect you sometimes from that."*

1. "Course" defined as *"the relationship of the supervisor and trainee to the training course."* An example of the impact of the relationship between a supervisor and training course staff was provided by a trainee in Focus Group 1 who felt her supervisor had been pressurized into accepting a supervisee at a time when he was already struggling to cope with the demands of his job *"I think I'd like it to be easier for supervisors to say 'no' to their new trainees when they don't feel up to it."*

A summary of all the factors coded in the four contextual categories can be found in the appendix. The memo I wrote on completion of coding the contextual factors records my thoughts about why the Focus Groups drew my attention to the important issue of the personal and social context in which supervision takes place while the previous two data sources did not.

Memo 5:

MEMO ON CONTEXTUAL FACTORS

It is interesting that when trainees related their worst experiences in supervision during the Focus Groups they were at pains to point out how a range of contextual factors had contributed to the difficulties they had encountered. In contrast I had not felt a need to create any contextual codes when analysing data from the critical incident reports or IPR commentaries. It may be that the less formal and restricted reflection encouraged by the Focus Group format allowed participants to provide more detailed descriptions of their experiences. An alternative explanation is that the importance of a factor such as having a placement within a well-run department that actively supports professional training only becomes obvious in its absence. So the "hygiene factors" (Pugh D.S. & Hickson D.J., 1989) that needed to be present for supervisors to function effectively when providing a helpful service to trainees were not clearly recognized or reported in the earlier stages of the study.

Summary

I found that the analysis of the Focus Group discussions mirrored my experience of coding the IPR commentaries, in that the exercise both confirmed the relevance of the theoretical model of effective supervision that I had developed thus far in the study and extended my ideas in a significant new direction. The juxtaposition of helpful and unhelpful experiences in supervision can serve to highlight key issues in effective practice when "poor" supervisors are identified as in some sense doing the opposite of "good" supervisors (Henry et al., 1993). However the Focus Groups also placed an important emphasis on the personal and organizational context in which supervision is conducted.

Trainees' reports described a series of potentially "disabling" contextual factors which did not have any "enabling" counterparts in the reports of helpful supervision collected previously in the study.

In acknowledging that their own background was one of the critical contextual influences affecting the course and outcome of supervision, the trainees in the Focus Groups underlined the inter-active quality of supervisory relationships (Kennard B.D. et al., 1987). Supervision is not I decided, best construed as something done to trainees by more or less competent supervisors. It is a joint enterprise in which both parties have a crucial role to play - even if they don't always play straight with each other (Kadushin A. 1968).

Overall I was impressed (though not entirely surprised) by the candour of the criticisms voiced by those trainees who participated in the two Focus Groups. I had little sense that they were "pulling their punches" and indeed had arranged the timing and ground rules of the group to encourage a frank discussion. Nonetheless when I closed the second Focus Group by announcing that we had come to the end of our allotted time and suggested that the trainees might choose to continue their de-briefing elsewhere, one of them added "Then we can say what we really think!"

Not for the first time during our conversations in the Focus Groups I felt that the outburst of raucous laughter that followed this remark signalled more than the delivery of good joke. I was left with the distinct impression that there were still some supervisee secrets to which I had been denied access (Ladany N et al., 1996).

Chapter 6

Links with Relevant Literature

The purpose of this chapter is to make connections between the five major themes that I have identified in the study as pertinent to effective clinical supervision and relevant research literature in psychology.

Experiential Learning Cycle

The classic work to which my ideas on experiential learning owe an evident intellectual debt is that of Kolb (Kolb D, 1982). However Kelly in his presentation of personal construct theory (Kelly G, 1955) had also proposed cyclical models to understand the way we process experience and anticipate our futures (eg the C-P-C cycle).

The central role of reflection in promoting adult learning in general (Boud D, 1985) and during clinical supervision in particular (Mollon P. 1997) has been extensively documented. In his influential work investigating competence in a range of professions Schon (Schon D. 1997) has advocated the model of the "reflective practitioner" as the basis for professional training and practice. He argues that professional decision-making is a balancing act between "rigour and relevance" as published research findings rarely provide an absolute blueprint for how to tackle any particular problem. The professional needs to be able to integrate their intimate first hand experience of events with their wider disciplinary knowledge to create novel solutions to unique challenges. This picture of ideal professional practice is subtly different from the Scientist-Practitioner model often cited as the basis for clinical psychology training (Barlow D et al., 1984).

Schon's ideas about the reflective practitioner have been proposed as a viable alternative to the dominant training ideology in US clinical psychology training schools (Peterson D.K. 1995), and British clinical psychology educators have been encouraged to incorporate the principles of experiential learning into their programmes (Gibbs G. 1987).

Outside clinical psychology a number of medical schools across the world have sought to re-organize their curricula following the allied notion of "problem-based learning" (Norman G.R. & Schmidt H.G., 1992). The governing principle in these educational programmes is that the starting point of learning should be the experience of grappling with a real-life problem which students are urged to try and understand from first principles. The theoretical input is provided after students have engaged in this process of experiment and systematic reflection. This sequence reverses the traditional logic of theory first, practice second, and fits in well with the precepts of the experiential learning cycle. Indeed the notion that the experiential learning cycle is the best way to conceptualize the way trainees learn through supervised practice has been advocated as a way of improving the quality of placement experience across a range of health-care professions in the UK (Milne D. 1997).

Overall therefore my "discovery" that effective supervisory practice can be plausibly conceptualized as contributing to the ongoing experiential learning cycle in which the trainee is engaged is consistent with much current theorizing and innovative practice in professional education.

The Supervisory Relationship

Within the field of empirical psychotherapy research there is a large body of work attesting to the importance of the quality of the "working alliance" established between client and therapist in determining therapeutic outcome (Horwath A. & Greenberg L., 1994).

The idea that relationship factors might also be more important than issues of technique in predicting the outcomes of clinical supervision was first proposed by Bordin (Bordin E, 1983), and has subsequently prompted a good deal of empirical research such as attempts to develop psychometric instruments to measure the quality of the supervisory alliance (Efstation J. et al., 1990).

The supervisory alliance has been conceptualized as having both an organizational component, in which supervisor and supervisee agree the goals of supervision, and an emotional bond, construed as a sense of mutual concern and respect (Ladany N & Friedlander M.L., 1995). These ideas have close parallels with the "structure" and "attitude" codes incorporated in the relationship factors category of my theoretical model. Although the scientific status of research evidence conducted into the supervisory alliance has been open to criticism (Ellis M.V & Lafany N., 1997) there is some evidence to suggest that when trainees consider they have a good working relationship with their supervisor they are less likely to encounter role difficulties themselves (Ladany N & Friedlander M. L., 1995) and more likely to establish a good therapeutic alliance with their clients (D'Andrade R. 1987).

The idea that, as in therapy, the inter-personal climate established in supervision is a crucial determinant of how much growth will occur owes its origins to Rogers' client-centred theory (Rogers C, 1976). Indeed Rogers wrote specifically on the application of his model of human development to adult education. Although it has not been established that the facilitative conditions which Rogers advocated – high levels of empathy, genuineness, and positive regard – are either necessary or sufficient for supervision to be deemed successful, it does appear that common factors relating to the interpersonal climate between supervisor and supervisee are a better predictor of outcome than any procedural correctness on the supervisor's part (Lambert M.J & Ogles B.M., 1997)

In particular the sense that the supervisory relationship can provide a secure base from which to take the risks inherent in experiential learning has been described as an atmosphere of “safe uncertainty” within which the supervisee feels able to experiment (Mason B. 1993). Shapiro and his colleagues (Shapiro D.A et al., 1992) have also proposed a model of problem-solving in which the emotional state of the learner interacts dynamically with the stage of the problem solving sequence in which they find themselves. The implication of this “assimilation” model is also that the social environment in which individuals learn needs to be experienced as emotionally containing if effective problem resolution is to be achieved.

The sub-categories of “sensitivity” and “climate” within the relationship factors grouping of codes in my theoretical model are consistent with this “common factors” belief in the importance of the emotional milieu in which supervision is conducted.

Overall therefore the organizational, attitudinal, and broadly climatic components of the relationship factors category that I created in my theoretical model of effective clinical supervision are closely paralleled by other research findings in the field. Encouragingly there is also some suggestive evidence that good supervisory alliances may result in improved educational outcomes for supervisees and therapeutic benefits for their clients.

Sapiential Authority

The closest parallel to the category of “sapiential wisdom” which I could find in the supervision literature is the “social influence model” which broadly holds that if a supervisor is perceived as expert, attractive, and trustworthy they are likely to bring about desirable developments in the supervisee’s performance (Ellis M.V & Ladany N., 1997).

“Attractiveness” in this context is defined as being seen to possess the needed resources to effect change (Dodenhoff J.T. 1981). These three attributes of influential supervisors have close parallels with the sub-categories of special knowledge, credibility, and integrity in the sapiential authority grouping of codes in my theoretical model.

Moving outside the supervision literature, Baltes and his colleagues in Berlin have developed a theoretical model of human wisdom (Staudinger, 1996) which has implications for the way clinical psychology trainees might construe their supervisors. The social-interactive concept of wisdom which Baltes proposes is defined as “an expert knowledge system in the fundamental pragmatics of life” so that those we consider wise are seen as being experienced in and exercising good judgement about, difficult life problems. The social nature of wisdom in the Berlin model stems from the way it is triggered and identified. So wisdom-related knowledge only becomes evident in social exchanges between people such as when a supervisee presents a confusing or disturbing case to his or her supervisor. Furthermore the wisdom of the supervisor’s counsel is not self-proclaimed by the speaker but recognized by the listener. Thus wisdom is seen as a social attribution rather than a personality trait. I think my understanding of how supervisors come to be seen as credible authorities by their trainees has much in common with this social-interactive view of wisdom. Interestingly Baltes and his co-researchers (Smith et al., 1994) tested the prediction that experienced clinical psychologists would, by dint of their prolonged professional exposure to complex life problems, perform better on a range of wisdom-related tasks than a matched control group, and indeed they did. When, basking in the reflected glory of this finding, I announced the result of the Berlin research to my family they insisted, to a man, that there was a pressing need for a British replication study! As Baltes and his colleagues argued, and the truly wise person knows, self-praise (even when supported by scientific references) is no recommendation.

Returning to the literature on training in psychotherapies, the need for supervisors to be seen as authoritative and technically competent by their supervisees has been recognized in the field of cognitive therapy (Perris C. 1994) "Local knowledge", (which I employed to describe supervisor's awareness of local resources, professional networks etc) has been suggested as the critical ability that a clinician psychologist needs to possess to practice competently (Peterson D.R. 1997). Peterson is using the term to embrace an understanding of the specific local circumstances in which psychological treatment is delivered which must inform the general theoretical principles and research findings on which an intervention is based. This more substantive meaning puts local knowledge – of the individual client, of the cultural traditions they come from, of the community they live in – at the core of all clinical formulation. Since local knowledge can rarely be acquired through books, the beginner is very reliant on experienced colleagues who can provide a lead. Supervisors who by dint of their experience can inform and educate trainees on the specific local contexts in which they are working, do indeed therefore possess a special knowledge that enhances their authority significantly.

The theme of ethical conduct in clinical psychology practice and education has been receiving considerable attention in recent years (Marzillier J, 1993) Trainees regularly face ethical dilemmas over issues such as confidentiality and informed consent in the course of their clinical placements (Kent G. & McCauley D., 1995). Supervisor training programmes, such as ours at Leeds, place strong emphasis on the role the supervisor plays as a model of ethical practice both as a clinician and as an educator (Russell R.K & Petrie T., 1994). It is also probable, given widespread concerns about the potential abuse of power in supervision (Lewis N. 1997), that clinical psychology trainees will share the common preference of junior staff that those who are appointed to positions of authority over them should possess above all the quality of moral probity (Emler N et al., 1997).

Hence the identification of the supervisor's "integrity" as an important contributing factor in their perceived sapiential authority is in keeping with the prevailing zeitgeist within the clinical psychology profession.

Finally two studies in which supervisees were asked to contrast helpful and unhelpful experiences in supervision concluded that factors coded within the sapiential authority category discriminated between "good" and "bad" supervision. Clinical and counselling trainee psychologists considered two of the best discriminators of the quality of supervision, they received were the expertise and trustworthiness of their supervisors (Allen et al., 1986). Supervisees learning time-limited psychotherapy performed more effectively as therapists if they had received specific, focused, and, where necessary, challenging feedback from their supervisors (Henry et al., 1993).

Overall therefore although the term sapiential authority does not itself appear to occur in the literature on clinical supervision, the individual codes used to describe supervisor behaviour classified under the four sub-headings "feedback", "credibility", "special knowledge", and "integrity" find many plausible parallels in other relevant psychological studies.

Timing

There is a substantial literature in both educational psychology and clinical supervision research devoted to a number of matching hypotheses that claim learning will be enhanced if the supervisor acts in a way that corresponds to a particular characteristic of the trainee. Within the supervision literature developmental stage theory has been influential (Heppner P.P. & Roehlke H.J., 1984) which argues that supervisees will respond differentially to particular supervisors' styles depending on their level of experience with, for example, beginners appreciating more direction than more senior trainees.

Although this principle has face validity and was expressed in diluted form by one of the trainees in focus group 2, there is minimal empirical evidence to support its adoption as a canon of good supervisory practice. A series of meta-analyses of research conducted into the developmental stage and associated matching theories have commented critically on the imbalance between the wealth of conceptual discussion on the topic and the dearth of scientific evidence to support and inform debate (Ellis M.V & Ladany N., 1997; Watkins C.E., 1995; Worthington E.L. 1987).

Within the broader field of education the notion of cognitive styles has prompted research efforts into the prediction that learning will be enhanced if material is presented to an individual in a form that matches his or her preferred style of processing information. For example there is evidence to suggest that people are predominantly either “verbalizers” or “visualizers” and hence one would prefer a story to a diagram or vice-versa (Riding R. & Cheema I., 1991). Again however the expectation that learning outcomes will be improved if educators consciously adapt their teaching methods to the cognitive styles of their individual students has not been supported by empirical research (Moran A. 1991). Furthermore common-sensical suggestions that pitching together particular pairings of personality types in supervisory relationships would result in a predictable pattern of outcomes have proved misleading (Neufeldt S.A. et al., 1997). So even though the principle that successful communicators cognitively “tune” the messages they transmit to the characteristics of individual recipients has long-standing credibility in social psychology (Zajonc R. 1960), there appears to be little research evidence to support the contention in this study that effective supervisors demonstrate the ability to say the right thing to the right person at the right time.

It may be however that the research methodology used to test the matching hypothesis has inappropriately followed what Stiles and Shapiro termed the Drug Metaphor in calculating process-outcome correlations (Stiles W.B & Shapiro D.A., 1994). In supervision, as in psychotherapy, the crucial determinant of outcome is unlikely to be simply how much instruction or how many interpretations were delivered in one individual consultation. This is not a straightforward issue of dosage. In the free-flow of conversation the participants in supervisory or therapeutic discussions are almost instantaneously responsive to each others' communications. Effective supervision is therefore unlikely to be guided by some gross matching strategy such as "it's a first placement I'd better tell her what to do." On the contrary we would expect a much more subtle and sophisticated approach from an experienced mental health professional whose training has been "directed toward vigilance in sessions and adapting the type, depth, timing and phrasing of interventions to the needs of particular clients at particular moments in treatment" (Stiles W.B & Shapiro D.A., 1994). It is this description of moment-to-moment responsiveness – sometimes called having a good "nose" (Haber R. 1997) – which most closely resembles the interplay between supervisor and supervisee displayed on the videotapes I viewed in the IPR component of this study. There is also one piece of suggestive research evidence linking the immediate responses of supervisors to their trainees' communications to the longer term success of the supervisory relationship. In an experiment designed to test a complex theoretical prediction about the role complementary interactions might play in supervision Tracey and Sherry (Tracey T.J & Sherry P., 1993) videotaped a series of supervision sessions involving three supervisors and six trainees. The experimental hypothesis was unproven but the researchers noted a definite difference in the ways successful and unsuccessful supervisors responded to trainee hostility within sessions.

In less successful supervision supervisors tended to ignore passive hostility from the trainee who might be reluctant to take advice but rise to the challenge of overt antagonistic behaviour from the supervisee by pulling rank and venting his or her own irritation. In contrast during the more successful supervision sessions, the supervisor would pick up and explore expressions of passive hostility by the trainee and react to overt displays of antagonism in an unpredictable rather than complementary manner (ie not just doing the same thing back). The authors acknowledge that it would be unwise to generalize too enthusiastically on the basis of these observations, but here at least is a piece of evidence that is consistent with both Stiles and Shapiro's theoretical position and the central role given to the issue of timing in this study's analysis of supervisory competence.

Contextual Factors

Three of the four categories of contextual factors identified in the focus group discussions are very similar to those proposed by Holloway (Holloway E.L. 1995) in her recent integration of research findings into a systemic model of supervision (for further details see Chapter 9).

Holloway's four contextual factors of supervision are:

1. **Supervisor factors** such as the previous professional experience of the supervisor or the theoretical school they follow in their clinical work.
2. **Supervisee factors** such as the trainee's style of self-presentation within supervision or need for specific feedback.
3. **Institutional factors** such as organizational politics or the balance an agency strikes between its training and therapeutic commitments.

4. The fourth category identified in Holloway's theoretical model is **client factors**. This could be expressed as straightforwardly as the level of intractability of the problems the client brings into therapy. A further dimension can be added to the understanding of the manner in which the characteristics of clients influence the supervisory relationship by the psychoanalytic principle of "parallel process". This logic, which has some case-study evidence in its support (Friedlander M.L. et al., 1989), argues that the supervisee acts as a sensitive lynchpin between two relationships – one with the supervisor, the other with the client. The "parallel process" occurs when the dynamics of the therapeutic relationship are re-enacted in the trainee's exchanges with his or her supervisor. This mechanism reverses the direction of influence portrayed in the experiential learning cycle where reflections and formulations in supervision lead to a plan of action to be followed in subsequent therapeutic work undertaken by the supervisee.

Although I did not detect any compelling examples of "parallel processes" operating in the critical incident or IPR components of the research programme, both sources of data gave ample evidence that client factors exercised a significant influence both on the issues trainees chose to raise in supervision and on the manner in which they were discussed (see also Tracey et al 1989). I find it interesting and surprising that the coding system I adopted did not prompt me to incorporate client characteristics into the evolving theoretical model.

Although in her discussion of institutional factors Holloway refers to tensions agencies might experience between training and therapeutic priorities, her contextual model does not focus on the relationships between training courses and their supervisors and trainees in the same manner as the current study.

However Hitchen and her colleagues (Hitchen H. et al., 1997) specifically requested feedback on “communication issues between trainees, supervisors, and course staff” in their critical incidents survey in Oxford. This suggests that for contemporary British clinical psychology training programmes the quality of the working alliance between all members of the course community may be a contributory factor in determining the outcome of individual supervisory relationships.

It appears that little direct empirical work has been undertaken to research the influence organizational variables have on supervision, but a large scale Delphi survey seeking the opinions of marital and family therapists in the USA (White & Russell C.S., 1995) found that respondents agreed on no less than 74 contextual variables that were “very important” to its outcome. Most of these variables related to the attitudes and values of the organization within which supervision took place but Delphi panel members also made reference to some of the physical characteristics of the working environment (eg equipment, treatment facilities).

The authors conclude (as one might expect systemic therapists to conclude) that an understanding of effective supervision “must examine all aspects of the ecosystem” in which it occurs.

In summary therefore there is substantial overlap between the categories of contextual factors constructed in this study and those proposed as important in the wider literature on clinical supervision, with the notable inconsistency that my theoretical model has not given any significant weighting (with the exception of the “problem” codes developed in the analysis of the critical incident reports) to the influence of client characteristics.

Summary

One test of the validity of the findings of qualitative investigations is to see how well ideas that have been grounded in the subjective experience of a limited number of research participants, fit in with established theory and research evidence in the relevant field of study. The literature reviewed in this chapter suggests that the five major categories given prominence in my theoretical model of clinical supervision are not wildly out of kilter with the thoughts of other researchers into the topic who have adopted a different, usually quantitative, approach to their enquiries.

Chapter 7

Validity Checks

Testing Out the Emerging Theory

Qualitative researchers have developed a number of ways of trying to persuade readers that their findings are valid. A widely recommended practice is to present your results either to your respondents or to others of comparable background and see what they make of your ideas. Stiles (Stiles W, 1993) describes this as an exercise in “testimonial validity” which he explains in the bluntest of terms:

“One straightforward check on an interpretation’s accuracy is to ask the people whose experience it purports to represent.”

Other writers recommending this strategy in qualitative research have called it “respondent validation” (Boulton M. et al., 1996), demonstrating “face validity to others” (Turpin G. et al., 1997), and “providing credibility checks” (Elliot R. et al., 1997).

During the course of this research project I have regularly discussed my ideas with others most regularly in individual supervision and in seminars with my fellow students on the part-time D. Clin. Psychol. Course. I have also made three formal presentations of my research to selected audiences at different stages of the study’s development. I viewed these meetings as opportunities to confer with informed colleagues and anticipated that our discussions would serve to shape the future progress of my investigations. Accordingly I took careful notes both of other people’s responses to the study and of my own reactions to their comments.

An example of these “diary” recordings can be found in the appendix.

The first public presentation I gave of this study was a poster submitted to the European Congress of Psychology held in Dublin in July 1997. When submitting the conference abstract I had anticipated being in a position to present results from all three data sources but ended up describing my analysis of the first 50 critical incidents as “work in progress”. Since only a minority of delegates were clinical psychologists I viewed the conference as an opportunity to get feedback on the design and rationale of the study rather than as a vehicle to test the validity of its findings at this early stage of data analysis. The poster, to which I spoke in a “chaired” session, described the coding process, and the three broad theoretical categories of experiential learning cycle, relationship factors, and sapiential authority each explained by an accompanying memo (see A4 size copy in appendix). I noted in my diary record at the time that I found “the exercise of trying to convey your ideas briefly and convincingly to a fresh audience proved a timely challenge”, which implies I profited from the experience. As well as presenting my own work I was able to discuss questions concerning sampling strategy and rules of evidence with other qualitative researchers present at the conference (Prawat R. & Conway P., 1997).

The net result of this exchange of ideas was that I did not feel so fraudulent in passing myself off as a qualitative researcher and I found my thoughts about how I might organize the remainder of the study had been influenced by the opportunities for conversation and reflection the conference had presented.

The second public account I gave of the study was to a much more specialized audience with a sophisticated understanding of the business of clinical supervision.

I had been invited to contribute to an introductory training programme for clinical supervisors on the Newcastle and Teeside training courses, and took the opportunity to present the results of the research programme up to the completion of the analysis of the IPR commentaries (ie not including the focus group data). The audience of 15 all had prior experience of supervision in clinical psychology in the roles of both supervisor and supervisee. 4 of my fellow presenters on the training course were themselves tutors with a special interest in and responsibility for clinical supervision. I gave a spoken presentation of a little over an hour and was subsequently asked to discuss the project in further detail with the supervisors from the Teeside course. This group of about 10 psychologists had systematically reviewed the ideas I had raised, and wished to pursue a number of questions. The full memo of this meeting is reproduced in the appendix, but the major issues we debated were:

1. Despite my attempts to provide a comprehensive account of the study several members of the audience needed more contextual details concerning the trainees, their supervisors, the placement specialities etc, to allow them to decide on the relevance of the study's findings to their own professional practice.
2. I had not presented any data from the inter-judge agreement exercise conducted with my supervisor and the absence of any collaborative evidence weakened the credibility of the study in the eyes of two of the supervisors.
3. Few of the group were familiar with qualitative research procedures and wanted a more explicit description of exactly what was involved in the data analysis and theory-building phases of the project.
4. Those of the group who were relatively new to the supervisor's role voiced some frustration at not being able to hear the results of the focus group analysis as, for eminently understandable practical reasons, they wanted to know what bad practices to avoid as well as what good practices to adopt.

5. There was a clear consensus within the group that the study's major weakness was the absence of the supervisor's perspective on salient factors with the supervision process.

Despite these misgivings the majority of the group found the theoretical model of effective supervision plausible and could find within it some practical implications for their future practice.

I found this discussion stimulating and a more searching examination of my methods than I had anticipated. The challenges got me thinking, none more so than a comment from one of the tutors who said encouragingly "it's very interesting but you haven't finished yet." His point was that he wanted to hear my ideas about how the broad groups of factors I had identified interacted with each other - and he was still waiting. That struck me as a very good question; too good for me to answer at this stage in the project.

I listened closely to the testimony of this group who were well-versed in the world of clinical supervision. Their feedback centred primarily on methodological concerns rather than querying the main thrust of the study's theoretical findings which seemed relatively uncontroversial. This audience was interested at least as much in how I had reached my conceptualization of effective clinical supervision as in whether the picture I had painted matched their own experience of supervision.

The other formal consultation exercise I undertook came closest to the notion of "respondent validation" in which the participants in a study are provided with the researcher's interpretations and invited to comment. I presented a final synopsis of the study (including my attempts at a further level of theoretical integration see Chapter 8) to a combined group of first and second year trainees on the D. Clin. Psychol. course at Leeds. None of these students had provided data for the project.

They were however the immediate successors of the trainees who had participated in the research. During the course of their training they would work in the same departments with the same supervisors as those supervisees in whose placement experiences the study's was grounded.

I spoke for about 40 minutes and fielded questions for a further 20. Interestingly although the theoretical model was built on the testimony of supervisees, this trainee group thought my presentation under-played the contribution supervisees make to the outcome of both successful and unsuccessful supervision. One trainee also remarked how the "snapshots" of supervision experience collected in the course of the study did not portray the way supervisory relationships develop over time. Furthermore the critical incident reports and the focus groups in particular may have overlooked everyday good practice in supervision by directing trainees to recall events that stood out as memorable. A number of second year trainees endorsed the role good timing had played in the effective supervision they had received. The concluding theme of our discussion considered the risks of relying entirely on a consumer's view of what constitutes effective clinical supervision as a basis for my theorizing. One trainee said she would have felt very conscious of her inexperience if she had been asked to participate in the project. "How do I know at this stage what style of supervision I will benefit from in the long run?"

Overall this presentation provided me with feedback that the account I had given of the research and its findings made a plausible and coherent case, while also offering a number of pertinent methodological criticisms.

Before closing this chapter I want to consider seriously the implications of a question that I was asked during one of our mutual updating sessions on the part-time D. Clin. Psychol. Course.

I had just given my fellow course members a progress report on the results of the focus group analysis, when one of the group, an experienced supervisor with whom I regularly organize placements, asked “Has this study told you anything you didn’t know already?” This question had echoes of a remark made by one of the Teeside supervisors to the effect that the account of effective clinical supervision I had provided was credible but unremarkable. There is something disheartening about the realization that you may have spent many a long hour sweating over codes and computer programmes only to “discover” what was probably blindingly obvious to you and others with first-hand experience of the field in the first place.

However rather than consign my ever-thickening thesis to the bin, I took this challenge as grist to the qualitative researcher’s mill and attempted to step back and analyse why this question “hit the mark” so accurately. In part I realized that in my anxiety to avoid any accusation that I had failed to ground my theories in the experience of the research participants I had kept my arguments closely tethered to the evidence I had gathered. However in making what I hoped was a watertight case it seemed I was in danger of being too persuasive for my own good. Psychological theory, grounded or otherwise constructed, should aspire to “transcend the obvious” (Kelly G, 1969). There is evidently a tension between giving an account that is convincingly consistent with other research and acknowledged as a fair reflection of your research participants’ experience, and a wish to do more than re-state familiar arguments.

The endpoint of a grounded-theory enquiry should be a novel conceptualization of the phenomenon under investigation. In what sense are the ideas in this thesis new?

As the “forestructure” to this study outlined in Chapter 2 explained I did not venture naively into this research area.

I have been immersed in the business of clinical supervision for over a decade and in the process developed a reasonably sophisticated set of personal and professional constructs to guide me on my travels. On the one hand, this familiarity with the field is an asset as it increases the “theoretical sensitivity” (Strauss A. & Corrin J., 1994) that I can bring to the research. On the other hand, it is likely that I will use and develop those explanatory systems with which I am familiar to make theoretical sense of the raw data analysed in the study. The critical issue is whether I can demonstrate the “permeability” of the constructions with which I started this project in that my theories about what constitutes effective supervision have been changed by the data I examined. This has been termed a test of “reflexive validity” (Stiles W, 1993). As my memos in chapters 3 and 4 acknowledge I was already primed in some sense by previous reading and experience to elaborate the concepts of the experiential learning cycle and the supervisory alliance. Although I have encountered occasions when supervisors occupied a position of hierarchical seniority over their supervisees but were not respected for their competence in that role, I had not articulated that belief to the degree evident in the sapiential authority concept described in this study. In similar vein I have had plenty of first-hand experiences of a range of contextual factors influencing the outcome of supervision from arcane departmental politics to unreliable bus services, but I had not integrated this awareness into a comprehensive theoretical overview. In particular I have become more appreciative of the impact of course staff relationships with supervisors and supervisees on the outcome of clinical placements as a consequence of undertaking this research.

The timing category developed primarily as a result of monitoring the minute-by-minute exchanges in supervision recorded on video-tape. Without this unfolding account and the informative commentary provided by the supervisees I would not have been struck by the finely-tuned judgement exercised by supervisors in timing their interventions.

Finally I can confess genuine surprise at hearing more than one trainee in the focus groups complain how unhelpful they had found some self-disclosures on the part of their supervisors. As teacher, therapist, and indeed parent, I am something of an inveterate self-discloser and had convinced myself that my revelations generally benefited my various target audiences. Without doubt the focus group recollections made me think twice about that assumption.

“Did you discover anything you didn’t already know?” is , I suspect, a more profound question than it sounds. I am not sure I have answered it properly but I have attempted to explain some of the ways in which I came to understand the complexities of clinical supervision in different ways as a result of conducting this research.

Chapter 8

Further Theoretical Integration

Introduction

It was not only the incisive comment made by a fellow tutor on the supervisors' workshop that led me to think further about the workings of the theoretical model of supervision I have thus far proposed. The hierarchical tree structure of organizing codes favoured by the NUD*IST programme (Richards T & Richards L., 1995) leads the researcher towards the creation of some overarching superordinate construct that pulls together the various threads of a qualitative study. Empirical phenomenologists (Giorgi, 1992) also argue that the recommended conclusion of descriptive research should be a unifying conceptual theme. This would be a logical, tidy, and aesthetically pleasing next step to take in this study. Unfortunately at the time of writing it is a step I am not yet able to take.

A second strategy for portraying theoretical relationships between the five groups of codes I have identified in this project would be to represent some inter-actional pattern between them diagrammatically. Qualitative researchers have employed a number of visual devices such as flow charts and matrices to display their data to readers (Miles M.B. & Huberman A.M., 1994). Grounded theorists have advocated the use of "consensual circles" to portray the different levels of analysis in a study (Strauss A. & Corrin J., 1994). Within the field of supervision research a triangle has been employed to represent three dimensions of supervisory task (Hewson 1993 reproduced in Howard 1997), and the multi-winged diagrams used by Holloway to explain her "systems approach to supervision" model (Holloway E.L. 1995) bear a striking resemblance to orbiting satellites (see Chapter 9).

I too toyed with a number of images that might help me convey possible relationships between the various key elements in my model of effective clinical supervision. At one stage I held out hopes that a rough-hewn drawing of a three-legged milking stool would fit the bill. Again however I have accepted defeat. I cannot at this stage paint a convincing picture to provide a satisfying synthesis for my theorizing. I am however prepared to attempt a messier systemic analysis of how the components of the model might interact.

A Systemic Analysis

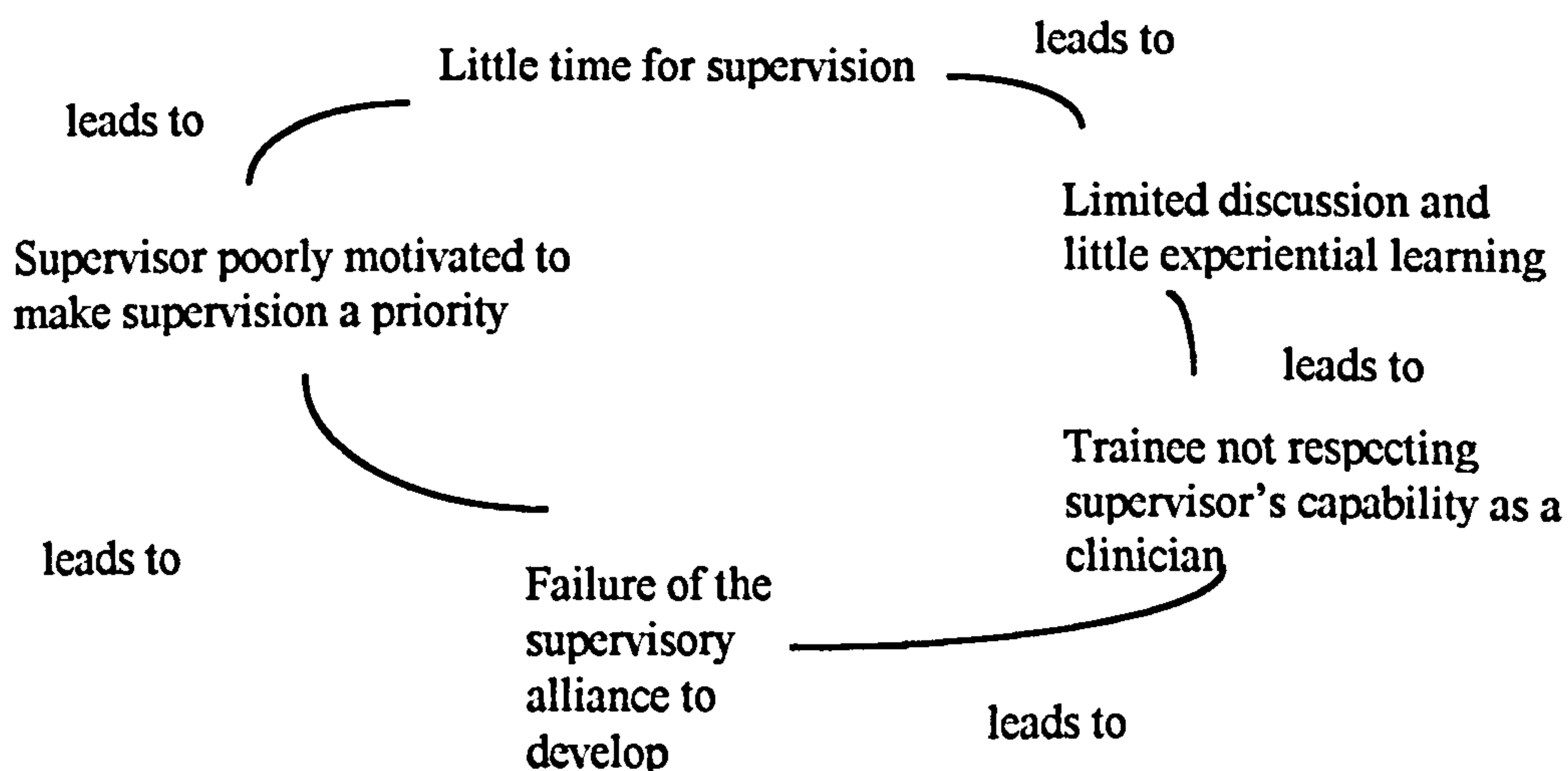
The grounded theory approach has resulted in the identification of five groups of factors - experiential learning, the supervisory relationship, the sapiential authority of the supervisor, issues of timing, and the context within which supervision takes place. The analysis however remains incomplete without some account of the ways these factors inter-act in their contribution to effective and ineffective supervision outcomes.

The contextual issues emerging from the analysis of the two Focus Group discussions suggest a systemic model may be a useful way of understanding these inter-relationships. The supervision pairing is placed in the organizational context of the prevailing culture within host departments and clinical psychology training courses. Furthermore the reflexive nature of many comments made by trainees in the Focus Groups acknowledges the part they play in shaping the process of supervision by both their behaviour and the expectations they import into placements. So a simple linear model of cause and effect which characterizes effective supervision as a set of competences displayed by the supervisor resulting straightforwardly in the development of increasing therapeutic efficacy on the part of the trainee is unconvincing.

The “dance” of supervision portrayed on the videotape recordings and the repeated reference to the importance of appropriate timing in the commentaries provided by the trainees when they observed the sessions in which they had participated, strongly suggest that a model of effective supervision should be circular not linear (McCaughan N. & Palmer B., 1994). That is to say that rather than view supervision as a process whereby the supervisor does something to the supervisee it will prove more useful to consider also the way in which the supervisee’s conduct influences the supervisor’s behaviour. Supervision is not just one-way traffic but a reciprocal process.

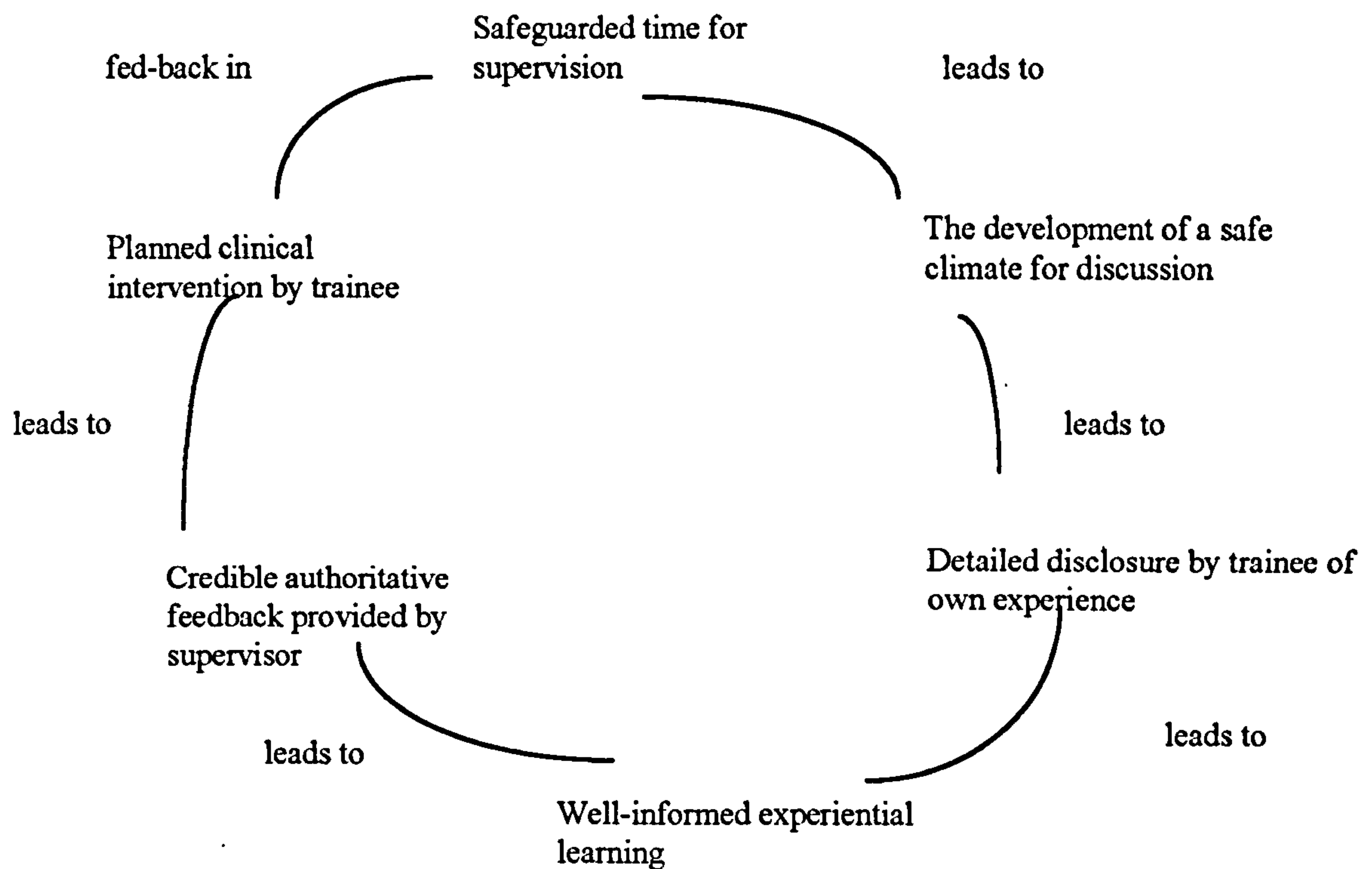
Systemic relationships have been described in terms of feedback loops. Positive or confirmatory feedback loops are those in which an action leads to an outcome which in turn leads to more of the initial action in a process of inevitable escalation. In common parlance this pattern is readily seen in the phenomenon known as a “vicious circle”. From the various accounts of supervisory experience provided by the participants, in this study an example of a supervisory vicious circle might run as follows:

Figure 8: Vicious Circle



By contrast an example of a confirmatory feedback loop leading to a “virtuous circle” in clinical supervision might be portrayed as follows:

Figure 9: Virtuous Circle



The risks of the vicious cycle of supervision are self-evident. Things go from the proverbial bad to worse unless or until something gives (such as one of the parties opts out on health grounds) or some counter-acting influence interferes with the closed system of the supervisory relationship (such as the external challenge of a visiting tutor reviewing the placement's progress).

The dangers inherent in a virtuous circle are not so obvious but confirmatory feedback loops always carry the same risk of establishing an ever-escalating "more of the same" pattern that is not open to correction. There are a number of ways in which a supervisor and trainee might end up getting on so well together that their effectiveness in their respective roles could be impaired.

The establishment of a "cult of the positive" (Brown B. & Marzillier J., 1983) can create a climate in which critical feedback feels completely out of place.

This may well suit the trainee who wishes to play the “evaluation is not for friends” game in supervision (Kadushin A. 1968) but undermines the supervisor’s role as a professional gatekeeper. Mutual admiration societies might also develop on occasion into romantic relationships between supervisor and supervisee. Sexual contacts of this sort set an inappropriate role-model for the supervisee who as a consequence may not themselves retain fitting professional boundaries in their subsequent relationships with their own supervisees (Russell R.K & Petrie T., 1994).

These considerations suggest that optimal clinical supervision is not best characterized as no more than a virtuous circle in which supervisor and supervisee spur each other onto ever more effective practice. What confirmatory feedback loops lack is the capacity to recognize and correct deviations from recognized norms of conduct. This self-righting function requires a negative or corrective feedback loop in which information signalling that all is not well in some sense triggers a “something different” response which returns the system to safe working order. When things start to go wrong in the supervisory process one of the parties has to initiate change by recognizing that a problem exists and taking some intentional corrective action.

An example of a trainee initiated corrective feedback was described in Focus Group 2 where the supervisee experienced frustration at the time being spent in her supervision session on low priority issues leaving no opportunity to discuss a case where she urgently needed advice. The trainee subsequently started the next supervision session by alerting the supervisor to a list of topics she had prepared in order of importance which she would like to discuss if possible. This initiative established a precedent by which supervisor and supervisee negotiated an agenda of business needing attention at the beginning of each supervision session.

An example of supervisor-initiated corrective action was described in critical incident 004. The trainee explained that repeated exposure to clients' accounts of having been abused, had left her feeling emotionally exhausted and despondent about what she could offer as clinical psychologist. She found herself holding back from empathetically engaging with clients as a self-protective measure. However the recognition of this pattern in turn led to her feeling guilty, which further fuelled her sense of despondency.

The trainee described this "vicious circle" to her supervisor. He offered an alternative interpretation of events portraying the trainee's experience as typical of the phenomenon of "secondary traumatization" in which therapists identify closely with their abused clients. He also emphasized the important lesson of professional self-care that could be learned from the episode and invited the trainee to use future supervision sessions to return to the theme of her emotional reactions to the harrowing accounts provided by abused clients. This reframing of the problem effectively interrupted the escalating spiral of self-doubt in which the trainee was previously caught.

Both these examples indicate how corrective initiatives have been taken by either supervisor or trainee to which the other party has responded helpfully. Scaife (Scaife J. 1995) has suggested that the supervisory system works most efficiently when corrective feedback loops stem from the joint acknowledgement of a problem by supervisor and supervisee which leads to a negotiated decision about how to proceed.

The evidence collected in this study included several examples of this process of shared problem-solving.

VTR 3 focused on the dilemma experienced by the trainee who was keen to offer further psychological help to a teenage girl who had given several signs that she was disengaging from therapy.

Her mother too was not responding to the psychologist's overtures. It seemed the more he pursued the more they retreated.

Within supervision trainee and supervisor took time to review the history of the case and realistically appraise the prospects for future therapeutic work with the family. The trainee's feelings of frustration were acknowledged and the supervisor disclosed that she too had struggled with the dilemma posed by patients who seem to need, but appear to reject, professional help. On reflection both parties agreed that it would be fruitless for the trainee to put further effort into trying to re-engage the family in therapy. This hard-headed but disappointing decision was normalized for the trainee by the supervisor's rueful observation that "you can't win them all". As a consequence the confirmatory feedback loop in which trainee and client were trapped was interrupted and a valuable exercise in experiential learning had been completed. Not all cases can end successfully.

Critical incident number 068 illustrated a similar process of negotiation in the management of a problem arising within the supervisory relationship itself. Supervisor and trainee had established a climate of honest communication within their discussions. The supervisor subsequently was candid with the trainee in revealing that personal difficulties with which she was struggling meant she felt she could not proceed with the placement as planned. She explained her circumstances to the trainee and expressed her wish to abort the placement at an early stage rather than fail to live up to appropriate standards of supervision.

The pair decided to find another supervisor and negotiated that the current supervisor would continue to play a supportive role in the placement where possible.

Not only had early action avoided the messy situation of having to re-organize supervision in the middle of an ongoing placement, but the transfer to a new supervisor had been managed in a manner that maintained the mutually respectful quality of the original supervisory alliance. The trainee concluded his account by reporting:

“On the whole a reasonably satisfactory handling of a potentially difficult situation.”

The arguments presented so far in this chapter have been securely anchored in the evidence provided by the research participants in the study. I should like to conclude with some more hypothetical musings.

I have proposed five broad factors which are likely to contribute to effective clinical supervision - promoting experiential learning; developing a strong supervisory alliance; accepting the sapiential authority of the supervisor; timing interventions in supervision appropriately; and working in a personal and professional context that facilitates good practice. Are all these five components of the model necessary for clinical supervision to achieve its intended outcomes? Is there an optimal balance that a training placement should ideally achieve in attending to each of these issues? What strategic adjustments might either supervisor or supervisee make if they notice an unhelpful imbalance of priorities has developed during a placement?

While it would be over-stretching the evidence to claim that the five factors identified in this study are either strictly necessary or sufficient for the achievement of successful outcomes in supervision, it is arguable that effective supervisors are likely to pay attention to all of the broad issues described in the research results. If, as regularly happens in practice, placements evolve their own idiosyncratic patterns it is probably necessary to work at maintaining this sense of harmonious balance.

For example if a supervisor perceives that an inappropriate balance is developing - for example authoritative feedback is not proving helpful because it has been delivered in an untimely manner, or the very "chumminess" of the relationship between supervisor and trainee means that opportunities for experiential learning are being missed - he or she could take appropriate corrective action.

If on the other hand a trainee perceives a similar imbalance in their experience of supervision - for example feeling inter-personally uncomfortable with a supervisor though recognizing his or her therapeutic expertise - other corrective moves could be made. If the option of a mutually agreed strategy devised jointly by trainee and supervisor is not available, the trainee might, recruit some other educational or personal support such as a fellow student, or tutorial group, to complement the learning opportunities on the placement.

Alternatively the trainee might elect to "play to the strengths" of the supervision on offer and take maximum advantage of the particular supervisor's assets as a trainer and construe some of the relationship factors described in this study as desirable but not strictly necessary components of effective supervision. In reflecting on the compensatory tactics a trainee might employ to make the most of a sub-optimal placement, I am reminded again that successful supervision requires competent performances by both participants - the supervisor and the supervisee.

Chapter 9

Comparison with Holloway's S.A.S Model

Holloway (Holloway E.L. 1995) has attempted to synthesize her long practical experience and familiarity with the research literature in supervision to produce a coherent and comprehensive model of effective practice that could provide a sound base for supervisor training. Although this model is founded primarily on studies in counselling psychology and has been developed in a US setting, I thought it would be informative to compare the model Holloway has proposed using existing research findings as her primary source of evidence, with the theoretical framework I have developed grounded in the first-hand experiences of British clinical psychology trainees.

Description of S.A.S Model

The S.A.S stands for a "System Approach to Supervision", and represents Holloway's best effort at constructing a dynamic working model which incorporates those factors that have been consistently identified in the research literature as contributing to the outcome of clinical supervision. The model is described diagrammatically (see Figures 11 and 12) as "wings" emanating from a common cylindrical core. The core structure is the supervisory relationship. One wing represents the tasks of supervision; another the functions of supervision; and the final four wings represent important contextual ingredients in supervision. Although this picture emphasises the centrality of the supervisory relationship Holloway is at pains to point out the mutual influence that all the factors represented in the diagram have on each other. I intend discussing each of these seven factors in turn and considering to what degree they correspond to the findings of my own research.

Figure 10:

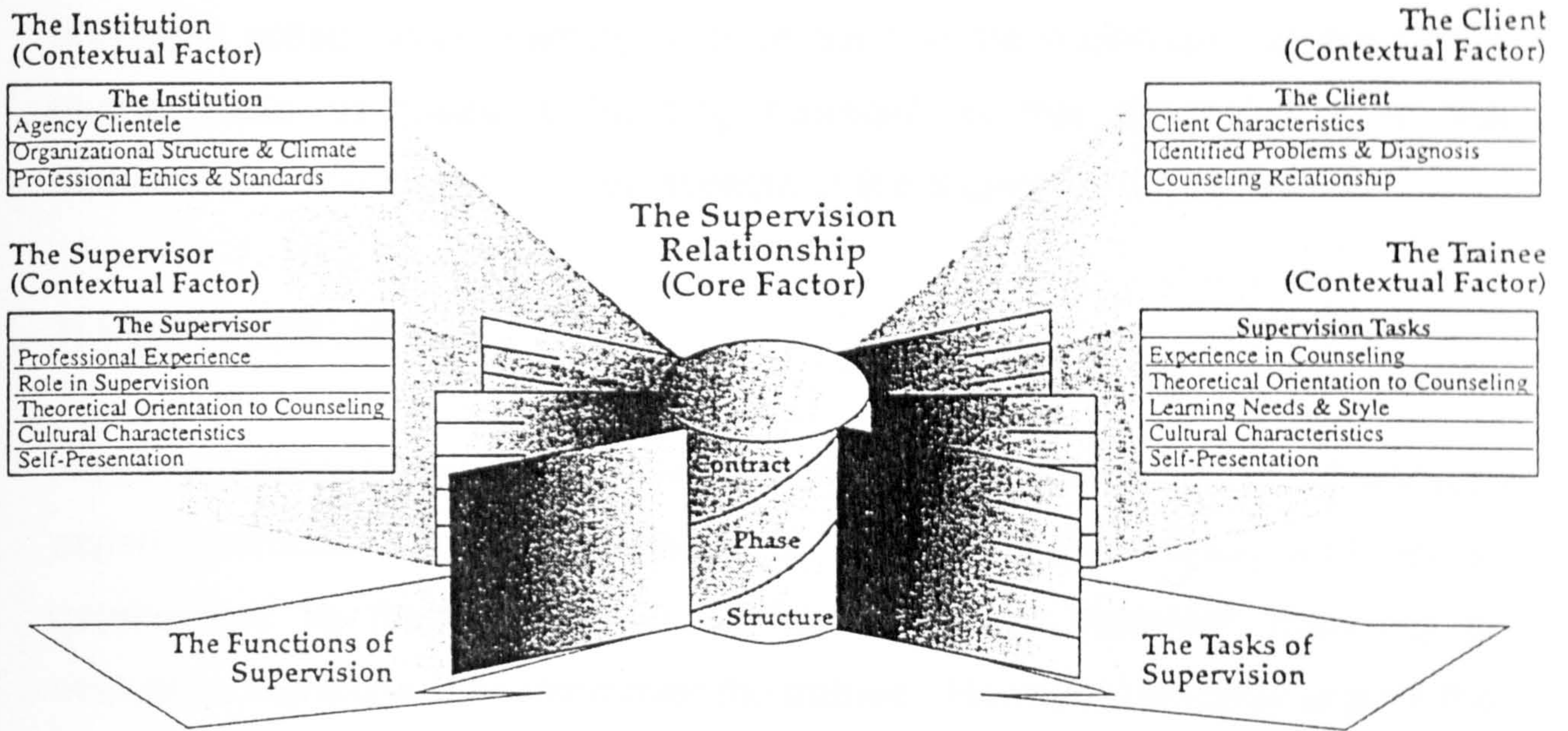


Figure 11:

Supervision Functions		Supervision Tasks						Supervision Tasks	
		Counseling Skill	Case Conceptualization	Professional Role	Emotional Awareness	Self-Evaluation			
Supervision Functions	Monitoring/Evaluating						Counseling Skill		
	Advising/Instructing						Case Conceptualization		
	Modeling						Professional Role		
	Consulting						Emotional Awareness		
	Supporting/Sharing						Self-Evaluation		

Process Matrix

From Holloway E L. (1995) Clinical Supervision: a systems approach, London: Sage.

The Supervision Relationship

Holloway considers that supervisor and supervisee share a responsibility for building a collaborative learning alliance but that the supervisor, as the senior partner, also exercises a “guiding function” in the development of the relationship. She identifies three aspects of the supervisory relationship:

1) Interpersonal Structure

Holloway acknowledges the power supervisors have over trainees. They give expert instruction, provide feedback on trainee’s performance and act as gatekeepers to their profession. The supervisor therefore occupies an evaluative hierarchical position over the trainee. However Holloway argues that in successful supervisory relationships the supervisor’s close involvement with the trainee results in their influence becoming increasingly personalized over the course of a placement. Their power in the supervisee’s eyes comes to stem from who they are and what they know as individuals rather than the role they occupy.

This factor has a lot in common with the “sapiential authority” category in my study. Also Focus Group 2 included an observation by one trainee who recalled how vulnerable he felt when under the jurisdiction of a supervisor with whom he was struggling to form a working alliance:

“some supervisors don’t realize the power they’ve got.”

2) Phases of the Relationship

Holloway draws on research into the establishment of friendships as well as the supervision literature to argue that supervisory relationships move through predictable sequences over time.

The process of “getting to know” each other as individuals is held to reduce some of the uncertainties inherent in a new working partnership as the other party becomes more predictable to both supervisor and supervisee. The pattern of communication within supervision thence becomes less formal and more idiosyncratic over time. Holloway does not however argue for any inevitable, uniform, unfolding of the phases of the supervisory relationship and recognizes the part that the inter-personal styles of both supervisor and trainee play in dictating the character of their dealings with each other.

A criticism of the current study, voiced in the consultation with the trainee group (see Chapter 7) is that its “snap-shot” recordings of supervisory exchanges gave little feel for the way any particular supervisor/trainee relationship evolved over time. However the video-taped sessions occurred at what Holloway termed a “mature phase” of the supervision relationship which may well have contributed to the fine judgement exercised by some supervisors in the timing of their interventions, which must have been informed by a close “reading” of cues emitted by the individual trainee. Also a number of the videotapes confirmed Holloway’s prediction that quite different and idiosyncratic ways of relating to each other would develop between supervision pairings over time (see for example the badinage of VTR 5). Although Holloway’s notion of the phases of the supervisory relationship shows some similarities with my category of timing, the concepts are significantly separate. Holloway is describing a developmental pattern over weeks and months whereas the theme of “timing” in my theory was derived from moment-to moment changes within individual supervision sessions.

3) Supervision Contracts

Holloway considers that the negotiation of clear goals and shared expectations within supervision forms a necessary basis for the satisfactory development of the supervisory relationship. This factor is very similar to the “structure” codes within the relationship category of my theoretical model (“goals”, “negotiate”, “expectations”, “organized”).

The Tasks of Supervision

Holloway usefully lists five broad tasks that she considers clinical supervisors need to help their supervisees master:

- * **Counselling Skill** - essentially intervention skill in therapy.
- * **Case - conceptualizing** - the capacity to produce a theoretical formulation of the client's problem.
- * **Professional Role** - learning the role expectations of a clinical psychologist, eg ethical standards.
- * **Emotional Awareness** - recognizing and using your own feelings during therapy.
- * **Self-Evaluation** - being aware of the limits of your own competence.

The critical incidents provided by the research participants in my study largely agree with Holloway's classification of the skills trainees develop through the experience of clinical supervision. Questions of therapeutic technique, problem formulation, professional issues, and counter-transference reactions were regularly the focus of the supervisory discussions reported.

However although I did create a “self-appraisal” code in the “consider” stage of the experiential learning cycle, this was infrequently identified as a competence to be developed through the medium of supervision.

Although it could be argued that opportunities to reflect on experience and receive feedback on one's performance would automatically promote accurate self-appraisal skills, research evidence suggest that a more systematic approach is required to achieve that task (Gordon M, 1991). I therefore consider that Holloway's identification of self-assessment as a task on which trainees should focus during supervision, did not stand out in my study.

The Functions of Supervision

If tasks are the "what" of supervision, functions are the "how" in the S.A.S model. Holloway lists five roles supervisors adopt in their dealings with trainees:

- * **Instructing/advising** - typical teacher/student communication.
- * **Modelling** - both implicitly as an exemplar of professional practice and explicitly when demonstrating a point using role-play.
- * **Consulting** - seeking out information, drawing out opinions from the supervisee.
- * **Supporting/Sharing** - providing "empathic attention" and encouragement for the trainee.
- * **Monitoring/Evaluating** - making judgements about the adequacy of the trainee's performance in their professional role.

All of these functions are to a greater or lesser extent also described in the current study. "Instruct", "advice", "role-play", and "demonstrate" are all codes in the planning stage of the experiential learning cycle. "Support", "encourage", "disclose", and "wavelength" are codes within the relationship category. The "problem definition" and "consider" quadrant of the experiential learning cycle includes a series of codes consistent with Holloway's "consulting" function such as "information seeking", "listen", "talk through", and "own view".

However it is harder to find clear examples of the monitoring/evaluating function described in my data. While the “feedback” group of codes within the “sapiential authority” category includes “positive feedback”, “monitor”, and “constructive criticism”, there is no explicit mention of summative evaluation on the supervisor’s part. Complaints in the Focus Group discussions also concerned the unhelpfulness of formative feedback from supervisors (unspecific, inconsistent etc). Perhaps if I had sought the views of supervisors rather than just trainees, the important gate-keeping job of passing or failing a clinical placement would have been more overtly discussed. On reflection it seems unlikely that the possibility of failing their placements never crossed the minds of the trainees who participated in this study. Either the questions I asked did not provide an opportunity for them to comment on this issue or they chose to keep this aspect of their experience in supervision to themselves (Ladany N et al., 1996).

Task + Function = Process

Holloway neatly defines the process of supervision as the roles supervisor and supervisee play at any given point in supervision to tackle a particular task. Some combinations within Holloway’s tasks/functions matrix make immediate intuitive sense for example providing a supportive climate in which the trainee’s emotional response to a client’s distress can be considered. However Holloway does not prescribe “correct” combinations for supervisors to follow but sees the choice of how best to achieve a particular learning objective with an individual trainee as a strategic decision for the supervisor to make. It is the success or failure of these “matching” decisions that characterizes episodes coded in this study under the “timing” category. The experiential learning cycle also suggests that some sequences of supervisor behaviour may be more effective in helping trainees achieve their goals (for example if instruction follows a process of problem definition, reflection, and formulation, rather than coming as a “just do it” injunction).

The ideal supervisor in Holloway's scheme would evidently be able to fulfil all five functions with equal facility. However in practice we are all probably more comfortable in some roles than others and ultimately these preferences may crystallize into a personal supervisory style (Friedlander M.L. & Ward L., 1984). Trainees will also likely develop relatively stable preferences for how they play their part in the supervisory process. Inflexible supervisor and trainee styles are rarely a recipe for successful supervision as neither party is well-equipped to use corrective feedback when the system hits trouble (see Chapter 8).

Contextual Factors

As Holloway's views on the influence of contextual factors on the outcome of supervision were discussed at some length in Chapter 6, I will provide only a brief synopsis of this aspect of her model here. Holloway identifies four categories of contextual influences on the outcome of clinical supervision:

- * **Supervisor factors** - eg role expectations, theoretical affiliation.
- * **Supervisee factors** - eg self-presentational style, specific learning need.
- * **Client factors** - eg presenting problem that particularly resonates with trainee's past experience, diagnosis.
- * **Institutional factors** - eg which client group the agency serves, organizational climate.

The accounts of unhelpful supervision in the Focus Groups gave ample evidence of the role supervisor, supervisee, and institutional factors can play in affecting the course of supervisory relationships. Both the critical incident reports and the videotape recording of individual supervision sessions provided vivid examples of client factors directly influencing both what material trainees chose to bring to supervision and how they discussed their clinical experience.

I did not however register any examples of what Holloway described as the “familiar phenomenon” of a parallel process within the supervisory relationship that replicated the dynamic of the trainee/client dyad. Since I did not clearly register the importance of client factors as part of my coding of contextual factors it may be that this reflects a lack of theoretical sensitivity on my part.

The model developed in this study instead lays an emphasis on the importance of the working relationship between the training course staff and both supervisors and supervisees. While Holloway notes as one of her institutional factors the tension agencies might experience when managing a conflict between therapeutic and educational priorities, her model does not specifically recognize the role played by the wider course community on what unfolds in the supervisory relationship. You win some you lose some.

Conclusion

The data collected in this study, particularly the critical incident accounts and Focus Group discussions, are strikingly similar to the material reported by other researchers investigating the experience of clinical psychology trainees in the UK (McCrea C. & Milsom J., 1996; Hitchen H. et al., 1997; Hirons A. 1991). It is instructive therefore to compare the theoretical model I have built from what could be called, without disrespect, commonly available raw materials, with Holloway’s conceptual framework. There is undoubtedly considerable overlap in our ideas. The supervisory relationship, the context in which supervision occurs, the process of learning, and the “earned” authority of the supervisor, are identified in both schemes. Both models are broadly systemic in nature recognizing both the reciprocal relationship between supervisor and supervisee and the dynamic interaction between the various factors specified within the theoretical framework.

Holloway's S.A.S scheme is more comprehensive in its scope incorporating important issues such as the development of the supervisory relationship over time and the direct impact clients have on supervision that were not identified in the current study.

On the other hand I am prepared to claim, somewhat immodestly, that some issues my model emphasises such as the timing of supervisory interventions and the emotional micro-climate of the supervisory relationship, add something extra to Holloway's thinking.

Chapter 10

Conclusions

Wolcott in his short book entitled "Writing Up Qualitative Research" (Wolcott H. 1990) offers two bits of sage advice for those struggling to find the right way to conclude a piece of work such as this. First he quotes Lewis Carroll's tip to inexperienced authors - "When you come to the end, stop." To this he adds his own pithy recommendation that "it is not necessary to push a canoe into the sunset at the end of every paper." So nothing too long and nothing too dramatic seems to be the order of the day. I shall therefore restrict my concluding comments to those two traditional mainstays of the final chapter - limitations of the study and implications of its findings.

Limitations

I have tried to provide a full and detailed account of all aspects of this research programme, so I think it unlikely any reader will have got this far into the thesis without noting a flaw or two in its design and implementation. I intend discussing only three issues here (without implying these are the only faults I could find).

The sample of trainees who participated in this study was not randomly selected. On the contrary they were something of a captive audience over whom I exercised a social influence over and above that of the detached researcher. I was (and am still for some) their boss. In the Critical Incident phase of the project some trainees provided many more reports than others (see Chapter 3). The index-searching facility of the NUD*IST programme allowed me to check how much of my theorizing was based on the evidence provided by the three most active participants who contributed 28% of the total pool of critical incidents.

In fact only 3 of the 160 codes in the final theoretical model (“recall” and “flexible” from within the experiential learning category and “apologise” from within the relationship category) relied exclusively on the testament of this subset of critical incident reports. Nonetheless there is no doubt that the experience of some trainees on our course has inevitably been disproportionately represented in this study.

This acknowledgement does not, in my view, seriously undermine the results reported here. “Convenience Sampling” is commonplace in qualitative research and was supplemented by purposive sampling for the IPR exercise in which I invited a small but representative group of trainees to participate (Cohen L. & Mannion L., 1994). In practice the sample of participants turned out to be typical of the trainee group as a whole (eg gender mix, range of specialities, year of study) and these characteristics in association with a detailed description of the context in which the research was conducted should allow readers to make a judgement on the transferability of the study’s findings to other settings (Schofield J.W. 1990). Maybe generalization in qualitative research is more about “theoretical propositions than populations” anyway (Hartley J. 1994).

Despite this robust defence of the way the evidence in this study was accumulated, it is important to acknowledge that its findings would probably carry more weight if I had employed a more systematic way of recruiting participants, for example by quota sampling (Cohen L. & Mannion L., 1994).

My second reservation about the study is the decision to base my theorizing solely on the supervisee’s experience of the process of clinical supervision. It would have been instructive to have been able to simultaneously tap the supervisor’s perspective on events (eg Hiron 1991). This would I think have had two primary benefits.

Firstly the results of the study would have been more credible in the eyes of clinical supervisors who are the most likely consumers of research in this field (see the diary report of the supervisors' workshop in the appendix). Secondly I think incorporating the supervisor's experience would have highlighted earlier in the study the importance of the trainee's contribution to effective supervision. The supervisee's perspective necessarily has the supervisor in line of sight, and vice-versa. I took a long time to recognize that supervisee as well as supervisor competence matters in supervision. I think I would have got there more quickly if I had adopted a research strategy which investigated the experience of both sides of the supervisory partnership.

My third reservation about the design of this study concerns the "snapshot" quality of the data collection. A strength of the theoretical account that has been developed is its secure grounding on the specific experiences of trainees. However, with the possible exception of the IPR exercise when trainees commented on videotape recordings of supervision sessions, I failed to place these episodes in the context of the evolving relationship between the trainee and their supervisor. Holloway's emphasis on the "phase" of the developing relationship in supervision was echoed by one of the year 1 trainees I consulted in one of the validation checks (see Chapter 7). Had I been able to "track" a supervisory relationship over time it would also have been possible to collect more meaningful outcome data than that provided by the crude classification of outcomes from the critical incident reports. It is unquestionably hard to relate specific interventions in supervision to consequent clinical outcomes in therapy (Holloway E.L. & Neufeldt S.A., 1995) but precedents for monitoring both the process and the results of supervision over time do exist (Rabinowitz F.E et al., 1986).

The final limitation of which I am acutely conscious does not concern the design or conduct of the research programme but my frustrations at trying to find the words to describe my efforts. When writing-up this account I have struggled to strike a balance between providing an appropriate level of detail and overloading the reader with redundant information. Since qualitative research has not yet developed a standard template for novice investigators like me to adopt, I have made my own decisions about what to put in and what to leave out. I know I have, as a consequence, erred towards the over-inclusive in a way that few journal editors would tolerate (Golden-Biddle K & Locke K., 1997). I think perhaps I should have followed Wolcott's maxim "do less more thoroughly" (Wolcott H. 1990).

Implications

Although the provisional theorizing favoured by qualitative researchers accords with recent developments in post-modernist philosophy (Kvale S. 1996) and social constructionism (Burr V, 1995), it is also consistent with the earlier principles of American pragmatism (Dewey J. 1930). Dewey argued that a characteristic of all practical endeavours, supervision included, is the inherent uncertainty of their outcome. He hence advocated that research into practical matters be judged by its usefulness not its truthfulness.

I too ventured into this research programme with the expectation that I could apply its findings in my day-to-day work. I think the primary implication this study has is for the local supervisor training programme which I co-organize. The pertinence of this research to supervisors and supervisees on the Leeds course is unlikely to be questioned. The study may also inform a wider debate on what form supervisor training within clinical psychology should take in the future.

In Britain the accreditation criteria for post-graduate clinical psychology courses currently direct programme organizers to run supervisor training events but provide no guidance as to content. In North America, APA accreditation of doctoral programmes does not require any training whatsoever in how to supervise (Knapp S & VandeCreek L., 1997). However the picture is changing and recent publications have suggested appropriate content material for supervisor training courses (Green D.R. & Wang M., 1997; Russell R.K & Petrie T., 1994) and formats to promote learning such as manuals for novice supervisors (Neufeldt S.A. 1994) and consultation groups for more experienced practitioners (Holloway E. 1997) The findings of this study can add to the expanding intellectual resource on which course organizers can draw. When clinical psychologists in the UK are being exhorted to make a serious commitment to their continued professional development in general, and in particular to enhance their supervisory skill (DCP, 1998) this may prove a timely contribution.

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Appendix 1

Critical Incident Report Form

CRITICAL INCIDENTS ANALYSIS

As part of a research project to try and identify the component skills of effective supervision, I am seeking to collect real-life examples of particularly helpful practice. I am therefore asking all trainees to record at the time descriptions of episodes in which they feel they have definitely benefited from the process of clinical supervision. Please describe:

1. The context ie the nature of the problem you were seeking to resolve, any pertinent history.
2. What the supervisor actually did, said, conveyed etc.
3. How this was related to a beneficial outcome for the trainee and/or the client concerned.

It will help me both to gather a representative sample of incidents and to pursue any interesting hypotheses if you could record the following details:

Trainee name:.....

Placement Speciality: Adult / Child / Learning Disability / Elderly / Elective

Year of Training: 1 2 3

Date of reported supervision session:.....

**PLEASE COMPLETE A SEPARATE FORM FOR EACH INCIDENT
SEE OVERLEAF**

I intend collecting this material routinely for all placements completed before 1/10/1996. Thanks for your help.

David Green

APPENDIX 2

Three Examples of Critical Incident Reports

1

***Problem**

Solicitor hassling me for comments on a particular client - re. court compensation claim.

***Supervisor**

- a) Found out whether I was qualified to give this information.
- b) Talked to me about what court reports/appearances entail.
- c) Phoned solicitor on my behalf and explained situation.

***Outcome**

- a) Took pressure off me to respond to something I didn't feel experienced to do.
- b) Told solicitor what channels to go through should he want that sort of information.
- c) Took the guilt and responsibility away from me i.e. he defined my limits/boundaries/expectations for me

2

***Problem**

Meeting young man with learning disabilities in training centre for individual sessions. During sessions client begins to touch my arms and hands inappropriately if given opportunity.

I am uncertain how to respond.

***Supervisor**

Speak to supervisor re inappropriate touching - not wanting to simply say stop/don't or removing opportunity, but not wanting to sanction this touch. Supervisor and I discuss nature of touch (caress vs need for contact/nurture) and when it happens. Suggest I comment on the touch if it happens again eg. "I notice you like to". Why is that? Etc.

***Outcome**

Follow advice and discussion re. need for touch becomes important part of therapy sessions.

3***Problem**

The penultimate session with a client was very traumatic. The client was a 9 year old boy who had been sexually abused (extra-familial). I was undertaking play therapy with him. This session was very worrying for me. He was very agitated and spent much of his time "boundary testing". He seemed intent on frightening me and laughing at my response. I was worried that he was trying to give me a message I wasn't picking up. I was also unhappy about the content of the session and how I had responded to it.

***Supervisor**

My supervisor dealt with the problem in 2 ways. She clearly demarcated supervision: practical professional help and support: helping me explore how I had been affected by the session. These were separated out and dealt with at different times. In supervision, we explored the process and content and my supervisor guided me with a description of therapeutic progress with previous clients in her experience. My concerns about missing something were somewhat allayed by advice to trust the client. Support enabled me to separate out how I felt about the session.

***Outcome**

I had been very worried about seeing the client for the final session. This helped me to understand why I felt that way and enabled me to re-focus on my client. I did trust the client and was gratified with a very useful final session. I was able to keep my issues separate and keep my "feet on dry land". We had a good ending.

APPENDIX 3

Full List of all Codes used in the Study with Definitions

expel

experiential learning promoted by supervision

probdef

problem is defined as part of supervision

observe

supervisor directly observed the trainee's performance in a clinical setting

listen

supervisor listened closely to what trainee had to say

tapes

supervisor listened to and reviewed audio-tape or video-tape recordings of the trainee's therapy sessions

question

supervisor asked trainee why s/he was taking a particular approach

focus

supervisor homed in on a key issue

infoseek

supervisor elicited relevant information from the trainee or other relevant source

de-brief

detailed review of trainee's experience

clarify

supervisor's intervention makes a point clearer

consider

supervisee is encouraged to stop and think

reflect

supervisor promoted reflection on the part of the trainee ie encouraged trainee to think about what had happened in a session and why

discuss

supervisor and trainee talked over an issue (eg arising from clinical work) and considered alternative viewpoint

stepback

supervision allowed the trainee to gain distance from a therapeutic situation and feel more able to "see the wood from the trees"

loosen

supervisor enabled trainee to adopt a more flexible view of their position

play

supervisor encouraged trainee to "play around" with ideas. Allowed trainee to move away from the notion of a definite right or wrong answer

alternative

supervisor encouraged trainee to consider alternative perspectives

re-attribute

supervisor helped trainee make a different sense of a problem by re-locating the responsibility for a particular outcome

challenge

supervisor's comments constructively challenged the analysis of a session presented by the trainee

compare

supervisor considered and compared alternative explanations

shoes

invited trainee to put self in client's shoes

identify

noted particular patterns

self-app

helped trainee develop self-appraisal skills

recall

systematic process recall of session

talk through

supervisor and trainee reviewed in depth particular session

own view

supervisor sought trainee's views on an issue

theory

supervisor made links with wider theory

papers

supervisor provided trainee with copies of relevant scientific articles from psychology journals

refer

supervisor made reference to an established research finding or publication

sense

discussion in supervision enabled the trainee to make coherent sense of his/her experiences

overview

supervisor noted a recurrent theme or pattern across a number of cases or situations

integration

as a result of supervision trainee thought things "fitted in" together more convincingly

interpret

supervisor offered an interpretation of a particular pattern of interaction between trainee and client

formulate

supervisor encouraged trainee to generate hypotheses about why a client was acting/talking in a particular way

framework

supervisor suggested a theoretical framework within which the trainee could make sense of their experience

links

made therapeutic connections

process

made sense of an emotionally intense experience

revise

revised formulation in light of new evidence

history

supervisor enabled trainee to appreciate historical context of case

diagnosis

supervisor and trainee discussed appropriate medical diagnosis

theoprac

the art of turning theory into practice

imply

supervisor considered with trainee what implications a particular analysis might have for future practice

apply

supervisor provided a forum in which the application of theory to a particular case could be discussed. Characteristic of the "scientist/practitioner" approach

strategy

broad planning principles discussed

plan

action plan devised in supervision

anticipate

supervisor asked trainee to imagine what s/he might say or do in certain circumstances. What if.....

prepare

supervisor helped trainee prepare for forthcoming challenge

demo

supervisor modelled an intervention for the trainee to copy

role-play

supervisor role-played a scenario with the trainee

instruct

supervisor basically told the trainee what to do next

suggest

supervisor made an explicit suggestion about a route the trainee might follow

D.I.Y

supervisor encouraged the trainee to work out a problem him/herself

describe

supervisor described approach in close detail

decide

supervisor and trainee jointly decided on a course of action

flexible

provisional plan agreed subject to review

advice

supervisor offered direct advice to trainee

enact

plan put into practice

step-in

supervisor acted on trainee's behalf to help resolve a problem

joint

supervisor and trainee agreed to collaborate to resolve a particular problem

relationship

factors influencing the supervisory alliance

attitude

attitude supervisor conveyed to trainee

non-judge

supervisor adopted a non-judgemental attitude towards trainee

seriously

supervisor took trainee's concerns seriously

respect

supervisor's attitude to trainee indicated the respect appropriate for professional colleague. Leads to trainee feeling "valued"

apologise

supervisor straightforwardly said "sorry" to the trainee

candour

trainee and supervisor openly aired differences of opinion

encourage

supervisor encouraged trainee to contribute in supervision

collaborate

supervisor created a collegiate relationship with trainee

sensitivity

emotional sensitivity of supervisor

cues

supervisor picked up cues that the trainee was ill-at-ease for some reason and explored why

feelings

supervisor demonstrated sensitivity to the trainee's emotional state

express

supervisor encouraged trainee to be open about his/her feelings

disclosure

supervisor shared some helpful aspect of their own experience

counter-trans

supervisor helped trainee to make sense of their own emotional reactions to a particular case. Sometimes resulted in a useful "separating out" of client's as opposed to trainee's feelings

wavelength

trainee felt supervisor was tuned in to what they were saying

structure

the placement logistics

organized

supervisor took care to organize trainee's experience appropriately eg detailed placement plan, or clearly defined structure to a particular supervision session

access

supervisor made him/herself available to the trainee in a notably helpful way

negotiate

supervisor negotiated structure of supervision with trainee

goals

clear placement goals agreed

expectations

supervisor was clear about what trainee was expected to do

climate

the interpersonal climate established in supervision

containment

supervisor's reactions helped the trainee to manage their own emotions eg not to panic

safety

supervisor established a climate in which the trainee felt safe to take a personal risk such as self-disclosure

protect

supervisor took action to protect the trainee from a perceived threat

support

trainee experienced supervisor's attitude as supportive

relaxed

supervisor and trainee at ease in each others' company

careful

supervisor paid careful attention to material in supervision

business

relationship had a business-like professionalism

fun

supervisor and trainee laughed a lot together

permission

supervisor felt given green light to talk in a particular way

authority

sapiential authority gave weight to supervisor's opinions

feedback

supervisor's feedback on trainee's performance

positive

supervisor provided positive feedback to the trainee on what they had been doing right

reassure

supervisor re-assured trainee that s/he was on the right track

concrit

supervisor made specific helpful criticism of the trainee's work

monitor

supervisor checked on trainee's work eg read letters

specknow

supervisor had useful specialist knowledge

local know

supervisor had useful information available courtesy of his/her position in the local professional system

expert

supervisor's expertise in using a particular therapeutic approach was appreciated

experience

trainee appreciated access to a senior colleague's wider knowledge and experience

therapist

supervisor used their therapeutic skill to help trainee appropriately

credibility

supervisor's experience and seniority gave credible status

validation

supervisor endorsed some aspect of trainee's experience that was felt to legitimize their point of view

normalize

supervisor took a "these things happen" approach to some aspect of trainee's work that worried them

realist

supervisor recognized what was realistic in a given situation

integrity

trainee considered supervisor acted in a moral manner

C welfare

supervisor demonstrated concern for client's welfare

T welfare

supervisor showed practical concern for trainee's welfare

responsibility

supervisor accepted responsibility that came with their role

timing

supervisor did or said the right thing at the right time

development

supervisor was judged to be appropriately tuned to the developmental needs of the trainee at a specific stage of their training

match

supervisor's approach was experienced as well-matched to the trainee's individual needs

prompt

supervisor responded immediately to a potential crisis

interrupt

supervisor stopped trainee's flow of conversation to make point

wait

supervisor did not interrupt flow of trainee's account

pace

supervisor adjusted to tempo of trainee's account

summarize

supervisor summed up what had just been discussed in supervision

problem

why trainee sought help in supervision

noproblem

no immediate problem

T's emstate

trainee's emotional state was main issue

anxiety

trainee was worried about some aspect of therapy

angry client

client expressed anger at trainee

fed-up

trainee was unhappy

de-skilled

trainee felt incompetent

overcome

trainee overwhelmed by own emotional reaction to case

too close

trainee felt over-involved in case

understanding

trainee sought greater intellectual understanding

struggle

trainee unsure how best to make sense of therapeutic material

don't know

trainee hadn't much idea at all

critpoint

therapy had reached a critical point in trainee's view

stuck

therapy stuck

crisis

therapy in crisis

uncertainty

trainee was unsure about own performance

what next

trainee not sure of future course of therapy

doubt

trainee unclear about why therapy had taken a particular course

content

nature of particular problem raised in supervision

sexabuse

trainee concerned about possibility of sexual abuse

supervision

problem identified in supervision relationship

ethic dilemma

trainee faced an ethical dilemma

intparties

supervision centred on other interested parties

profcon

potentially problematic contact with other professionals

family

possible problem with a member of client's family

other

possible problem with a non-family and non-professional interested party

outcome

what followed supervisory intervention

trainee

trainee had benefited directly from supervision

client

client benefited directly from supervision session

T and C

both trainee and client benefited from supervision

other

someone else not trainee or client benefited from supervision

context

the background factors influencing supervision

supervisor

factors in supervisor's life affecting supervision

trainee

factors in trainee's life affecting supervision

department

organizational factors in host department

course

relationship of supervisor and trainee to training course

Appendix 4

Minute of "Dialogic Intersubjectivity" Exercise

CODING AGREEMENT

INCIDENT NO 90

	CS	1	2	3
DG	1	✓2,2,1 ✓2,2,4 ✓3,3,1		
	2		✓2,2,1 ✓2,2,4 ✓3,3,1	
	3			✓2,2,1 ✓2,2,4 ✓3,3,1

EXTRA CODINGS

A BY DG BUT NOT CS

1,1,4. QUESTION

1,2,7. RE-ATTRIBUTE

B BY CS BUT NOT DG

2,2,2. FEELINGS; 2,1,5. CANDOUR; 2,4,1. CONTAINMENT;

2,4,3. PROTECT; 1,5,5. INSTRUCT.

Comment

1. QUESTION (coded by DG but not CS) and INSTRUCT (coded by CS but not DG) seem like omissions rather than disagreements.
2. CS homes in on the RELATIONSHIP (2-) factors that allowed trainee to be open. Some of these factors (2,2,1 and 2,2,4) noted by DG but not all.
3. DG notes RE-ATTRIBUTE by T in not seeing the problem as within herself. Not remarked by CS.
4. Joint decision to accept all codes.

APPENDIX 5

Transcript of Trainees Commentary on VTR 1

***1.16**

G asked who I wanted to start discussing first during the session, which he usually did and which I found helpful to structure how I was going to talk over the work I'd done that week.

***2.12**

G interrupted my flow to ask questions which is useful because otherwise I would tend to just talk and talk and talk.

***2.43**

G interrupted me, not to ask a question this time but, to help me think more about why the client had told me what she had.

***3.09**

The way in which we were discussing what the client had told me was very much to weigh our views on it which again I found helpful. G wasn't telling me but letting me think back to the session.

***3.59**

As I'm talking G is nodding and agreeing and encouraging me to carry on which gave me confidence in what I was talking about and that he understood and agreed with what I was saying.

***5.52**

I've been talking for some time about a session that happened that morning. G's not interrupting he's just letting me recount what happened, which I think I find helpful because by talking through what happened it's reminding me of the key things that I want to pick out and know that G will help me pick those out when I come to them, but without interrupting I can just work through the session at my own pace.

***8.47**

Following on from what I've been talking about G's asked a question of me which I hadn't actually asked directly in the session. That's making me feel awkward because I'm realising that maybe it's a logical question following on from what we've been talking about that I should have asked.

At the same time it's helping me understand what might be a better way to move forward in that kind of situation in the future.

*10.05

G's reflecting back on what I've told him about the session which is helpful because I'm tending to be stuck in the content of what happened in the session and he's helping me look more objectively back over the meaning of what the client has told me.

*12.07

My answer to G's previous question was long and rambling but that was while I was thinking through it and now G is summarising some of what I've been saying which is helping me draw together the thoughts that I've been rambling through.

*13.46

Over the previous couple of minutes G and I have been having more of a dialogue, both commenting and reflecting equally. At this point we're looking at an eating diary that the client had kept a few months previously and again it feels comfortable for me to be working and thinking together with G about the client.

*14.58

As this is my final session with G I'm reviewing the progress the client has made looking back at some questionnaires. She's shown improvement which I'm pleased about and we're both laughing and pleased that the work has gone quite well.

*17.02

G's summarising our joint understanding of the client following the completion of the second round of questionnaires and again helping me think more objectively and coming out of the detail of the questionnaires and thinking more globally about what overall that means for her and how she's changed.

*20.32

G's pointing out to me possible meanings for the client's behaviour during the final session I had with her, which having given me the space to talk about I hadn't brought up.

*22.25

G's comments are drawing me away from describing the content of the sessions and towards thinking about and analysing the meaning and trying to understand the client more.

*25.14

G's explaining the referral procedure that operates within the hospital so that I'm clear who to write back to in the progress letter.

26.36

G's read through my letter that I've written to the referrer carefully with a view to making comments and suggestions for changes and is taking the task seriously.

*29.26

G's making notes on this client whom he's going to take on at the end of my placement. This is reassuring for me as it helps me realise that G's taking seriously what I'm saying and listening attentively, also that what I'm saying will be useful in the work he goes on to do with the client.

*31.41

I've been describing how the client presented herself during the session and G's helping me to make links between what I've observed in this client and what I've learnt from teaching about other conditions.

*33.48

G's comment shows that he can remember about the client and remember things I've told him about her before.

*38.32

G's comment shows that he's listening and that he understands what I'm saying and thinking.

*42.51

As I'm relating one of the parts of the session with the client G's reactions of concern and surprise mirror the reactions that I had when the client was with me in the session. This is reassuring for me to see that his reactions are similar.

*48.30

What I'm telling G about the previous session is information that I feel will be important to the work he continues to do with the client. He's clearly listening closely and the questions he's asking me are showing he's picking up on the same things that I'd felt were important during the session. So this is reassuring for me to know that in the next session that he will have with the client on her own without me there, they'll be able to pick up on the previous session quite smoothly.

*49.07

G is reflecting back his understanding of what I've told him from our session which again confirms to me that he's understanding what I'm saying and the feelings that came out from that session with the client.

*50.29

G's recalling back something that we talked about earlier in an earlier supervision session which links to what we're talking about this time. This is helpful because I don't think it's a link I'd made myself at that point.

*54.15

In the last couple of minutes G has been summarising some of what he's thought from what I've told him which is reassuring to me for knowing that my part in that session was adequate.

*56.56

Again G's summarising what I've been saying and agreeing with the thoughts that I've had which is helpful in that I know both that my role in the session was OK and that the following session he has with the client it will continue in the same vein.

APPENDIX 6

Researcher's Memo Concerning Appendix 5

This tape is notable for the way it re-inforces and extends the key components of the supervisory model developed so far in the analysis:

1. There are clear indications of all phases of the experiential learning cycle being employed within the discussion of a single case. Also the supervisor is commended for offering a summary of his/their understanding on several occasions. I think the summarizing completes one learning cycle and then provides the basis for further joint reflection.
2. The two participants evidently get on well together. This is made explicit in some of the trainee's comments about being on the same wavelength and sharing a laugh, but is also evident from the non-verbal information on the tape - posture, facial expression, acknowledgements etc. The attentive way in which the supervisor notes what the trainee is saying and has said in past sessions, adds a further element to the analysis.
3. The supervisor's authority is recognized both in his knowledge of the local hospital system and in his moral integrity as evidenced in an impressive professionalism in trying to ensure that he can provide proper care for a client he is taking over from the trainee on the completion of her placement.
4. The timing issue is intriguing. Within a matter of minutes the supervisor is commended for interrupting then not interrupting. At a later stage he is commended for validating then for challenging the trainee's viewpoint. Seen in the full context of the supervisory conversation there is no contradiction in these seemingly incompatible behaviours. It is a straightforward issue of timing and matching - no doubt aided somewhat by the fact that this is the last supervision session of a successful 6 month placement, and the two parties know each other well.

APPENDIX 7

Extract From Transcript of Focus Group 2

*HE

I think I needed someone to tell me what to do on the first placement but I didn't actually respect the person who was doing the telling which made it very difficult with what I was doing because I, it was a weird placement in that he used to be very personal about things and always commenting on things like my appearance and quite sort of sexual connotations quite often and also with clients. And I felt very uncomfortable sitting in with him with his erm, clients and also some of the comments he used to make to me, talked to my clients about; so that I didn't respect what he was trying to get me to do in sessions and I found this very difficult, it wasn't the way I wanted to work. At least certainly not in that first placement, erm, so that wasn't at all helpful, he just never got any respect from me, which was unfortunate.

*DG

Well yes, this is a theme that I wouldn't mind us exploring a bit further, in that these are professional models to whom you're responsible erm, what about the dilemma you might be in if you can't take them seriously or even worse than that you have concerns for how ethical their practice is, is basically what you're saying.

*HE

It was but I didn't realise it the time, I just felt uncomfortable and thinking why am I here, what am I doing on the first placement. It just felt you know, I didn't really..never worked in that area before and I didn't know what was going on. Now I would say something.

*RB

Mmm, the stage is quite crucial isn't it? When you start you're so unconfident and I was anyway, I mean sort of felt absolutely, I really didn't know what I was doing erm, you don't have the confidence if something's wrong you don't have the confidence to say. You have no previous model to compare your experiences to. I mean I had no idea what to expect, I'd never been a psychology assistant, I'd never really been in a clinical psychology department, so having no frame of reference I suppose you accept, well I suppose it's just the way it is and wouldn't speak out, well I didn't speak out.

*HE

You don't want to jeopardise your placement either, your first year on the course you don't really want to sort of say anything in case you're not believed or somehow you're putting yourself in a vulnerable position and sort of like go along with it and keep quiet.

*CT

Because overriding all that is the very fact that you're new to this and your supervisor..

*HE

And they have to pass you at the end of it.

*CT

....and they have to pass you.

*AS

And I think if there is a mismatch between the way they work and the way you want to work you don't really know that at that time because you're not.....

*CT

No, but it feels funny.

*AS

..You just know 'I can't do this', so that just feels like your inadequacy. Because I know I couldn't do, like I would sit in with my first supervisor and his client sessions quite often lasted fifteen minutes and they were very directive and I just couldn't work like that but I would just put that down to my slowness or inadequacy or whatever, but now I think there's no way I would want to work like that. First placement seems so important and it seems to be the one with all the bad experiences.

*DG

Well that's partly to do with you learning how to be a trainee an effective trainee as well as, there's a big responsibility with the supervisors to induct you into that.

*RB

Think one of the specific problems I had in the first placement was knowing the nature of the relationship between the supervisee and the supervisor and in that placement it was very erm, I suppose formal and it was very, very much focused on work and not really talking about anything personal at all. Erm, that's been quite a different in other erm, placements. That was very much work-focused, which was good in one way because it was, my supervisor was very clear that this is what it's about, but then I mean I had quite a few problems in the first placement.

Not so much to do with the placement but more a matter of adjusting to..to being a trainee and I did try to talk about that and I mean the response wasn't undermining, it was just sort of blocking in a way, although I think the supervisor was trying to be...to help, but it was just in a way that I didn't find helpful and so I didn't feel able to then talk about it again and so...I mean like J the point about communication, I was left feeling very, very anxious and very sort of erm, can't think of the word but erm, yeah inadequate but not feeling able to say that to the supervisor.

*DG

And that contrasts with subsequent experiences you've had in supervision when you've taken those sort of risks of revealing your feelings and it's been confirmed in some ways.

*RB

And the response has been very helpful, yeah. I suppose it's about, I don't know, I don't think it's going back to one of the supervisors I'm not saying it was a problem with the supervisor it was knowing, knowing that you can take that risk, it was mainly being encouraged a bit more, to talk a little bit more because that's what I really needed to do in my first placement .

*HE

I think that's the opposite to mine 'cos I felt mine wanted to know too much about my personal life, always going on, kept asking questions that I felt totally inappropriate and wrong entirely, whereas yours didn't want to know enough about you.

*RB

Yeah, yours was sort of invasive wasn't it.

NB DG is the researcher acting as facilitator of the group discussion.

APPENDIX 8

Threats to Experiential Learning

- * "You couldn't actually learn anything - just reporting back."
- * S provides "case-management not training".
- * Feedback problems - none or not specific enough to be helpful.
- * "You're doing just fine."
- * No space for 2 parties to discuss different points of view.
- * Pressure on T to take on more clinical cases - spare pair of hands.
- * T overloaded with "interesting cases" - no time to reflect.

Threats to the Supervision Relationship

- * S not taking trainee's concerns seriously
- * Communication problems. Not tuned into each other's expectations.
- * S's self-disclosure experienced as unhelpful by T.
- * T does not feel safe to take risks.
- * T does not feel adequately protected by S eg home visits/local politics.
- * S makes intrusive personal remarks to T.
- * Friend/Supervisor balance goes awry - too reserved or too chummy.
- * T loses trust in S - "felt betrayed" by S's unreliability.
- * S is inattentive (eg to patient details).
- * S misuses power to intimidate T.

Threats to Sapiential Authority of Supervisor

- * T doubts S's clinical competence.
- * S acts in unethical fashion eg sexual innuendo.
- * S does not monitor T's caseload appropriately.
- * S does not take supervisory responsibilities seriously.
- * S avoids or postpones discussion of difficult cases.
- * S seen as "too expert" - categorical directions, only one right way.

- * S not seen as expert enough - "not technically up to it."
- * S does not engage in own CPD - especially own supervision.
- * S not able to reflect on the process of supervision itself.
- * S seemingly unresponsive to feedback on own performance.
- * T unsure of knowledge base of S - better to acknowledge areas of ignorance/inexperience.
- * S threatened by "up-to-date" trainees.
- * S feels status undermined by "doctoral" students.

Timing Problems

Mistimings:

- * S "didn't want to be there" - 15 minutes maximum.
- * Informal chats instead of time-tabled supervision.
- * Availability is a question of attitude not just competing priorities.
- * S discusses own cases in supervision (unhelpful to T).
- * S mounts own hobby horse too regularly, Wastes time.
- * T needs to "pin down" S to get formal supervision.
- * S not available outside formal supervision slot.
- * Supervision curtailed - "got to go!"
- * Alternative supervision not arranged.
- * Pressure of other commitments on S's time.
- * T left to organize the agenda for supervision.

Mis-matches:

- * S a practical problem-solver, but T needs emotional understanding.
- * T urgently wants to discuss a case, S suggest they go shopping instead.
- * T needs reassurance but this is not S's style.
- * Developmental mismatch eg too much direction at end of training.
- * Incompatible ways of working therapeutically.

APPENDIX 9

Contextual Factors

a) The Supervisor

- * "own issues" eg domestic problems
- * "screwed-up themselves"
- * job under threat
- * own support and CPD needs not being met
- * S's vulnerability deters T from making otherwise reasonable demands

b) The Trainee

- * previous experience of supervision (eg first placement)
- * self-confidence versus fear of failure
- * reputation of supervisor - the grapevine

c) The Department

- * patients before students when resources are scarce
- * single-handed practitioners in smaller specialities
- * recent experiences with trainees - positive or negative
- * local politics
- * no shared commitment to trainees

d) The Training Course

- * supervisors pressured to provide placements
- * course is reliant on its supervisors
- * bit of an "old boys' (girls') network"
- * mid-placement visits not effective in resolving problems
- * out of Region placements when S unfamiliar with Course
- * split-placements organized

Appendix 10

Diary Account of Newcastle Supervisor Training Course

16 th September.

I presented the story so far to a group of 15 supervisors and clinical tutors at a Newcastle/Teeside supervisor training workshop. I got general feedback from the audience as a whole but the Teeside contingent (a sub-group of 8) also spent the next hour discussing the study and invited me to listen and respond to their comments. Although there were plenty of encouraging remarks it is worth recording those aspects of the research with which some were uneasy. NB Detailed record of group discussions on flip charts.

- 1) Several remarks about the need to provide adequate contextual information to allow the listener/reader to appreciate the circumstances under which the data was collected. How many trainees contributed and in what form? Is this a self-selected and hence unrepresentative sample of students? Gender mix, stage of training, speciality etc.
- 2) The credibility issue mattered to this group. Needed some way of answering their reasonable scepticism that the basic codes I employed were not my own idiosyncratic views. Therefore the inter-judge agreement exercise with C.S seems well worth emphasizing. In fact this group said they would have been even more impressed if I had used a naive non-psychologist as the second rater. I see the point but I think the effort and commitment required to train up a complete newcomer to understand and use my system would be more substantial than I can muster at this time.
- 3) Understandably this group lamented the absence of the supervisors' perspective in the study.
- 4) At this stage the presentation did not include the analysis of "bad" experiences in supervision. New supervisors wanted to know what unhelpful behaviours to avoid as well as which helpful attitudes to adopt.
- 5) Despite my presentation having extended 10 minutes over the allotted time as I tried to give the audience details of how I analysed my data as well as what my headline findings were, this group still felt a bit in the dark about certain key procedures such as the move from basic codings to the more abstract second order groupings. I noted this issue also arose at the Bangor conference on Qualitative Research in Clinical Psychology .

Just exactly what did you do? This puts pressure on a time-limited oral presentation, but I think is an important reminder of the high profile an explicit description of method should occupy in the final write-up of the research. Transparency matters.

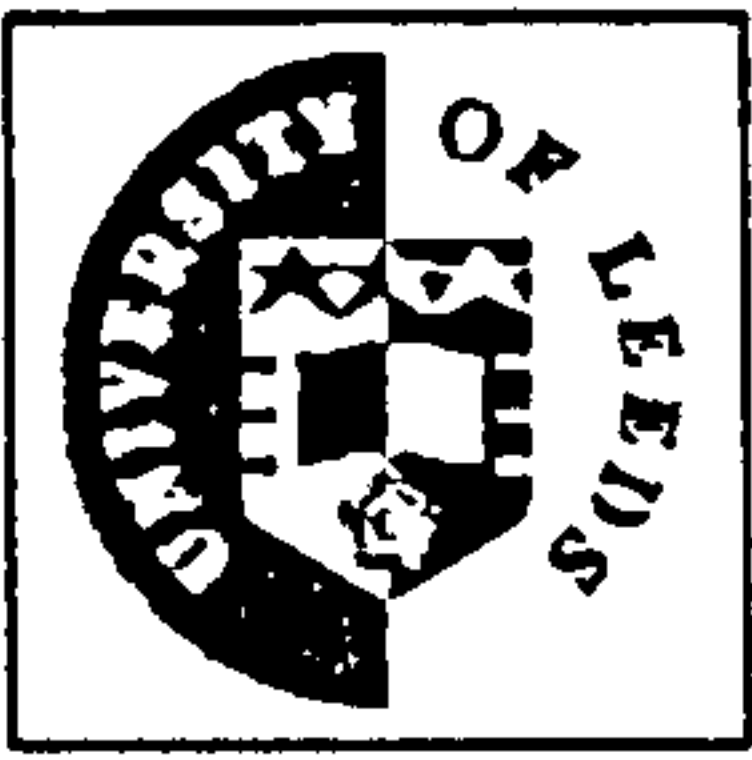
6) Interesting comments on whether the results of the study came up with anything new. Evidently if my findings were way out of line with other research findings or theories in the area eyebrows would be raised. Equally the fact that the conclusions were so congruent with supervisors' experience as to appear obvious is somewhat reassuring. However there is a point here that grounded theory research should go beyond description and offer a new conceptual understanding. I think therefore I should illuminate those aspects of the study where I did not find what I expected to find (like perhaps examples of unhelpful disclosure on the part of the supervisor). Also W.R, tutor on the Teeside course, made the salient point that he felt the analysis should not stop at its current level, but that there was potential for a further coming together of the 4 or 5 major themes in a way that would offer further integration of the various "bits" of the model. I'm not sure how I might do that yet but I agree this further step would be both conceptually and aesthetically appealing.

7) If I am to argue that this study is more appropriately judged on how useful it proves rather than how "true" its findings are I will have to put some more work into spelling out the practical implications of my "discoveries". Although some members of this group could immediately see some professional implications of the study for their work as supervisors, others still struggled with the crucial "so what?" question. I think at the end of the analysis I should put time into elucidating what this might all mean for the practice of everyday clinical supervision. Suggestions such as supervisor evaluation, problem-solving, basic theoretical framework for understanding what works in supervision.

8) The group grasped that they were being invited to join in the research process and took their task seriously. So seriously they want a mention in the final thesis. Quite right too!

Appendix 11

**A4 copy of poster presented at European Congress of Psychology,
Dublin, July 1997**



Investigating the Core Skills of Clinical Supervision: a Qualitative Analysis.

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Introduction

Although clinical supervision is a central component of the training of healthcare professionals the evidential base on which it is practised remains surprisingly limited. The substantial research literature on supervision is open to criticism on methodological grounds (ELLIS et al 1998) and very few studies have investigated the training of clinical psychologists in a British context (HIRONS and VELLEMAN 1993). In recent years qualitative approaches which focus on the meanings participants ascribe to their experiences in supervision have supplemented more traditional quantitative research methods in the field (HOLLOWAY 1995).

Method

All trainees on the D Clin Psychol training course at Leeds were invited to provide critical incident reports (DUNN and HAMILTON 1988) describing positive experiences in supervision. A total of 100 reports were collected over a 3 year period. 65% of the trainee group participated and the sample reflects supervisee experience at all stages of training and across the full range of placements on the course. The first 50 incidents have been analysed using a grounded theory approach (PIDGEON and HENWOOD 1996).

Example

Problem
Uncertainty as to whether I am working appropriately with a client is worried as to her capacity to tolerate the pain of difficult feelings associated with child sexual abuse

Supervisor
Encouraged me to reflect on my fears - and on alternative ways in which I might work. Asked me why I was working as I was, what had informed my decision and who was leading the work. Offered an example of another client who he is working with who is currently going through a difficult time

Outcome
I had been supported by my supervisor, recognised that given the same situation, I would do the same, that some of my anxieties reflected those of the client, that the client's painful feelings would be difficult to bear, but an essential part of working through, that I currently am experiencing doubt and uncertainty about my professional competence (to do with getting a job?) and that client issues are feeding in; ultimately - less anxiety, greater understanding and more availability of me to client

2. RELATIONSHIP FACTORS

SUPERVISOR'S ATTITUDE	EMOTIONAL SENSITIVITY	STRUCTURE	INTERPERSONAL CLIMATE
non-judgmental serenely respect apologise	uses feelings express disclosure counter-transference	organised access prompt	containment safety protect support

MEMO ABOUT RELATIONSHIP FACTORS

This is a variant on the "facilitative conditions" notion common in psychotherapy research. Two key components are a supportive interpersonal climate and a strong sense of a supervisory alliance. The effective supervisor seems to be able to foster the conditions in which a supervisee can learn e.g. feels safe to take risks, knows what to expect, feels valued. I suspect the opposite side of this particular coin will come out from the focus groups on unhelpful experiences in supervision. A good test.

3. SAPIENTIAL AUTHORITY

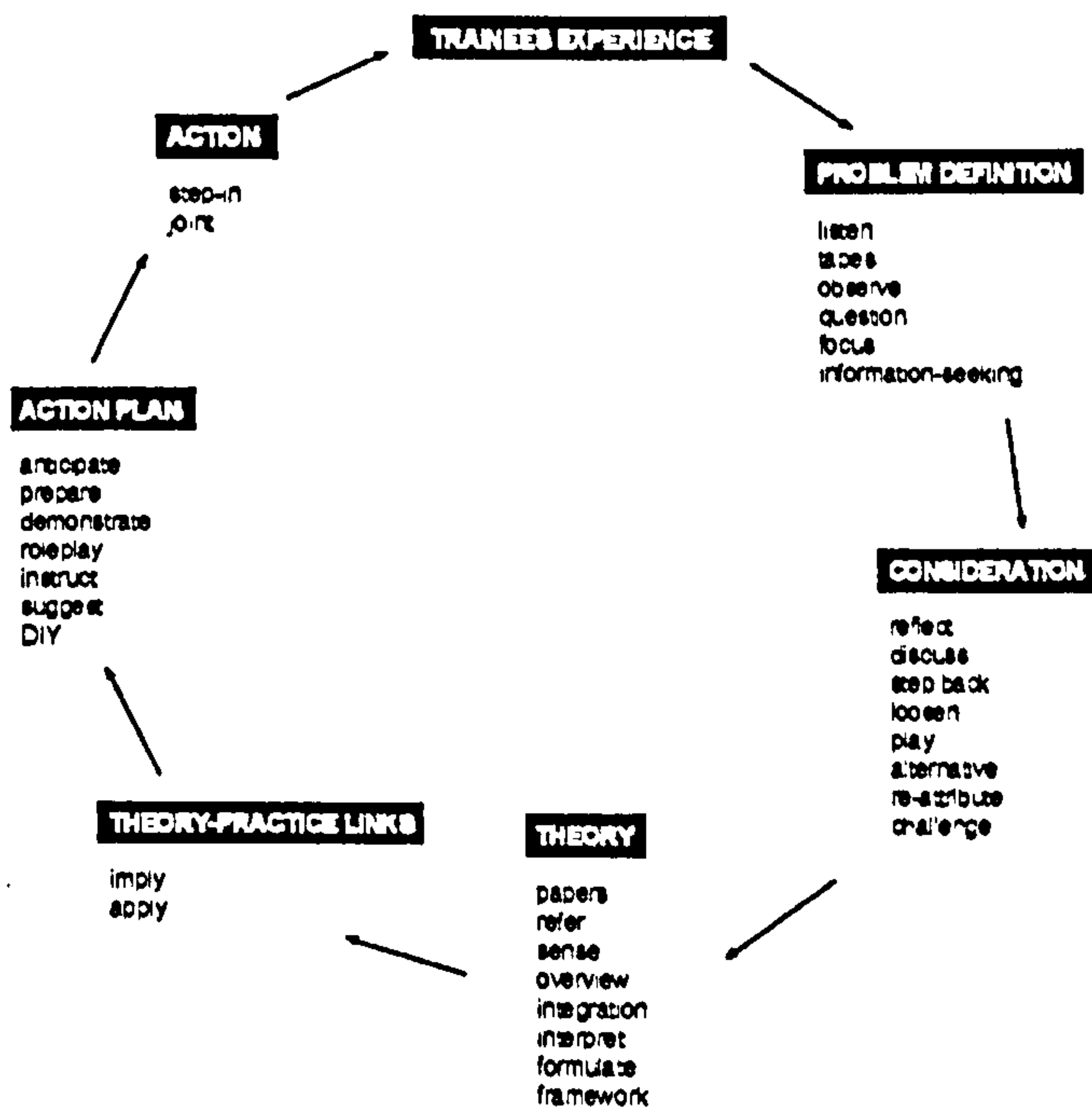
FEEDBACK	SPECIAL KNOWLEDGE	CREDIBILITY THROUGH SENIORITY
positive reassure constructive criticism	local knowledge expert experience	validation normalise realist

MEMO ABOUT SAPIENTIAL AUTHORITY

This group of descriptive codes is linked by the hierarchical nature of the exchanges described. The success of the supervisors' interventions relies on their being recognised by the trainee as having sapiential authority that is commensurate with their supervisory status. The provision of helpful feedback requires that the supervisor's opinion is respected. The special knowledge of the supervisor may take various forms such as being expert in a particular form of psychotherapy or knowing the local professional network well. Being able to offer authoritative comment such that the supervisee experiences a convincing sense that their analysis of a problem is reasonable or the anxiety they are experiencing is normal, or that their therapeutic expectations of a particular case are unrealistic, all depend on the trainee's acceptance of the supervisor's legitimate seniority. What if the supervisee does not see their supervisor in this respectful light? Not all of us can be revered elder statesmen and women!

EMERGENT THEMES

1. EXPERIENTIAL LEARNING



MEMO ABOUT EXPERIENTIAL LEARNING

After creating 60+ descriptive codes for the first 50 critical incidents, a majority can be subsumed as distinguishable parts of an experiential learning cycle. The broad sequential stages of problem definition, consideration of possible meanings, conducting a more or less formal theoretical analysis, translating theory into a practical plan of action, and finally basically getting on with it, are very similar to Kolb's experiential learning cycle. I think my prior knowledge of this model (and respect for its potential usefulness in training supervisors) has undoubtedly influenced these initial explanatory ideas. However the higher order coding is still closely grounded in the details of the incidents themselves. I did not code with Kolb's model in mind at all. Rather, a bit like a jigsaw enthusiast I did the equivalent of "putting all the blue bits together". It was only as I sought for some broader pattern that the "fit" with an experiential learning cycle struck me. It wasn't exactly an "aha" moment but I felt a convincing and apt summary of some emerging pattern in the data.

Further Analysis

This poster represents "the story so far". The next stage involves analysing the remaining 50 critical incidents and amending the initial theoretical model where fresh coding is required to make sense of the supervisory experiences described.

Thereafter the emerging picture of effective supervision will be tested against two further sources of data using a triangulation strategy.

a) Following the principles of inter-personal process recall nine trainees observed videotaped recordings of supervision sessions in which they participated and commented on helpful behaviour on their supervisor's part.

This approach offers a more fine-grained analysis of everyday good practice in supervision.

b) Two cohorts of supervisees at the end of their training took part in focus group discussions in which they were invited to reflect on their worst experiences in supervision.

This represents a deliberate attempt to collect information on ineffective supervisory practice.

In addition measures will be taken to check the coding systems created can be used consistently by other judges. This is essentially a reliability test (KING 1994).

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Appendix 12

Final Summary of the Study's Findings:

Experiential Learning Cycle

Problem Brought to Supervision

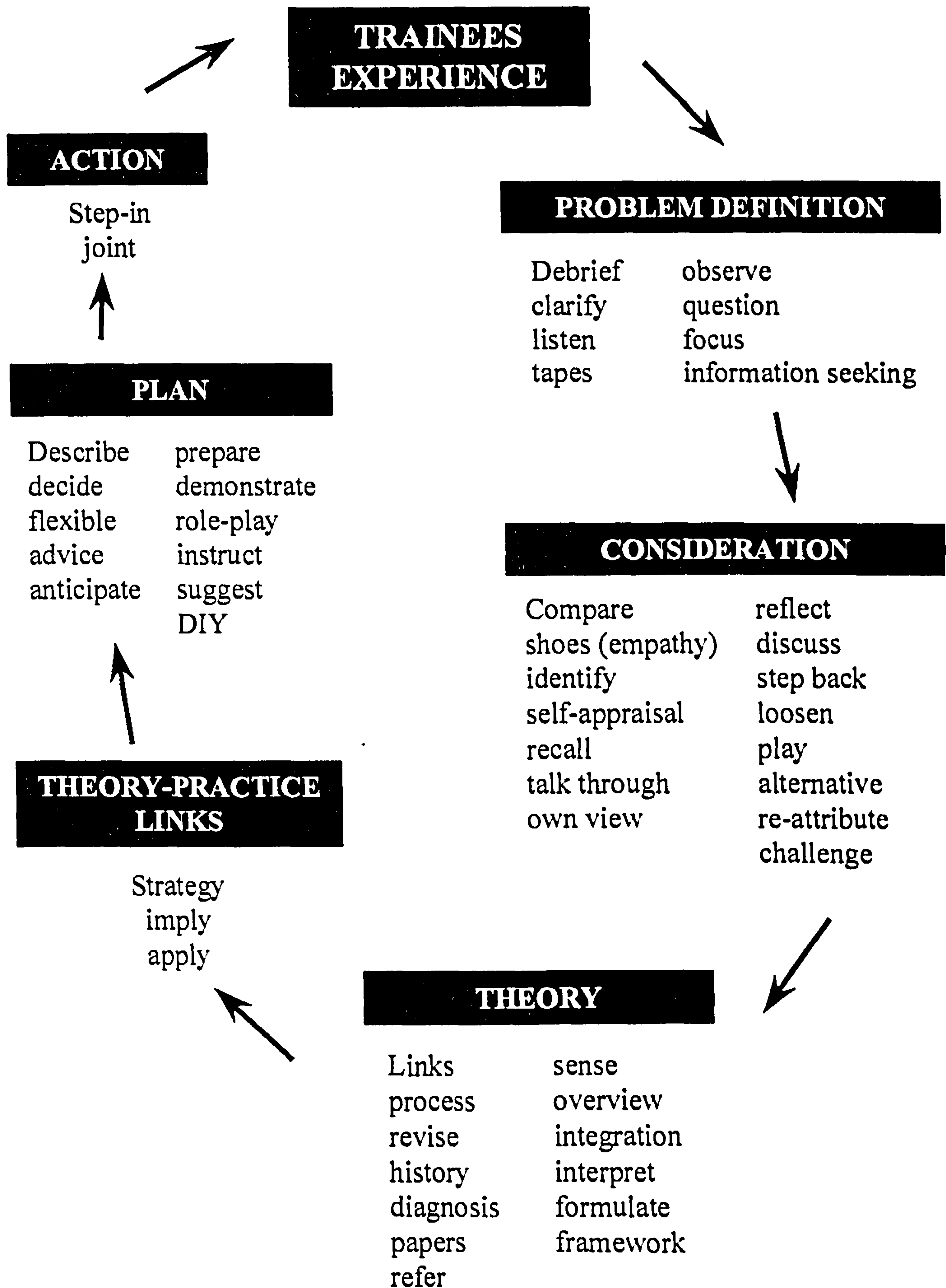
Relationship Factors

Sapiential Authority

Timing

Contextual Factors

Experiential Learning Cycle



PROBLEM BROUGHT TO SUPERVISION

TRAINEE'S EMOTIONAL STATE

Anxiety
Fed-up
Too close

TRAINEE'S UNDERSTANDING

Don't know
Struggle

CONTENT

Ethical dilemma
Supervision
Child abuse

CRITICAL POINT IN THERAPY

Crisis
Stuck

UNCERTAINTY

Past
Future

INTERESTED PARTIES

Other professions
Wider family
Other

NO PROBLEM

RELATIONSHIP FACTORS

SUPERVISOR'S ATTITUDE

Non-judgmental
Seriously
Respect
Apologise
Encourage
Collaborate
Candour

STRUCTURE

Organised
Access
Goals
Negotiate
Expectations

EMOTIONAL SENSITIVITY

Cues
Feelings
Express
Disclosure
Counter-transference
Wavelength

INTERPERSONAL CLIMATE

Containment
Safety
Protect
Permission
Support
Relaxed
Fun
Careful
Businesslike

SAPIENTIAL AUTHORITY

FEEDBACK

Positive
Reassure
Constructive criticism
Monitor

SPECIAL KNOWLEDGE

Local knowledge
Expert
Experience
Therapist

CREDIBILITY THROUGH SENIORITY

Validation
Normalise
Realist

INTEGRITY

Concern for client's welfare
Concern for trainee's welfare
Accepts responsibility
Committed to own CPD

TIMING

MATCH

Individual
Development

MOMENT

Interrupt
Wait
Prompt
Summarize
Pace

CONTEXTUAL FACTORS

THE SUPERVISOR

“own issues” eg domestic problems
“screwed-up themselves”
job under threat
own support and CPD needs not met
perceived as vulnerable by trainee

THE TRAINEE

Previous experience of supervision
Self-confidence v fear of failure
Expectation of supervisor – the
grapevine

THE DEPARTMENT

Patients before students
Single-handed practitioners in
smaller specialties
Recent experiences with trainees
(+ve or – ve)
Local politics
No shared commitment to trainees

THE TRAINING COURSE

Supervisors pressured to take
students
Course is reliant on its supervisors
Bit of an “old boys’ (and girls’)
network”
MPVs not effective in resolving
problems
Out of Region supervisor unfamiliar
with course
Split-placements organized

