University of Derby

"There's a Six-Foot Monkey That's Not Being Talked About"

Improving Access to Psychological Therapies (IAPT): Cognitive Behavioural supervisors' and supervisees' experiences of interpersonal processes in the supervisory relationship. An Interpretative Phenomenological Analysis

Doctorate Health & Social Care Practice

2024

Abstract

Improving Access to Psychological Therapies (Department of Health 2008) has transformed the treatment of common mental health problems through the development of evidence-based CBT training for therapists, which recognises the centrality of evidence-based clinical supervision for both trainees and qualified therapists. Within psychotherapy literature, the supervisory relationship is recognised to play a crucial role (Carroll 1996; Ybrandt et al. 2016; Bordin 1986). Yet, a review of supervision literature suggests that 'significant' non-disclosure within the relationship is the norm (Mehr et al. 2010; Ladany et al. 1996). Whilst clinical supervision research and literature has expanded, few studies focus upon relational processes, and studies of supervision undertaken in the last couple of decades have tended to use quantitative research methods retrospectively, typically from a supervisee's perspective (Watkins 2014).

This study sought to address the gap via semi-structured, in-depth interviews of five CBT supervisory dyads working within IAPT on their experiences of being in a supervisory dyad. The ten participants were interviewed separately, following which recorded interviews were transcribed and analysed for recurring themes using Interpretative Phenomenological Analysis (IPA). Three inter-related superordinate themes and seven sub-themes were identified. These themes are presented and discussed in relation to extant literature. Findings suggest that one's self-concept and internal representation of the self-play a significant part in how one perceives experiences, and in turn, how one feels and behaves within the supervisory relationship. Implications for CBT supervision practice include the role of reflection in enhancing therapist self-awareness and the ability to identify self-care needs, given the emotional labour involved in being an IAPT therapist.

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Acknowledgements

My sincere gratitude to my Director of Studies Dr Jamie Bird and supervisor Dr Dzintra Stalmeisters for your support, wisdom and patience throughout this journey. You have endured a version of me that I didn't know existed. I feel truly privileged to have had your input. Special thanks also to Dr Clive Holmwood for your kindness and encouragement at a point when I doubted my ability to complete. Thank you Dr Wendy Wood, the Director of Studies for my first two years of study.

Thank you to my long-suffering husband Alan and to my children Ben, Claire and Lucy, for your love and support despite not understanding why I put myself through this. I look forward to making up for lost time. Last but not least, I am so grateful to the therapists who participated in this study and shared their experiences of clinical supervision.

Abbreviations

BT	Behavioural Therapy
BAME	Black Asian Minority Ethnic
BABCP	British Association of Behavioural & Cognitive Psychotherapists
BACP	British Association of Counselling Psychotherapists
BPS	British Psychological Society
BT	Behavioural Therapy
BITE	Bug-in-the-eye
CBASP	CBT analysis system of psychotherapy
CBT	Cognitive Behavioural Therapy
CQR	Consensual Qualitative Research
CS	Clinical supervision
DA	Discourse Analysis
DOH	Department of Health
DPR	Declarative Procedural Reflective
EBCS	Evidence-based clinical supervision
FCS	Feminist Multicultural Supervision
GAD	Generalised Anxiety Disorder
GT	Grounded theory
HEE	Health Education England
HEI	Higher Educational Institute
HESE	Health Education South-East
HIT	High intensity Therapist
IAPT	Improving Access to Psychological Therapies
IBS-CW	Internet-based training with consultation worksheet
IBT-S	Internet-based training with supervision
IP	Interpersonal
IPA	Interpretative Phenomenological Analysis
KPI	Key Performance Indicators
KSA	Key Skills and Attitude
LSE	London School of Economics
MDS	Minimum Data Sets
MHN	Mental Health Nurse
NCCMH	National Collaborative Centre for Mental Health
NRES	National Research Ethics Services
NMC	Nursing & Midwifery Code
PbR	Payment by results

PIS	Participant Information Sheet
PTSD	Post-Traumatic Stress Disorder
PWP	Psychological Wellbeing Practitioners
QTD	Quoted
RCT	Randomised control trial
REC	Research Ethics Committees
SAGE	Supervision: Adherence and Guidance Evaluation
SCC	Self-concept clarity
SP/SR	Self-Practice/Self-Reflection
SR	Supervisory Relationship
SWA	Supervisory Working Alliance
THIT	Trainee high-intensity therapist
TR	Therapeutic Relationship
WA	Working Alliance

CHAPTER 1: INTRODUCTION

1.1 Introduction to IAPT

The introduction of *Improving Access to Psychological Therapies* (IAPT) by the Department of Health (DOH) in 2008 represents the radical restructuring of the provision of psychological therapies in the UK (Rizq 2012; McPherson et al. 2009) with the principal aim of supporting the implementation of National Institute for Health and Clinical Excellence (NICE) guidelines for people with depression and anxiety (Middleton et al. 2005a; NICE 2004; McIntosh, 2004). A workforce has been established to deliver evidence-based interventions (mainly CBT) on the National Health Service (NHS) to treat people with depression and anxiety (Layard 2006). The innovative 'Stepped Care Model' followed the successful roll-out of two pilot projects in 2006 (NCCMH 2020; Williams & Martinez 2008), whereby people treated within IAPT services were offered the least restrictive intervention, or the lowest intensity, highest capacity intervention first, delivered by Psychological Wellbeing Practitioners (PWP). If unsuccessful, patients are 'stepped-up' to a 'high-intensity' intervention i.e., a specialist psychologist therapy such as CBT (Roth and Pilling 2007). To support the roll-out of the IAPT programme, over £150 million was made available to train therapists in low- and high-intensity CBT interventions.

In the space of fifteen years, a newly created, accredited profession of High Intensity Therapist has come to dominate primary care mental health services. From the outset, there has been criticism of the use of a biomedical model to provide a psychological framework for pathology and therapy (Pickersgill 2019), which Mollon (2009) contends has led to psychotherapy being classed as a measurable intervention akin to medication, whilst other psychological treatments that are as effective as CBT have been disregarded. Concerns that CBT is limiting have been expressed, with Boyle (2011) arguing that whilst individual

CBT conceptualisations take contextual factors into account, the focus on thoughts and behaviours can underestimate other contributing factors. Similarly, Sarris et al. (2014) point to compelling evidence that multiple factors are involved in the aetiology of depression, which can be modified through lifestyle changes. They refer to 'lifestyle medicines' (p.8) such as socialisation, exercise and diet, which first-line treatments for depression such as CBT do not integrate as standard.

Controversies have plagued the evidence-base supporting CBT, with many questioning the validity of methodologies and an emphasis on Randomised Control Trials (RCT) thought to limit perspective (Williams 2015; Middleton et al. 2005). Indeed, Keller et al. (2000) argue that, in the endorsement of CBT, NICE have included interventions that are not standard practice in CBT, such as Cognitive Behavioural Analysis (CBASP), an analysis system of psychotherapy model comprising the study of transference. Furthermore, Gilbert (2009) argues that comparison of CBT to interventions judged to have insufficient evidence, as is commonly seen in the NICE guidelines, does not validate its superiority. The projection of CBT as a homogenised therapy has been challenged, with Williams (2015) arguing that in reality there are several versions, including Cognitive Therapy, CBT and Behavioural Therapy (BT), leading Gaudiano (2009) to use the metaphor of comparing apples with oranges.

It is argued that to refer to IAPT as a 'gold standard' psychological model is inaccurate, given that the required 50% recovery rate required to achieve this accolade is not being met (Scott 2018a). Indeed, findings of the mental health trajectory of a sample of people treated within IAPT as measured by an independent witness found the recovery rate to be 24% (ibid.), leading Scott (2018b) to suggest that 'the great and the good make their own interpretation' of RCTs (Scott 2018b p.1165). The need for an independent means of

investigating IAPT recovery rates is highlighted by Marks (2018) who suggests that a reduction in the use of antidepressants would indicate the success of IAPT; however, there has been no reduction in the use of such medication.

Critics contend that the newfound dominance of CBT eclipses essential aspects of human development such as motivational psychology, attachment theory and the relevance of neuroplasticity (Gilbert 2009). Furthermore, IAPT's emphasis on science and the delivery of techniques over the therapeutic relationship has been likened to Ritzer's (1993) use of the term 'McDonaldization', depicting a therapeutic approach built on the fast-food model of efficiency, predictability and control, with an emphasis on quantity and standardisation rather than values (Strawbridge & Woolfe 2010). This, Rizq (2011a) posits, exemplifies the NHS business model whereby human suffering is eclipsed by '*targets, outcomes, protocols and policies*' (p.9).

1.2 The IAPT High Intensity therapist

In contrast to traditional psychological services such as clinical and counselling psychology that offer a broad church of therapies, IAPT CBT therapists are trained to deliver disorder-specific interventions, based on NICE guidance. The IAPT career pathway has seen the introduction of Psychological Wellbeing Practitioners (PWP). This group typically does not have a core profession but has demonstrated Knowledge, Skills and Attitude (KSA) in skills equivalent to a core profession (BABCP 2018) enabling progression to High Intensity Therapy (HIT) training. This has become a well-trodden path with 285 PWPs undertaking HIT training in 2019 (Health Education England 2020). Consequently, the turnover of staff within IAPT services is high and a study by Liness et al. (2018) indicates that trainee therapists without a core profession can require additional support to achieve competence during their professional training. Notably, it seems that

aspects of the PWP passage to CBT therapist are more straightforward than that of other groups. Grounded theory analysis also found that the transition of the KSA group was smoother (Wilcockson 2017; 2020), and it is surmised that their previous training (as PWP) is not dissimilar to CBT training. Furthermore, Wilcockson (2020) identifies that core professionals, particularly mental health nurses, can experience difficulties integrating unfamiliar CBT components whilst over-identifying with aspects of CBT that reflect their core profession.

The significant impact of the introduction of IAPT on therapists of other modalities is apparent from an analytical autoethnographic study by Mason & Reeves (2017), which highlighted those counsellors who worked within IAPT had a sense of being part of an *'out*-group' that led many to reluctantly retrain in a therapy valued within IAPT (such as CBT or Interpersonal therapy), in turn becoming '*in*-group' (Willetts & Clarke 2014). This reflects social identity theory (Tafel & Turner 1979) and the psychological basis of inter-group behaviours.

IAPT was set up to treat people with common mental health problems of mild to moderate pathology (DOH 2007). However, closer analysis suggests that patients often have complex mental health problems. A study by Hepgul et al. (2016) involving the assessment of 147 people on the waiting list of a South London IAPT service provides a clinically representative sample of those seen within IAPT services. There was definitive evidence of personality disorders in 16% of the sample. Co-morbidity was the rule rather than the exception, with 58% of the sample meeting the criteria for three or more diagnoses. A third of the sample had experienced childhood trauma and 31% emotional neglect. Findings are endorsed by a more recent study by Lamph et al. (2021), which also highlights the prevalence of people with personality disorders being treated within IAPT. Participants were deemed to be of similar complexity to those typically seen within secondary services, with the exception that manageable risk

enables treatment within IAPT. The study concludes that therapists working with those with complex presentations need to work more flexibly and individually, over a greater number of sessions. This has implications for HI therapists whose training may not have extended to working with more complex patients. Furthermore, a survey on access to therapies (Mind.org.uk 2013), involving 1,639 people with mental health problems who had received psychological therapies, found that half believed they had too few sessions of therapy.

Considering the complex nature of people seen within IAPT services, the pressure for 'movement to recovery' is considerable for a professional group, many of whom are young (Steel et al. 2015; Sodeke-Gregson et al. 2013) and relatively inexperienced (Rizq 2012). The greater risk of burnout associated with treatment of people with personality disorders is recognised within literature (Westwood et al. 2017; Steel et al. 2015; Sodeke-Gregson et al. 2013). Indeed, an online survey of IAPT HI therapists and Psychological Wellbeing Practitioners indicates a higher-than-normal prevalence of burnout (up to 60%) amongst HI therapists (Westwood et al. 2017). Receiving higher levels of clinical supervision (CS) is associated with lower levels of disengagement and burnout (Sodeke-Gregson et al. 2013), which emphasises the importance of CS within IAPT.

537,000 people receive NICE recommended treatment within IAPT each year, with 81% completing treatment (Clark et al. 2017). There are potential costs, however. The IAPT workforce is immersed in a fast-paced, target-driven environment, in which relatively inexperienced therapists are providing therapy to patients with mental health difficulties more complex than was originally intended for IAPT. The IAPT model recognises the centrality of effective CS for High Intensity (HI) therapists and given the context in which they are immersed, it is critically important that this reflects the needs of the HIT working within IAPT.

Within this thesis IAPT high intensity CBT therapists will be referred to as HI Therapists, whilst non IAPT CBT therapists are referred to as CBT therapists.

1.3 Defining IAPT CBT Clinical Supervision

Recognised as an '*essential prerequisite for the practice of psychotherapy'* (Roth and Fonagy 1996 p. 373), regular Clinical Supervision (CS) is mandatory for accredited CBT Therapists, though not at IAPT service level (Roth 2007; Carroll 2001; BABCP 2010). CBT clinical supervision has traditionally used a framework comprising key elements of a CBT session as set out by Liese & Beck (1997) and Padesky (1996) whereby the session is highly structured and utilises a goal-orientated framework. This includes agenda setting, review of homework, session content which included discussion of case formulation, and focus on processes such as interpersonal issues (Reiser, 2014).

The push for CS to be recognised as a scientifically-informed specialism (Milne, Reiser & Cliffe 2013) is reflected in Milne's (2007) logical analysis and systematic review of 24 empirical studies of supervision. This aimed at best evidence synthesis, to test and enhance the definition of clinical supervision. The previously widely accepted definition by Bernard & Goodyear (2004) fell short in each criterion of a "good" definition i.e., precision, specification, operationalization and corroboration (Kazdin 1998). A subsequent systematic review (Milne 2007) supports the working definition of clinical supervision. For the purpose of this study, clinical supervision is understood according to Milne's definition, outlined in Table 1.1. and will be referred to as IAPT clinical supervision or Clinical supervision. When reference is made to IAPT clinical supervision within the text, it can be assumed to relate to CBT practice unless otherwise stated.

FORM OF SUPERVISION:
Formal provision sanctioned by the organisation.
Delivered by senior qualified health practitioners.
Relationship-based (confidential, collaborative, featuring decision-making, shared agenda, interpersonal qualities)
Education and training (generally problem-solving capability)
Case focused; supervisor overlays professional & organisational considerations and/or standards
FUNCTIONS OF SUPERVISION:
Quality control (gatekeeping; ethical practice)
Maintaining and facilitating therapist competence and capability
Help the supervisee to work effectively

Table 1.1 Definition of Clinical Supervision (Milne 2007)

IAPT's commitment to the provision of quality CS and therapist fidelity to the evidence base (Turpin & Wheeler 2008) is central to the success of the programme (DOH 2008). To this end, a supervision competency framework has been developed by Roth and Pilling (2008), based on supervision research and consensus statements from an Expert Reference Group (DOH 2007 p.10). Higher Educational Institutes (HEIs), in turn, have developed postgraduate-level CS courses (typically five days), the content of which reflects the supervision competency framework (Roth & Pilling 2009).

Whilst supervision competencies are generalised to all therapeutic modalities within IAPT, Owen-Pugh & Symons (2013) support the application of the framework to specific contexts. The framework marks a growing awareness of the role of competency-based models of supervision as advocated by Falender (2018), who emphasises the importance of supervisors understanding the relevance, validity and functions of the competencies. Since the inauguration of IAPT, there is more emphasis on the governance of therapists, with clinical supervision used as a forum for therapists to justify their clinical decisions (Corrie & Lane 2015). Indeed, Lane and Corrie (2006) acknowledge tension between the

scientist-practitioner model requiring scientific objectiveness and maintaining subjectivity as required in clinical practice.

The centrality of CS within IAPT is evidenced by its position as a mandatory requirement dictated by professional codes (including BABCP, BPS, BACP) and what seems an unwavering appreciation within the literature. Indeed, Woolfe and Tholstrup (2010) suggest that there is a reluctance to challenge the assumption of goodness of something perceived as 'next to Godliness' (p.591). Scratch beneath the surface, however, and the supervision literature (expanded upon in chapter 2) contains is a dissonance between the 'goodness' of CS, viewed as an essential ingredient of psychotherapy, and the extensive reference to supervisee non-disclosure and power dynamics within the supervisory relationship (SR). This is elaborated upon below.

1.3.1 Defining the Supervisory Relationship and the Supervisory Working Alliance

Within psychotherapy literature, reference is made to the supervisory relationship (SR) and supervisory working alliance (SWA). Whilst often referred to interchangeably, these are distinct. Each term has originated from the therapeutic context, with the SR describing the relationship between the supervisor and supervisee in CS. Viewed by Ladany, Ellis & Friedlander (1999) as the critical mediator of supervisee development, the quality of the relationship is influenced by interpersonal attractiveness, interpersonal sensitivity and task orientation (Corrie & Lane 2015). Central to the SR is that its boundaried nature enables the supervisee to feel safe (Beinart 2002).

The SWA originates from Bordin's work on therapeutic alliance (TA) (1979), which expands on psychoanalytic work such as Greenson (1967), who suggest that if TA promotes therapeutic change, so too can the SWA. Just as TA is developed through shared goals, shared tasks and the collaborative bond

required to affect change, the SWA can be used to promote change in therapeutic practice (Bordin 1983; Hawkins & Shohet 2012; Falender & Shafranke 2004). Whilst it has been argued that transactional models are potentially restrictive, as therapy and CS and therapy are fundamentally different (Beinart (2012), the transtheoretical nature of the relationship is accepted by Safran (1993). This is reflected in the later work of Safran, Muran, Stephens & Rothman (2008), which addresses alliance ruptures and repair in CS. Furthermore, Holloway (1995) acknowledges the role of power in the SR, and the dynamic process of supervisor and supervisee negotiating a means of working collaboratively.

Within this thesis, the broader conceptualisation of the Supervisory Relationship (SR) as advocated by Holloway (1995) and Safran et al. (2008) is applied. This acknowledges the relevance of psychological constructs such as interpersonal attractiveness, power dynamics and shame in the SR and consideration is given to how these have the potential to impact level of disclosure and management of ruptures within the SR.

This study focuses upon IAPT supervisors' and supervisees' experiences of interpersonal processes in the IAPT supervisory relationship. For this, IAPT supervisors and their supervisees were interviewed separately with the aim of promoting reflective consideration of their current and previous experiences of the supervisory relationship. Narratives relating to previous supervisory relationships have added context and depth to participants' accounts of the SR. This has strengthened the study and enabled recurring themes to be identified.

1.4 Rationale for this study

Working within the milieu of a business model sets IAPT supervisory dyads apart from other therapists within NHS mental health services. IAPT defines recovery according to the patients' rate of '*movement to recovery'* which is monitored through the completion of minimum data sets (MDS) at each point of contact (Grant et al. 2014). IAPT is characterised by the principle that evidence-based therapy is provided in the appropriate dose (Kendall & Pilling 2018). However, studies suggest that patients seen within IAPT receive fewer than the recommended number of sessions (Hepgul 2016), thus potentially reducing the likelihood of sustained recovery. Furthermore, the evidence on which NICE has based its recommendations for the treatment of depression and anxiety has been called into question; for example, Williams (2015) is critical of what is perceived as a dependence on positivist epistemology to the detriment of interpretation. Such factors, combined with the changing demographic of CBT therapists receiving and providing supervision, warrants in-depth analysis of IAPT CS.

Within psychotherapy practice, research and literature, CS is lauded as a critical component in developing and maintaining the clinical skills of psychotherapists, and we see evidence of this in The IAPT Supervision Framework (Roth & Pilling 2009) and IAPT Supervision Guidance (Revised) (Turpin and Wheeler 2011). Notable by its absence, however, is acknowledgement that IAPT is different to traditional primary care psychotherapy services, in terms of the workforce, the volume of people accessing the service, and working practices. Given the fast-paced, target-driven environment, in which an often young and inexperienced workforce (NHS England &Health Education, 2016) treats people with complex presentations, it seems imperative that the provision of CS reflects the *real world* of the IAPT HI therapist, and those being treated within IAPT.

This study provides an opportunity to advance the limited knowledge of IAPT CS of recently trained CBT therapists and their supervisors' experience of the SR. This enables the supervisory relationship to be analysed from a dual perspective. Whilst generalisability is the goal within traditional psychology research, idiographic inquiry (consistent with interpretative phenomenological analysis (IPA) research) aims for transferability of findings to similar contexts (Hefferon & Gil-Rodriguez 2011) and thus enables theoretical rather than empirical generalisability (Smith et al. 2008). Links are made between study findings, pertinent literature and the individuals' own experiences of the phenomenon so that specific statements can be made. This is in contrast to nomothetic studies where analysis is at group and population-level, enabling probabilistic claims only.

Until recently no such study of the SR has been undertaken in the context of IAPT and this is an area ripe for research. Interpretative analysis of the SR will contribute to the literature relating specifically to this area and will provide greater understanding of interpersonal dynamics in the IAPT supervisory relationship, which will in turn will inform CS practice specific to the IAPT context. My interest in the subject is fuelled by my role as Course Leader and Clinical Supervisor for the Postgraduate Diploma CBT (IAPT) programme, and therefore my regular contact with trainee therapists. Furthermore, I am module leader for the IAPT Clinical supervision training course, and I receive clinical supervision of my own CBT clinical practice. Given the centrality of CS within the IAPT model and the relative newness of IAPT, a study of the SR in IAPT is long overdue. The research question presented below reflects my intention to study people's experiences and perceptions idiographically, consistent with an open inductive approach used in IPA to generate rich and detailed descriptions of the

phenomenon under investigation (Smith & Eatough 2012). This will be elaborated upon in Chapter 3.

1.5 Research question

How do IAPT supervisors and supervisees make sense of their experiences of interpersonal processes in the supervisory relationship?

1.6 Study aims and objectives.

This study aims to address the current gap within existing IAPT clinical supervision literature by conducting an in-depth analysis of how IAPT high intensity therapists make sense of and perceive the experience of being in a supervisory relationship. The central concern is to understand the lifeworld of participants in a supervisory relationship and in turn evaluate the content and complexity of cultures that influence the meaning-making processes in an IAPT SR. It is hoped that such an exploration of therapists' perceptions of the experience will contribute to theoretical discourse on the supervisory relationship in IAPT. The study objectives are as follows:

- To interview 5 IAPT supervisors and their supervisees separately, in order to gain insights into what is happening interpersonally within the supervisory relationship;
- To explore participants' experiences, thus gaining an understanding of the lifeworld of those in an IAPT supervisory relationship by conducting one-to-one interviews using an open inductive approach with the purpose of extending the limits of what is currently known of the SR in IAPT;
- To audio-record and transcribe verbatim each interview, enabling in-depth analysis;

- To use IPA to analyse participants' transcripts, following which a narrative account of superordinate and sub-themes is presented; and
- To synthesise findings and consider implications for IAPT supervisory practice.

1.7 Outline of Chapters

Chapter 2: Literature Review. The search strategy is discussed. Literature from the broader context of psychological therapies and clinical supervision is presented thematically and related to the research question.

Chapter 3: Methods. A discussion of IPA and a rationale for choosing this over other methods are provided. The epistemological and ontological assumptions that underpin IPA, and therefore this study, are discussed. Study participants are introduced, and a summary of the processes employed for data collection is presented. Finally, ethics are considered, and the measures undertaken to ensure that participants wellbeing is at the centre of the study.

Chapter 4: Findings. Findings from the IPA study is presented thematically through superordinate and sub-themes, supported by verbatim extracts.

Chapter 5: Discussion. Superordinate and sub-themes are revisited and analysed in relation to extant theories and research in order to address the research question.

Chapter 6: Implications for practice and dissemination. The main conclusions drawn from the study are presented, and the implications for supervisory practice are considered.

Chapter 7: Conclusion. The main findings of the study are summarised, and the implications revisited.

CHAPTER 2: Literature Review Part 1 & 2

2.1 Introduction

The purpose of Part 1 of this chapter is to objectively provide a comprehensive overview of literature relevant to the research question: *What are IAPT CBT therapists experiences of the supervisory relationship?'* Part 2 of this chapter (Post-analysis Literature review, section 2.9 onwards) will present new literature that relates to the study findings, which I draw upon to support the discussion of the study findings in a wider context.

Whilst this is not a systematic literature review, the search was undertaken using systematic methods to ensure relevant papers were sourced. Systematic literature reviews employ detailed and specific methods in order to be exhaustive and comprehensive in identifying literature (Booth, Pamaioannou & Sutton (2012) and are conducive to answering focused questions. A narrative literature review was chosen as it enables a broad perspective of the supervisory relationship to be explored (Green, Johnson & Adams 2006). A summary of the search strategy is presented following which the literature is discussed by theme. Part One of the chapter concludes with a summary of the main findings. Details of the searches undertaken can be found in Chapter 8 (Appendices)

2.1.1 Literature search strategy

The process of searching clinical supervision literature relevant to the research topic was conducted in three stages beginning with an initial scoping review to ascertain what literature existed and to shape the research question. The aim of the review was to critically examine literature pertinent to the research question and identify themes that inform the study. Details of the searches undertaken can be found in Appendix I. All papers reviewed have been peer reviewed and published.

Review questions (1-5 below) were used to focus the literature search, each of which had relevance to the central research question. From this, keywords were drawn and used for the search (presented in *italics*) as follows:

1. What are Improving Access to Psychological Therapies (IAPT) supervisors' and supervisees' experiences of the supervisory relationship?
2. What is the evidence base supporting the role of clinical supervision in psychotherapy?
3. What is the relationship between Clinical Supervision, the Supervisory Relationship and treatment outcomes?
4. What factors impact CBT therapists' experiences of clinical supervision?
5. What factors influence the supervisory relationship?

A PIO framework (Population, Intervention, Outcome) improves literature screening efficacy (Mezaoui et al. 2019) and was used to formulate the search questions and to consider component concepts (Table 2.1). Using EbSCO host, a database search of AMED, CINAHL, PsychArticles, Psychology and Behavioural Sciences Collection and APA Psychinfo was conducted. Initially broad search terms were used: "*IAPT'* AND *'CBT supervision",* "*the supervisory relationship*" AND "*psychotherapy* OR Cognitive Behavioural Therapy OT CBT", "*Clinical supervision* AND *outcomes"*. More specific search terms were then applied: "*The supervisory relationship* AND *non-disclosure*", "*The supervisory relationship* AND *conflict*" (see Appendix I) Boolean logic connectors 'AND' 'OR' 'NOT' were used to combine synonyms and concepts. Truncations (such as * or $ or #) and wildcards (such as '?') were used to ensure that different word forms and spellings were accessed.

Table 2.1. PIO framework used for inclusion.

Population	Intervention	Outcome
Superv*	Clinical supervision	Improvement
Therap*	Super*	Recovery
Psychotherapist	Support	Outcomes
Counsellor	Effect	Development
Patient	Psychological therap*	Learning
Client	CBT	Clinical outcomes
IAPT	Cognitive behavio?r	Wellbeing
Improving access to psychological	Cognitive therapy	Caseness
Cognitive Behaviour Therap*	CT	Skills
	Alliance	Competence
	Bond	Alliance
	Rapport	Variance
	Interpersonal	Evidence
	Relationship	Experiences
		Conflict
		Disclosure/non-disclosure
		Shame
		Self-esteem

A Web of Knowledge reference search provided access to further relevant papers, as did a search of key authors' names (which included C. E. Watkins, D. L. Milne, H. Beinhart, S. Corrie, A. K. Hess, E. P. Shafranke, C. Falender, J. Bennett-Levy). Each author has had work published in peer-reviewed journals, on topics specific to IAPT/ CBT CS or the SR and is recognised within the field of psychotherapy supervision. Relevant textbooks on Psychotherapy supervision were searched and references/bibliographies sourced. Google Scholar was used to access and review papers in reference lists. To get a sense of relevance, a critical synopsis coded 1-5, proposed by Wallace & Wray (2011), was completed for each paper (see Appendix I). Those deemed irrelevant were discarded, whilst those deemed highly relevant were coded 1, indicating that detailed analysis was required.

2.2 Introduction to themes

What follows is an introduction to the findings from an extensive search of literature relating to psychotherapy CS and the supervisory relationship. The review is organised into broad themes, each of which is either directly relevant to the research question or to the context within which clinical supervision operates.

2.2.1 The role of clinical supervision in maintaining treatment fidelity.

Clinical supervision has long been recognised as '*the cornerstone of education and training'* (Falender and Shafranke 2004 p.3) and increases the value of the therapeutic process for the good of the client (Prasko et al. 2012; Newman 2010). CS is a means of ensuring clinical competence in both trainee and qualified psychotherapists (Pretorius 2006; Watkins 2014). IAPT represents the systematic implementation of evidence-based psychological treatments, the outcomes of which are evaluated on a mass scale through routine outcome monitoring (Kellett 2020). Mean non-attendance rates within IAPT, however, are 42-48% (Marshall et al. 2016) and re-referrals rates are significant (Cairns 2014). Indeed, a systematic review and random effects analysis of 60 studies conducted by Wakefield et al. (2020) concluded that whilst 50% recovery is being achieved (IAPT 2019), patients with severe presentations such as socioeconomic adversity and personality disorder traits, benefit less. Consequently, movement to recovery is more challenging for therapists working in socially deprived areas who are treating people with complex presentations. Surprisingly, treatment fidelity within IAPT is not recorded, despite the significant drop-out rate.

Several studies support the role of CS in promoting adherence to treatment protocols, yet studies of CS outcomes are limited (White 2017; Roth & Pilling 2015). The question of the extent that training and supervision play within clinical trials has been addressed by Roth et al. (2010), who used data from 27

studies that examined the efficacy of CBT interventions, from which they acknowledged the superior treatment fidelity in such trials. They concluded that whilst the treatment protocols are important, other factors such as close monitoring to ensure treatment fidelity and provision of clinical supervision are vital. This is further supported by a more recent randomised control effectiveness trial by Monson et al. (2018), who also found that the provision of clinical supervision maximises patient outcomes. Study findings suggest that adherence to protocols both as a supervisor (attending to the normative function of the role and ensuring therapist adherence to protocols), and subsequent therapist adherence, produces favourable outcomes. The role of CS in promoting science-informed practice is well documented (Milne & Reiser 2012; Lane & Corrie 2006). Indeed Falender & Shafranke (2004) identify this as a defining characteristic of the profession, however studies suggest that some supervision practices are being neglected. The experiential nature of CBT supervision is recognised within literature (Milne & Reiser 2017; Roscoe 2021; Pugh & Margetts 2020). However, supervision drift from such recommended CS practice was apparent in an IPA study by Roscoe and colleagues (2022). Whilst the study involved a single cohort within a training institution and therefore cannot be generalised, this is concerning given the well documented role of reflection in professional development (Schon 1983; Bennet-Levy et al. 2009).

Well-conducted treatment trials ensure that the correct ingredients are in place by recruiting experienced therapists and providing relevant training (Roth et al. 2010). The significance of such ingredients is apparent from a study by Gibbons (2013), who compared therapy outcomes of 23 adults receiving CBT in an outpatient setting with 18 patients receiving CBT in a RCT. Symptom reduction was three times greater in the RCT setting than in routine clinical practice and the better treatment outcomes are surmised to be due to adherence to evidence-

based treatments. It is noteworthy that in this study, therapist competency levels were lower than typically found in many effectiveness studies such as Roth (2010), in which patients are usually offered a large number of sessions by more experienced and often pre-selected therapists. This suggests that the better outcomes were a result of CS promoting adherence to treatment protocols rather than the favourable conditions associated with studies.

This is consistent with the work of Gyani et al. (2013), a prospective cohort study examining adherence to treatment protocols using data from 32 year-one IAPT services in which NICE-recommended treatments were found to be associated with superior recovery rates. Therapists received clinical supervision, which was recognised to have contributed to recovery, although the strength of the effect is unknown. Further evidence to support the vital role that CS plays in improving treatment outcomes is found in a study of supervision using mixed effects regression models, by Schoenwald, Sheidow & Chapman (2009). Results indicate that supervisor adherence to supervision structure and process, in addition to supervisor focus on adherence to treatment principles, predicts therapist adherence and changes in patient behaviour, which accounts for the superior symptom reduction in RCTs.

Empirical studies support the role of CS in maintaining treatment fidelity however few studies are conducted within the context of IAPT. The ballooning number of therapists within IAPT puts pressure on services to train more supervisors, which runs the risk of therapists having less time to consolidate their development as a therapist and indeed supervisor in training (Worrell 2018). This is likely to challenge the *'developmental unfolding*' of competencies (Callahan & Love 2020 p.2) which describes the exponential professional growth curve which is maximised through clinical supervision during the training period.

2.2.2 Clinical supervision and therapy outcomes

Studies that address the impact of supervision on patient outcomes are seen as the 'acid test' of effective supervision (Ellis & Ladany 1997 p.485) and Watkins (2011) urges that this be explored. Indeed, Watkins & Milne (2014) refer to '*the increasing international status of clinical supervision*' (qtd. Milne & Reiser 2017 p.1.), despite a paucity of conclusive evidence. The limited studies of CS outcomes (on supervisee development and/or patient outcomes) are plagued by methodological weaknesses (Alfonsson et al. 2017; Rousmaniere et al. 2016) and do not always support the association that is often assumed within supervision literature. This is apparent in a systematic review of empirical studies that examined the effect of CS on clinical outcomes, conducted by Alfonsson et al. (2018). Although 4,104 relevant publications were identified, only 5 met the criteria and just one provided firm empirical support for the effect of CS on therapy outcomes. The remaining studies had methodological weaknesses but supported the role of CS in developing therapists' skills.

The results of a systematic review by Lohani & Sharma (2022) are promising. The aim was to investigate the effect of CS on self-awareness and self-efficacy of supervisees. 17 studies that examined the effect of clinical supervision on therapist self-awareness and self-efficacy were reviewed. It was found that therapists who received supervision had higher counselling self-efficacy and lower anxiety; moreover, a positive impact on patients was apparent. Further evidence of a link between CS and therapy outcomes is apparent in a study of 16 psychotherapists by Anderson et al. (2012), which found that supervisor discussion of specific techniques and strategies predicted therapist adherence in the subsequent therapy session. Whilst therapist warmth was associated with supervisory adherence, it was found that gains in skills over the course of the training year were not maintained. Indeed, therapists no longer responded to

supervisor influence after training. In summary, supervisees responded positively to supervision and whilst there was evidence of positive changes in behaviour which shaped therapists' clinical practice, this was not maintained.

There is growing evidence of the benefits of CS on supervisee development and patient outcomes, but White (2017) cautions against literature being cherrypicked to support unconvincing claims. A weak association was found by Keum & Wang (2021) in their meta-analysis of 12 studies, in which supervision accounted for just 4% of variables. The difficulty in measuring clinical supervision outcomes is thought to lie in a lack of agreed definitions of supervision, components, and competencies. Olds & Hawkins (2014) have addressed this by drawing on existing competency frameworks and available evidence, and subsequently conducting thematic analysis to examine evidence for specific competencies. Whilst this offers a broad domain of supervision competencies, they acknowledge the potential for researcher bias, conceding a need for a Delphi study involving experts in clinical supervision to identify supervisor competencies.

Further attempts have been made to standardise CS (Falender & Shafranke 2004; Milne & Reiser 2017; Roth & Pilling 2008), but the complexity of accounting for the multiple supervision variables within studies (patient-therapist-supervisor-context) has been acknowledged within literature (Ybrandt, Sudin & Copone 2016) and is reflected in a study by Rousmaniere et al. (2016). Their 5-year archival data set of psychotherapy outcomes of 6,521 patients, 175 trainee therapists and 23 supervisors were used to establish whether treatment outcomes were influenced by the clinical supervisor. Supervision was found to explain less than 0.5% of the variance of clinical outcomes. The authors surmise that the multiple variables may moderate the effects of therapy; furthermore, the absence of a control group prevents comparisons between supervised and

unsupervised therapy. These results support an earlier study by White & Winstanley (2010) that attempted to compare the relationship between clinical supervision and therapy outcomes in a RCT of mental health nurses. Although a statistical difference in quality of care was not demonstrated, supervisees evaluated supervision positively. Of significance, however, is that supervisors received just four days of training and clinical supervision was provided to groups of 6-9 people once a month. It is questionable whether the dosage of supervision was sufficient to have an impact. Moreover, a review of clinical supervision by Simpson-Southward et al. (2017) found weak evidence for the role of clinical supervision in improving patient outcomes. This suggests that supervisees experience of CS does not necessarily impact patient outcomes.

There are studies that support a positive association between CS and therapy outcomes. An experimental pilot study by Alfonsson, Lundgren & Andersson (2020) found a significant numerical increase in the CBT competence of six therapists with basic training in CBT (measured using the CTS-r) who received protocolised CBT supervision which focused on CBT competencies. Whilst the study provides much needed evidence in support of CS improving CBT competence, results need to be interpreted with caution given that the experimental study involved a single-case, thus reducing generalisability. A correlation research design study by DePue et al. (2022) also provide evidence of the relationship between the therapeutic alliance (TA) of novice therapists, Supervisory Working Alliance (SWA) and clinical outcomes. Patient outcome measures and their perspective of the SR and the SWA was found to be directly and indirectly related to client outcomes. Whilst findings are promising, the researchers caution that the study was small, involving one site only, and involved inexperienced therapists. The need for a more diverse sample enabling comparison of WA, SWA and therapy outcomes, was acknowledged.

A study by Öst et al. (2011) suggests that sufficient CS provided by extremely specialist supervisors can have far-reaching consequences for patients with long-standing anxiety, even when treated by inexperienced clinicians. In their study involving 591 consecutive patients referred to a psychotherapy clinic in Sweden, it was found that the patients who received a mean of eighteen sessions from clinically inexperienced trainee psychologists, showed significant improvement through standard and disorder specific measures, with 63% reduction in Beck's Anxiety Inventory and 60% reduction in Beck's Depression Inventory, consistent with efficacy trials. More than half of patients had previously received psychotherapy or psychotropic medication with little or no effect and 27% had comorbidity. Outcomes are consistent with a study conducted in the UK involving experienced CBT therapists (Westbrook & Kirk 2005), in which improvement was more modest. The dosage of supervision in the Öst et al. study was much higher than that received by trainee CBT therapists in the UK, which may account for the variation; furthermore, in Sweden clinical supervisors spend at least nine years as licenced psychologists & psychotherapists. Supervision training is three semesters in duration, which overshadows IAPT Clinical supervision training that typically comprises five days of university-based teaching. Unexpected

Given the inconsistent findings from supervision studies, supervisor and supervisee perspectives of the impact of CS are most relevant. Using qualitative methods in addition to a Likert scale to answer supervision-based questions, Rast et al. (2017) found that supervisors and supervisees consider supervision to impact positively upon therapy outcomes. Further, supervisees consider supervision important for reducing deterioration in patients. Interestingly, whilst supervisees view the SR as the most impactful on patient outcomes, supervisors believe the therapeutic relationship to be the most important. This may reflect

supervisees need for a SR in which they can discuss clinical issues, and hence fully engage with the supervision process.

Widely acknowledged as an exemplar of supervision outcome research (Wrape 2015; Rousmaniere et al. 2016; Watkins 2011) is a study by Bambling et al. (2006) that examined the impact of supervision on patient outcome and working alliance, with standard measures of therapeutic alliance and symptom changes used as dependent variables. Therapists were randomised into a supervised treatment group and an unsupervised treatment group. Patients in the supervised group rated their symptoms lower and were more satisfied with treatment and the working alliance than the unsupervised group. A later study (Callahan et al. 2009) also found that the supervisor related significantly to clinical outcomes and may account for 16% of variance, thus supporting the argument that clinical supervision is a vital ingredient of psychotherapy (Bernard & Goodyear 2014; Holloway 2014)

Commended for its scientific rigour (Alfonsson et al. 2018) is a study by Rakovshik et al. (2016) that adds further credence to the role of supervision in the development of clinical skills. To investigate the effect of internet-based CBT training (IBT), 61 people were randomised into three groups: those receiving internet-based training with a consultation worksheet (IBS-CW); those receiving internet-based training with supervision (IBT-S); and those receiving delayed training (DT). Hierarchical linear analysis showed greater CBT competence in the IBT-S group. There was no significant difference in competence levels between the remaining groups. Arguably, receiving three 30-minute sessions of clinical supervision to support the internet training may have enhanced participants' level of engagement in training, but both groups were found to have engaged well through completing the worksheets. This suggests that the greater improvement in the IBT-S group is likely to be due to the clinical supervision.

In summary, a review of literature pertaining to the role of clinical supervision in enhancing therapist and patient outcomes provides some empirical evidence of this as an important ingredient of psychotherapy, however this is largely assumed. Methodological weakness within studies is a recurring theme, with many eliminated from systematic reviews due to design faults (Wheeler & Richards 2007; Watkins 2011; Alfonsson et al. 2017). Studies are plagued by an insufficiently developed theoretical framework for clinical supervision (Alfonsson et al. 2017), lack of validated measures (Schoenwald et al. 2009) and poor design (Milne & James 2000), to the extent that a systematic review of supervision literature by Alfonsson (2018) selected 133 studies for analysis, but only five were included in the review.

2.2.3 Methods of Clinical Supervision

In the last two decades there is evidence of a shift in focus to meeting specific supervision competencies (Watkins & Milne 2017). Within supervision literature, the use of video and/or audio recordings to evaluate supervisee practice is often considered the 'gold standard' (Lewis, Scott & Hendricks 2014), reflected in BABCP mandatory supervision requirements for HIT trainee therapists and CBT therapists (Turpin & Wheeler 2011). The use of action-based methods such as role play and chairwork, commonly associated with Gestalt therapy (Perls 1972) are advocated by Pugh and Margetts (2020) and Bird & Jonnson (2020). Such methods involve the supervisee engaging in '*imaginal dialogue with an "other"*' (Pugh and Margetts (2020 p.2) and are consistent with establishing a context for reflecting on supervision process, thus preventing supervisory drift. Viewing therapy recordings is standard practice within IAPT, particularly for developing therapists and can provoke high anxiety for some. Simon (2020) recommends further research into this mode of supervision. The use of recordings can be time-consuming (Pugh and Margetts 2020) and should involve the promotion of

evidence-based practice (Roth & Pilling 2008) and supervisee development (Milne et al., 2011). Whether the use of recordings enhances patient outcomes is an important consideration, as it can be resource-intensive.

Studies give mixed reviews and a RCT involving 66 clinicians and 450 patients (Martino et al. 2016) that compared 'enhanced' supervision and standard supervision suggests not. The former involved the use of an assessment tool for enhanced proficiency (MIA: STEP), which entailed the use of clinical recordings to provide skills coaching. All clinicians demonstrated improvement in skills, but there was no difference in patient outcomes. Similarly, Monson and colleague's (2018) comparative study found that standard supervision involving discussion and conceptualisation (without recording) maximised patient outcomes and adherence to treatment protocols. The sample were CBT therapists who had received minimal training in Cognitive Processing Therapy, and clinical supervision focused on specific interventions such as Socratic dialogue, identifying key beliefs and identifying avoidance. It is conceivable that CS in which recordings are used reduces the time for discussion of theories and/or interventions, which is also central to supervision. This suggests that consideration of the balance between clinical discussion and viewing of recordings is warranted.

Other forms of 'live' clinical supervision that digress from the standard format of case discussion and the reviewing therapy skills using video recordings, have been studied. Co-therapy involves the supervisor and supervisee each sharing the role of therapist, with the novice therapist gradually increasing their input within the therapy session. A RCT by Tanner et al. (2012) compared the effects of co-therapy (supervisor and supervisee) and solo trainee supervision methods on patient outcomes, attrition and trainee CBT therapist effectiveness (2012). No difference in improvement rates of patients who received co-therapy

and solo trainee supervision, was found. Although all patients showed significant reduction in symptoms, there was no support for the hypothesised benefits for co-therapy. Arguably, standard CBT supervision entailing use of recordings, offers more flexibility and is conducive to supervisee reflection.

There is some evidence to support 'bug-in-the-eye' (BITE) supervision, in which the supervisor views the session 'live' from another room and provides 'live' supervision through messages sent to the therapist's laptop, accessed during the session. In a RCT of therapeutic alliance and competence, Weck et al. (2016) assigned 23 therapists to either BITE or DVD supervision, which were viewed by two independent assessors to establish the effect. The quality of alliance was better in the BITE group and those therapists were rated as more competent. Findings are supported by a study by Carmel (2016) which also found that BITE supervision was associated with better clinical formulations. This suggests the superiority of timely supervision to enable feedback during or soon after the therapy session. Furthermore, BITE supervision allows supervisors access to therapists' uncensored practice. It is conceivable that, in standard clinical supervision, supervisees bring recordings of their 'better' therapy sessions for viewing within supervision, thus reducing opportunities for corrective feedback that would enhance practice.

In summary, studies of the use of recordings in clinical supervision are mixed. Use of recordings play a role in superior patient outcomes by promoting adherence to treatment protocols, however supervision without the use of recordings also enhances therapy outcomes. Given the additional costs involved in viewing recordings (such as time for viewing prior to supervision, supervisor time, training workshops for markers, equipment etc.) and the prevailing lack of NHS resources, it seems prudent to undertake further studies to establish the cost-effectiveness of such resource-heavy practices.

2.2.4 The Supervisory relationship

Establishing a Supervisory Relationship (SR) whereby the supervisor and supervisee engage in a variety of roles that enhance the learning of the supervisee is deemed to be of utmost importance (Carroll 2010; Scaife 2014) and is considered critical in the development of the therapist (Ladany, Ellis & Friedlander 1999). Thwaites & Haarhoff (2016) emphasise the crucial role of the relationship 'within which reflection can flourish' (p.29); indeed, Safran et al. (2008) caution that strain within the alliance arouses insecurity in the novice therapist and may undermine confidence. There is evident pointing at supervisees experiences of harmful supervision such as psychological distress (Ellis et al. 2014; Reiser & Milne 2017).

Few studies address the impact of the SR and Ellis (2010), in his review of 28 years of research, highlighted the lack of empirical support. Whilst the therapeutic relationship tends to be consistent throughout treatment, Ybrandt et al. (2016) found that the supervisory relationship is more variable. Furthermore, therapists with a stronger supervisory alliance showed less variation in therapeutic alliance, leading the researchers to conclude that the SR is a more complex relationship than the TR.

Although the term 'supervisory relationship' is used frequently, little is written on what this means and what it entails. Within the literature, reference is made to working alliance (WA) and supervisory working alliance (SWA). WA is defined by Bordin (1979) as the strength of the relationship between therapist and patient, comprising three key components: the therapy tasks i.e., the interventions that occur within therapy; the bond that develops between patient and therapist; and the agreed goals of therapy. Such a model, Bordin (1983) argues, is applicable to clinical supervision, which he defines as Supervisory Working Alliance (SWA). The SR, however encompasses other elements namely

the educative, restorative, and gatekeeping roles (Beinart 2012). Within this thesis the SR is understood in the broader sense with the SWA recognised as a component of this.

The restorative function of clinical supervision has long been recognised (Bambling 2014; Shafranske & Falender 2008; Proctor 1986) and signifies the need for the therapist to consider their emotional experience within the safe setting of the supervisory relationship (Hawkins & Shohet 2012), yet research on the role of supervision in stress reduction is limited. Sterner (2009) suggests that SWA positively impacts work satisfaction and negatively correlates with work-related stress. Furthermore, supervisee-perceived stress had a significant negative impact on both WA and SWA (Gnilka, Ashby & Noble 2012), meaning that being stressed may inhibit the supervisees' ability to reach out for support. Supervisee maladaptive perfectionism negatively correlates with supervisory alliance and working alliance (Ganske et al. 2015) but is moderated by self-efficacy. This suggests that the perfectionist supervisee may have difficulty establishing a TA and SWA if they perceive their practice to be sub-standard.

Supervisees who use coping strategies such as support from family and mental tension control, referred to as career-sustaining behaviours (Stevanovic & Rupert 2004), have lower stress levels and can form stronger supervisory relationships (Gnilka et al. 2012; Briggs & Munley 2008). Age and experience correlate with the ability to undertake career-sustaining behaviours and cope with large caseloads (Briggs and Munley 2008; Lawson 2007). There is a dearth of studies that explore supervisors' phenomenological experiences in the supervisory relationship. Glover & Philbin's (2017) hermeneutic (interpretative) phenomenological study involved 14 participants and provides insight into the sense of responsibility felt by supervisors, which, they posit, is '*fuelled by a theory bound approach [that was] of limited assistance'* (p.241). The authors draw on

the Heideggerian phrase '*Leaping-in and leaping-ahead*' to illuminate supervisor behaviours. 'Leaping-in' reflects *inauthentic solicitude,* often fuelled by supervisor anxiety which can lead to supervisees losing confidence and become over-dependent on supervisor guidance, while '*leaping-ahead*' reflects *authentic solicitude,* which encourages growth and autonomy.

Further insights into "expert" supervisors' experiences of the SR are provided by Grant, Schofield & Crawford (2012) in their study of 16 experienced supervisors who were interviewed about their experiences. Interpersonal process recall was used to explore their reflections on a recorded supervision session that provided evident of 'expert' use of relational approaches to maintain or repair the SR. Reflectivity strategies were used and the supervisors' demonstrated internalisation of theories that they drew upon within the supervision session to support critical reflection of supervisee practice. The study highlights the importance of supervisors having the necessary skills to deal with difficulties likely to surface in the SR. If all else failed, confrontative approaches were drawn upon and concerning behaviours challenged.

In considering wellbeing, Rizq (2011) highlights the susceptibility of IAPT workers to burnout and whilst not specific to IAPT, the propensity for psychological therapists to burnout is highlighted by Mena & Bailey (2007) who examined the relationship between the quality of the SR, supervisee job satisfaction and the level of burnout. Using a hierarchical linear model analysis of survey results from 51 supervisors and 80 supervisees, results support the role of a strong SR in preventing burnout. This is consistent with a study by Livni et al. (2012), which suggests that whilst clinical supervision alone is not sufficient to reduce burnout and increase therapist wellbeing, a positive SR is associated with lower burnout and greater job satisfaction. A more recent by Johnson, Corker & O'Conner (2019) also supports the role of CS in preventing burnout in

psychological therapists. The cross-sectional online survey involving 298 psychological therapists found that high quality supervision was associated with lower disengagement. Such studies underscore the restorative function of CS, and the value of promoting coping strategies likely to impact positively on stress. Given that studies point at interpersonal issues arising in response to stress (Gnilka et al. 2012), it seems prudent to prioritise the supervisory alliance whilst monitoring supervisee stress levels from the outset.

2.2.4.1 Supervisory relationship outcome studies

In recent years the role of clinical supervision in CBT has received greater recognition, as demonstrated by Government investment in supervisor training to support IAPT (DOH 2008). Inherent within the IAPT supervision training curriculum (Roth & Pilling 2008b) and supervision literature is a recognition of the role of the SR in therapists' development, and an assumed link with patient outcomes (explored below).

SR outcome studies are few but present a case for getting it right. A strong SR makes for the development of therapeutic skills in the trainee, enhances reflexivity (Orchowski et al. 2010) and is associated with increased confidence, enhanced therapeutic perception and ability to conceptualise (Worthen & McNeill 1996). A good SR is concomitant with positive patient alliance (McCarthy 2013; DePue et al. 2016; Bambling et al. 2006; Bucky et al. 2010) and enhanced trainees' counselling skills (Patton & Kivlighan 1997). Supervisees who are satisfied with their clinical supervision are more likely to be satisfied with their work, and in a study of 71 participants, a negative correlation between SWA and work-related stress was apparent (Sterner 2009). Indeed the benefits of a positive SWA has been found to extend to supervision of supervision in a mixed methods study by Vandette et al. (2021) which involved 33 psychology students, 29 supervisors in training and 20 supervisors. Quantitative data was analysed

using a mixed linear model whilst thematic analysis was applied to qualitative data with each study supported the influence of SWA to supervision of supervision. Also supporting a relationship between supervision and therapy process and outcomes, is a study by Gerstenblith et al. (2022) which involved 28 trainees and 15 supervisors and data collection over 663 weeks of therapy. Findings suggest that when supervisors form stronger alliances with their trainees, the patients of the trainees form stronger TA and believe that they received better therapy.

A strong therapeutic relationship however, does not translate to a good SR, as highlighted by Bell, Hagedorn, & Robinson (2016), who examined the relationship between facilitative conditions within the SR and the TR using a correlational research design. There was no significant correlation between the SR and TR, possibly signifying the difference between interpersonal relatedness in supervision and therapy. The researchers surmise that this may signify therapists' focus being on developing a therapeutic alliance rather than developing a rapport with their supervisor, whilst the supervisor focus is on overseeing the supervisee development rather than on developing a SR.

It seems plausible that roles specific to the supervisor such as evaluating or challenging the supervisee may challenge the SR (as perceived by the supervisee), despite enhancing supervisee skills and ultimately patient outcomes. A therapist skilled in the use of facilitative conditions (as evidenced by good patient outcomes) may expect such conditions within their SR and consequently be more attuned to their absence.

A poor SWA can impact the supervision process and in turn supervisee growth (Enlow et al. 2019). Studies point to the far-reaching, deleterious consequences of negative supervisory experiences (Ramos-Sánchez et al. 2002; Gray et al. 2001), which were found to negatively impact therapist training, the

supervisory experience and work with patients. Further insights are drawn from Callahan & Love's (2020) analysis of supervisees narratives of their perspective of the SR which provide insight into microaggressions, negative gender-related comments and lack of acknowledgement of diversity within CS which impacted negatively on the SR. Cartwright (2019) uses narrative enquiry to analyse supervisor and supervisee interviews which provide insight into how supervisees' experience of anxiety led to avoidance. In turn 'pseudo-alliances' were created with neither supervisor nor supervisee being open within the relationship.

The question of what constitutes 'good' supervisory practice is an important consideration and a study by Bambling & King (2014) throws light on factors instrumental in the formation of an alliance. The role of supervisor social skills in the development of a supervisory alliance was evident with a correlation between supervisor social skills (measured using the Social Skills Inventory; Riggio 1986), supervisor interpersonal skills (evaluated by supervisees) and supervisee-rated supervisory and working alliance.

This suggests the pivotal role of skills such as emotional expressivity, sensitivity and the ability to regulate emotions in establishing a rapport. Such findings are endorsed in a study by Xu et al. (2021) which provides insight into the practice of expert supervisors and their use of relational behaviours. They operationalised five trans theoretical relational supervisory behaviours from the critical events model of supervision: focus on the therapeutic relationship; focus on supervisory alliance; explore feelings; focus on countertransference; and attend to parallel processes. They assessed the use of relational behaviours using demonstration videos from American Psychological Association (APA) Master supervision video series and found a modest to strong use of relational supervisory behaviours by expert supervision. Findings reflect a study of the priorities of "*expert*" supervisors by Kemer, Borders & Yel (2016) which found

little difference in the approach of supervisors, regardless of whether the supervisee was deemed to be 'difficult' or 'easy'. Supervisors prioritised interpersonal strategies such as ensuring that the supervisee not experiencing feelings of shame and providing feedback sensitively. Components such as self-awareness, being humble and flexible were attributes recognised in experts. These findings underscore the importance of integrating such behaviours in supervision practice.

The question of how supervisee relational skills can be developed is extremely valid, given the focus on competency-based supervision (Roth & Pilling 2008b), and has been addressed by Calvert, Crowe & Grenyer (2017), who investigated supervisor practices that are conducive to development of relational and reflective competencies. They identified the SR as a valuable context for experiential learning. Furthermore, multiple correlations were identified between the strength of the SR and the perceived usefulness of interventions within the SR for the purpose of enhancing relational competence. Indeed Vandament et al. (2022) highlight the relevance of SWA in the supervision of ethnic minority therapists receiving supervision from white supervisors. Their study which explored the supervisory experience of trainees of colour found that the SWA mediated the relationship between supervisee perception of supervisor cultural humility and self-efficacy. On this theme, Crockett & Hays (2015) developed a mediation model that found a relation between multicultural competence, SWA, supervisee self-efficacy and supervisee satisfaction with supervision. Furthermore, Jones, Welfare & Cook (2021), in their study of 94 supervisees, found that those who identified with a marginalised or minority group were likely to rate identity as most salient within the SR. They refer to the need for supervisors' '*respectful inquisitiveness*' (p.402) and ability to consider social and cultural identities within the SR. This underscores the importance of

supervisors facilitating discussion of difference, particularly in ethnically diverse populations, as it was found to positively impact supervisee practice.

As discussed in chapter 1 (section 1.2), IAPT therapists treat large volumes of people with complex presentations including childhood trauma, which increases the risk of vicarious traumatisation (Leahy, Tirch & Napolitano 2011; Moorey & Lavender 2019). In their study of vicarious trauma, Del Tosta, Ellis & McNamara (2019) found that when supervisees perceived the SWA to be strong, they experienced fewer negative thoughts about themselves and were less at risk of vicarious trauma. This supports the importance of the SR and the centrality of fostering a positive SWA in preventing supervisee vicarious trauma.

Review of SR literature by Watkins (2011) points out that the majority of studies carried out in the preceding 25 years have been university-based, whereby typically Masters or Doctoral students acted as study participants and, in most cases, completed questionnaires asking questions about their psychotherapy supervisory experiences. It is argued that questionnaires can limit the information that participants provide in written answers and are less likely to provide the flexibility for discussion and/or clarification (Harding 2013) that qualitative methods enable. Furthermore, the non-clinical context within which therapy and supervision was provided, limited the generalisability of findings to standard mental health services within which complexity and comorbidity is the norm. Watkins (2011) observed that studies that focus on process and intricacies of the SR are rare. One such study, an intervention-based RCT study (Deal, Bennett, Mohr & Hwang 2011), lacked statistical power and relied on self-reports. The need for research conducted within a clinical setting, from multiple perspectives and using various methodologies conducive to the study of alliance, has been identified (Watkins 2014). A review of more recent SR studies (Watkins 2020) highlights the void of evidence that provides 'proof' for the value of clinical

supervision, and he concludes that this is more by association. Study samples were found to be small and evidence to support the impact of SC on therapy outcomes remains weak. He concludes that the review approach restricts the number of studies that can be included in systematic reviews. Studies that are variable in content provide less robust review findings, making comparisons difficult (Watkins 2020; Alfonsson 2018) leading to the conclusion that for CS to be sufficiently evidence-based, broader and higher quality studies are required.

2.3 An attachment perspective on the supervisory relationship

In the last decade, researchers have built upon the evidence base supporting the application of attachment theory as a framework for understanding interpersonal dynamics in the supervisory relationship (Bennett & Deal 2009). Attachment theory was developed by psychiatrist and psychoanalyst Bowlby in the 1950s and '60s, culminating in an esteemed paper 'Attachment and Loss' (1998), which proposes that, during infancy and childhood, bonds with child and parents exist and continue in adolescence and adulthood, fulfilling the need for safety and security with a person of emotional importance (Neswald-McCalip 2001). Early attachment relationships are believed to enable the infant to learn to interact with others and to communicate emotional needs (Duquette 2010), from which infants develop internal working models of themselves and others (Collins, 1996).

So-called 'attachment style' refers to one's pattern of relating, based on interpersonal experiences, which Ainsworth et al. (1978) first identified through laboratory studies of children separated from their primary caregiver. Subsequent research has elaborated on this work (e.g., Bartholomew 1991; Brennan, Clark & Shafer 1998). The attachment system is now understood to consist of two primary dimensions: attachment anxiety, relating to a negative working model of oneself; and attachment avoidance, relating to a negative working model of others (Muckulincer & Shaver 2012).

In his critique of Bowlby's theory, Harris (1998) contends that the role that parents play in the character and personality development of their offspring is overemphasised, with other sources of influence not given due consideration. Indeed, feminist critics seek to dispel the notion of attachment as biologically determined and monotropic, which effectively puts responsibility on the mother (Knudson-Martin 2012). It seems that studies that contradict Bowlby's original theory are few and seldom referred to, despite their relevance. A study of attachment by Shaffer & Emmerson (1964) found that despite all mothers who participated being fulltime care-givers, half of the babies responded adversely to separation from figures other than the mother, such as siblings, father or grandparent, suggesting that the attachment relationship is not exclusively mother-infant. Indeed, attachment is increasingly regarded as inherently systemic and not confined to adult-infant relationships (Knudson-Martin 2012), recognising wider socio-cultural influences such as schooling, access to healthcare and level of exposure to crime (Birns 1999).

Attachment experiences shape how people think and behave in close relationships (Mikulincer & Shaver 2012) and are known to extend the realms of cognitive and behavioural functioning. The 'broaden & build' cycle of attachment security (Fredrickson 2001) recognises the function of secure attachment in positive developmental experiences, including building resilience (Mikulincer & Shaver 2007). This is initiated by consistent interactions with supportive attachment figures attuned to the child (Bennett 2008). General studies of attachment, such as Gentzler et al. (2020), which examined individuals' responses to positive and negative feedback, can relate to the supervision context. This study of 119 college students found that those with an anxious attachment style were highly reactive to negative events and tended to engage in excessive processing. Also of relevance to CS is a study by Kawamoto (2020)

that found a statistically significant relationship between anxious attachment and self-esteem in university students. Thus, attachment style offers a window into personality factors that may play out in CS and/or the SR.

It is theorised that adult attachment behaviours such as seeking closeness can be directed at non-attachment figures, for instance the clinical supervisor, hence the importance of considering supervisee attachment styles (Bennett 2008) that can be activated through stress or novel experiences (Pistole and Watkins 1995). In turn, behavioural systems can deactivate, leading to a reduction in supervisee exploratory behaviour (for example, learning a new skill). A supervisee in distress may struggle to problem-solve and may have real difficulty supporting patients. Consideration of the caregiving-attachment relationship and the conditions necessary for bonding and maintaining the relationship are conducive to providing a safe haven for supervisees (Fitch, Pistole & Gunn 2010). However, Fitch et al. (2020) propose that clinical supervisors' own stress may impact their ability to support supervisees, thus highlighting the importance of CSs being provided with support in their role as therapist and supervisor.

The integration of attachment theory into the domain of clinical supervision, whilst largely theoretical, does have empirical support. In their study of the SR in 73 social work students, Bennett et al. (2008) found that supervisee-specific attachment (determined via Fraley's (2005) Relationship Structures Questionnaire) strongly predicts supervisory alliance and supervisory attachment style. Trainee therapists with greater avoidant attachment view their own clinical skills-efficacy more negatively (Mesrie, Diener & Clarke 2018), suggesting that they lack confidence in their skills and also may struggle to seek support. Level of experience was found to not significantly moderate the relation between attachment avoidance and perception of self-efficacy, suggesting that poor

attachment within the SR can have an enduring impact on therapists' clinical skills. This suggests the value of supervisors being mindful of supervisees' attachment styles in their effort to create an alliance. Indeed, findings of studies exploring attachment and CS underscore the benefits of considering attachment styles, particularly those of the supervisor.

A correlation between general and supervision specific attachment styles has been established, with ratings of supervisory alliance associated with general attachment styles (White & Queener 2003; Riggs & Bretz 2006). Furthermore, general attachment avoidance has been found to relate to insecure supervisor attachment (Bennett 2008). A positive association has been established between supervisor anxious attachment and negative affect, whilst positive affect in supervisors and supervisees was associated with strong supervisory alliance. Findings from Riggs & Bretz's (2006) study involving 87 doctoral students indicates that supervisor attachment style (as rated by the supervisee) predicts how supervisees rate task-related behaviours and in particular the supervisory alliance. Such findings are supported by a study on a larger sample by Dickson et al. (2011), which also used questionnaires, and found that supervisees' rating of the working alliance related to their perception of supervisors' attachment style: if the supervisor was deemed to be insecurely attached, the working alliance was rated less highly.

This literature suggests that supervisor attachment style can influence alliance within the SR. Given the power of the supervisor, this could have far-reaching implications for supervisees. In considering characteristics conducive to a positive SR, supervisors who report a favourable working alliance with supervisees are comfortable with close relationships and depending on others, indicating strong attachment (White and Queener 2003), which implies that an ability to form close relationships predicts a positive working alliance.

Attachment security is a positive predictor of patient focus, characterised by the supervisor assisting the trainee to develop their skills. Researchers found that the relation between attachment security and disclosure is stronger than rapport and disclosure, indicating that supervisees who are more secure in a supervisory attachment are more likely to be open (ibid.). Furthermore, there is a correlation between supervisee attachment and supervisory alliance. These findings are supported by Moldovan & David (2013), which comprised 33 trainees and 4 CBT supervisors. Supervisors' conditional self-acceptance and self-efficacy was associated with better trainee outcomes and an enhanced appreciation of the WA within supervision. The study sample of 33 is acknowledged by the authors to be too small to generalise the findings, but it does highlight the influence of CS on developing supervisees.

To summarise, study findings suggest that one's attachment history impacts the phenomenological experience of clinical supervision. Those who experienced adversity as a child may doubt their self-efficacy and struggle to open up. Those with avoidant attachment may find the process of being in a SR challenging and struggle interpersonally, to the extent that they avoid closeness. Likewise, the experience of receiving critical feedback is more challenging, given that both groups are likely to perceive feedback negatively. The literature supports the need for supervisors to consider psychological factors that can impact interpersonal relatedness, to enable adjustments to be made. Interestingly, supervision literature makes little reference to the need for pre-existing psychological factors to be considered within clinical supervision. Given that CBT therapists are not required to undergo therapy during their training (as is required of therapists of other modalities), it is conceivable that therapists' vulnerabilities may emerge within clinical supervision and/or the therapeutic relationship.

2.4 Disclosure in Clinical Supervision

The process of CS relies on a relationship of respect and mutual openness (Beinart & Clohessy 2009; Falender & Shafranke 2004; Bordin 1983). The SR is intended to provide a safe context for discussion of clients' (and therapists') thoughts, emotions and behaviours (Bernard 2009), which contributes to learning and development (Corrie & Lane 2015; Spence et al. 2014; Milne 2009) and ultimately positive clinical outcomes. Fulfilling clinical supervision professional requirements alone is insufficient (Webb & Wheeler 1998) and open discussion within supervision is crucial to supervisees' development and patient wellbeing (Mehr et al. 2010; Webb & Wheeler 1998; Hess et al. 2008; Yourman & Farber 1996; Gunn 2012). The merits of supervisor self-disclosure have been considered within literature with Knox (2015) arguing that self-disclosure on the part of the supervisor and supervisee, is an essential part of clinical supervision. Supervisor self-disclosure can strengthen alliance and enhance therapy outcomes (Guttman 2020) and can be used to normalise therapists experiences and provide learning opportunities (Boyle & Kenny 2020).

In their study of the effects of supervisor self-disclosure on supervisees using consensual qualitative research, Knox et al. (2007) found that when successful, disclosure can foster the relationship and normalise experiences, however when supervisor self-disclosure is dismissive of the supervisees' experience, this can be unsettling. Empirical evidence to support supervisor self-disclosure, however is limited and Mehr & Daltry (2022) found that whilst a good SR promotes supervisee disclosure, supervisor disclosure does not influence supervisee disclosure.

It seems that supervisee nondisclosure is commonplace, indeed a study by Ladany et al. (1996) found that 97% of supervisees withhold information in supervision. The figure was slightly lower in a study by Mehr et al. (2010) at

84.3%. Defined as the deliberate withholding of relevant information in Clinical supervision (Hess et al. 2008), studies of clinical supervision address the issue of nondisclosure in the supervisory relationship and factors that may impede openness within supervision.

Negative associations have been found between cultural concealment (by the supervisee) of themselves and their patients and satisfaction with supervision and SWA (Drinane et al. 2021). Reasons for nondisclosure commonly relate to negative experiences of supervision (Inman et al. 2011; Mehr et al. 2010; Ladany et al. 1996), perception of supervisor incompetence (Reichelt et al. 2012; Mehr, Nicklas & Harper 2020), perceived lack of supervisor commitment (Hess et al. 2008) or performance anxiety (Foskett & Van Vliet 2020). Studies point at the role of alliance in mediating disclosure and in their exploration of contributing factors and Cook & Welfare (2017) found that attachment avoidance and SWA predicted 60% variance in intentional nondisclosure of a sample of 146 counsellors in training. On this theme, Sweeney & Creanor's (2014) study using consensual qualitative research, found that nondisclosure relates to the quality of the SR and clinical concerns. A structural equation modelling by Mehr, Ladany & Caskie (2015), found that higher counselling self-efficacy was associated with greater willingness to disclose. This suggests that those in need of guidance may be more reticent to disclose and in turn miss potential learning opportunities.

Given that within IAPT, it is not uncommon for supervisees to be supervised by a clinical lead with management responsibilities, it seems important to consider the possible implications. The relationship between supervisory WA, supervisee role ambiguity and supervisor/supervisee counselling related disclosures in supervision is explored by Li, Kemer & Lu (2021.) They expand on the work of Mehr et al. (2015) and their cross-sectional study involving 222 supervisees, found that role ambiguity mediates the relationship between

SWA and supervisee disclosure in supervision. This suggests that supervisors need to ensure that supervisees are clear about their role, thus highlighting the importance of an induction to CS and conveying roles and expectations. The authors acknowledge that the cross-sectional study design limits generalisability of findings in that role ambiguity is likely to vary based on the supervisees stage of training which would be captured in a longitudinal study.

There is evidence that level of professional development predicts the level of disclosure within CS (Ladany 1996) which in turn, relates to the strength of the SR. Cook, Welfare & Sharma's (2019) study involved 10 trainee therapists who showed a recording of a clinical supervision session which was then reviewed using interpersonal process recall. Transcendental phenomenological analysis was used to identify themes. Whilst generalisability is bounded by the group studied, insight is provided into how nuanced aspects of the SR, such as desire to please the supervisor and awareness that the evaluative role of the CS, led to non-disclosure. Indeed, supervisee perspective of the SWA and supervisor multicultural competence, was found to predict supervisee nondisclosure collectively and inversely (Huttman & Ellis 2020). This suggests that supervisee disclosure is reliant on supervisor skill in promoting open discussion.

Supervisor difficulty in providing feedback has been found to relate to issues personal to the supervisee or the supervisory relationship (Hoffman 2005). Trainees are significantly less able to disclose sensitive issues relating to their supervisor or supervision (Webb & Wheeler 1998), indeed Hess et al. (2008) acknowledge that the act of providing feedback in the supervisory relationship, whilst difficult for supervisors, is far more challenging for trainees or less experienced therapists.

Whilst CS is deemed to be a suitable forum to address interpersonal issues, studies provide insight into the difficulties that supervisors experience in

addressing interpersonal behaviours. Consideration of *use-of-self* is accepted practice in psychotherapies, including CBT which Greenberg (1986) argues is essential for addressing behaviours in therapy and indeed in clinical supervision. Self-Practice/Self Reflection (Bennett-Levy et al. 2001) is inherent within CBT practice and elaborated upon in Section 2.5.1) and involves consideration of self in relation to therapeutic and supervisory practice. A thematic analysis by Vance, Theriault & Gazzola (2020) highlights supervisor difficulty in addressing supervisee issues such as therapeutic use-of-self, to conceptualise behaviours such as non-disclosure. Supervisors were reluctant to challenge supervisees whom they viewed as vulnerable and felt uncomfortable in bring up issues they believed to be personal. From a supervisee perspective, Spence et al.'s (2014) constructivist grounded theory study uncovered a dissonance between supervisees' desire to reflect, yet their concerns that an organisational culture seemed to associate self-disclosing with having difficulties.

The question of how disclosure can be encouraged in the supervisory relationship is an important consideration. The need to communicate that self-disclosure will not have negative consequences for the supervisee, is emphasised by Staples-Bradley, Duta & Gettens (2019), who caution that supervisee self-disclosure should serve a particular purpose and requires nuanced skills such as professional judgements on what is appropriate to share.

There is evidence for the role of relational factors to enhance disclosure in CS. In their study using structural equation modelling, Mehr, Ladany & Caskie (2015) found that trainees who perceive supervisory alliance to be strong are less anxious and more willing to disclose. They conclude that supervisors should strive to establish an alliance through empathy, respect and collegiality. Such an approach is supported by Gibson, Ellis & Friedlander (2019) who stress the merits of the 'interpersonally sensitive' supervisor placing emphasis on relational

factors. They compared clinical-related nondisclosure to supervision-related nondisclosure, testing the relation to three variables: supervisory alliance, collaborative supervision, and supervision relational behaviours (such as exploring feelings, alliance and processes). Relational behaviours were found to be the greatest determinants of disclosure, indicating that an interpersonal approach to supervision is conducive to disclosure. Being a non-random convenience sample, self-selection and social desirability bias may impact how the sample responded to questions however.

A retrospective exploration of nondisclosure (and how to prevent It) conducted by Sweeny & Creanor's (2013) also highlights the role of attending to interpersonal processes in the SR, in addition to providing a space in which to discuss personal issues. In their study of interpersonally sensitive supervision, Shaffer & Friedlander (2017) also found that the use of relational behaviours predicted an interpersonally sensitive supervision style that supervisees evaluated positively. It is noteworthy that CBT supervisors' use of such behaviours was significantly rarer than those of other therapy modalities such as psychodynamic and humanistic therapy.

Worthy of consideration is that that despite these behaviours being classed as generic, some (i.e., 'focus on counter-transference' and 'attend to parallel process') are not terms typically used within CBT and originate from a different theoretical tradition (Sterling & Byrne 2019). Furthermore, they are not reflective of definitions and behaviours associated with CBT supervision (see Milne & Reiser's 2009). CBT therapists are attuned to the use of reflective practice within clinical supervision, which is conceptually different to counter-transference. Supervisees accustomed to the use of these relational behaviours in supervision are likely to notice their absence of such behaviours and judge the quality of the alliance accordingly.

2.4.1 The Influence of Power on Disclosure in Supervision

From the outset of IAPT, CS arrangements were scrutinised to ensure that the required foundations were in place to support the development of CBT competence (Corrie & Lane 2015). Whilst a correlation between the quality of the supervisory relationship and the ability to disclose is apparent (Mehr & Daltry 2022; Mehr, Ladany & Caskie 2015; Webb & Wheeler 1998), it requires more than a healthy supervisory relationship to prevent nondisclosure in supervision. The relevance of power in the supervisory relationship cannot be ignored, given that the model of delivery of CS within IAPT services follows that therapists are supervised by more senior therapists, typically within the service and may have senior clinical or management roles. Working within the context of a business model with the expectation that therapists meet service targets, emphasises the potential power dynamic in the SR.

A study by Hess et al. (2008) highlights how power differentials can prevent supervisees in strained supervisory relationships from opening up, which is deemed to have a negative effect on supervisee wellbeing and clinical practice. From their IPA study, Singh-Pillay & Cartwright (2018) conclude that supervisee nondisclosure is a covert means of gaining control in the SR, otherwise defined by a power imbalance (Nelson et al. 2006). The phenomenon of supervisee power in the SR is highlighted in a study by Murphy & Wright (2005), within which participants acknowledged using their power to withhold information or feedback to supervisors. Given the explicit evaluative role of the supervisor, it is not surprising that there is hesitancy to disclose (McKibben et al. 2019). This is likely to create a tension for the supervisor wishing to work collaboratively, and potentially impact supervisee development. Feminist multicultural supervision (FMS) provides a means of acknowledging the power imbalance whilst promoting an ethos of collaboration. Just as feminist ideology recognises the influence of

power, culture, and race (Porter & Vasquez 1997), feminist supervision strives to empower the supervisee and avoid abuse of power (Porter 2009) within a collaborative, mutual and reflective context (Porter & Vasquez 1997).

In a study using multiple regression by McKibben et al. (2018), feminist supervision behaviours (collaboration, analysis of power, discussion of diversity, social difference, feminist advocacy and nondisclosure) were associated with fewer incidents of supervisee nondisclosure and each was mediated in part by the SR. Findings suggest that levels of disclosure could be enhanced through supervisors incorporating feminist behaviours into their practice, creating a safe context for supervisee openness. Application of feminist values within a hierarchical relationship supervision is not without challenge, however, as shown by Fickling & Tangen (2017) in their autoethnographic study. They conclude that, whilst a way of supervising without power has not been found, power can be used positively without minimising the power of the supervisee, who brings their subjectivity to the relationship.

The merits of supervisor self-disclosure have been considered within literature and it is argued that supervisor self-disclosure can strengthen alliance, enhance therapy outcomes (Guttman 2020) and normalise supervisees' experiences (Clevinger et al. 2019). Empirical evidence to support supervisor self-disclosure, however, is limited (Contrastono 2020). A study by Mehr & Daltry (2022) using multiple regression analysis found that, whilst a good SR promotes supervisee disclosure, supervisor disclosure does not influence this.

A phenomenological study by Mangione et al. (2011) notes how the subjective experience of the supervisor may differ from that of the supervisee. The goal of the study was to gain a greater understanding of power, reflexivity, collaboration, and authenticity within a female supervisory dyad. 'Outstanding' supervisors were sought by recommendation and participants got the permission

of an existing supervisee to participate. Supervision sessions were recorded, and semi-structured interviews were conducted. Participants were asked exploratory questions relating to power differentials, use of feminist values in supervision, collaboration, hierarchy, self-disclosure, and authenticity within the SR. There was a dissonance between supervisors, supervisees and researchers in terms of the extent to which feminist values were applied. For instance, supervisors often deemed supervision to be collaborative and reflective, but meaningful discussion of power or collaboration was minimal or absent. Reflexivity, which is characteristic of feminist supervision, was absent. Supervisors overestimated the degree to which feminist values were reflected within supervision, suggesting the need for further training.

This is in contrast to a study of SWA by Bilodeau et al. (2010), in which supervisors significantly underrated the alliance compared to the supervisees. It is surmised that because facilitative conditions (such as empathy, validation, and a non-judgemental approach) were present, and these are deemed to be valuable by supervisees, they scored the alliance highly.

Finally, to compare 'good' supervision as defined within literature (Bernard & Goodyear 2014) and feminist multicultural supervision, Arczynski & Morrow's constructivist grounded theory analysis (2017) successfully illuminates what constitutes the latter. Fourteen supervisors described their clinical supervision, from which several categories were generated. These aptly reflect feminist values and evidence the extent to which feminist supervisors integrate the principles. Discussion of issues including power, diversity and culture are not only considered but overtly discussed and analysed. Given the well documented power dynamic within the SR, and study participants making reference to this within interviews, this is relevant to IAPT CS. This will be expanded upon in chapter 4 (Findings).

2.5 Interpersonal processes in the Supervisory Relationship

Within supervision studies and literature, the merit of supervisors addressing interpersonal processes and thus providing an opportunity to discuss relational issues is acknowledged. Discussion of countertransference is predictive of less nondisclosure and greater supervisee satisfaction (Yourman & Faber 1996) with the supervisee being less likely to non-disclose or distort. Similarly, in a study by Hess et al. (2008), interns in a 'good' supervisory group believed that they may have disclosed more had the supervisor asked relevant questions.

The interpersonal (IP) cycle (Safran & Segal 1996) is helpful in considering the relevance of our unique early experiences, our means of adapting to these and how these can play out in the SR. Safran & Segal's cycle assumes a link between interpersonal relatedness and psychological health (Alden & Taylor 2004) with the theoretical construct of schema playing a large role. Defined as a generic cognitive representation (Safran 1990 p.89) and by Beck (1976) as an unspoken rule that guides how one evaluates the self, schemas directly impact how information is processed and the ensuing response. The theory suggests that expectations act as self-fulfilling prophecies. Schemas can be adaptive during early development as a means of communicating with an attachment figure, but difficulties occur if an interpersonal schema does not adapt to the new situation (Safran & Segal 1996). Consistent with Bordin's perspective that the building and repair of alliance ruptures is integral to change alliance (Bordin 1983), Safran & Kraus (2014) conceptualise the continual negotiation of alliance in a dyad as a functional means of interpersonal development.

According to Keisler (1983), there are two key relational components constantly being negotiated: the degree of friendliness and the degree of control the person has within the encounter. He proposes that the interpersonal circle is made up on an affirmative axis that represents the degree of friendliness and

hostility across the centre of the circle, and the control axis representing the degree of dominance over submission, which runs vertically through the centre of the circle. The theory suggests that affirmative behaviours (being friendly/hostile) prompt complementary behaviours, whilst controlling behaviours such as dominance prompt submission on the basis of reciprocity. Complementarity is a fundamental premise of a relationship and addresses a discrete component suggesting the 'ease' and 'fit' of the members and is separate to supervisory alliance, which relates to the conscious and realistic relationship (Kiesler 1989). Complementarity accentuates the relationship that stems from the individual's interpersonal behaviour and communicates how one wants the other to behave (Tracey, Sherry & Albright 1999). See Figure 2.1.

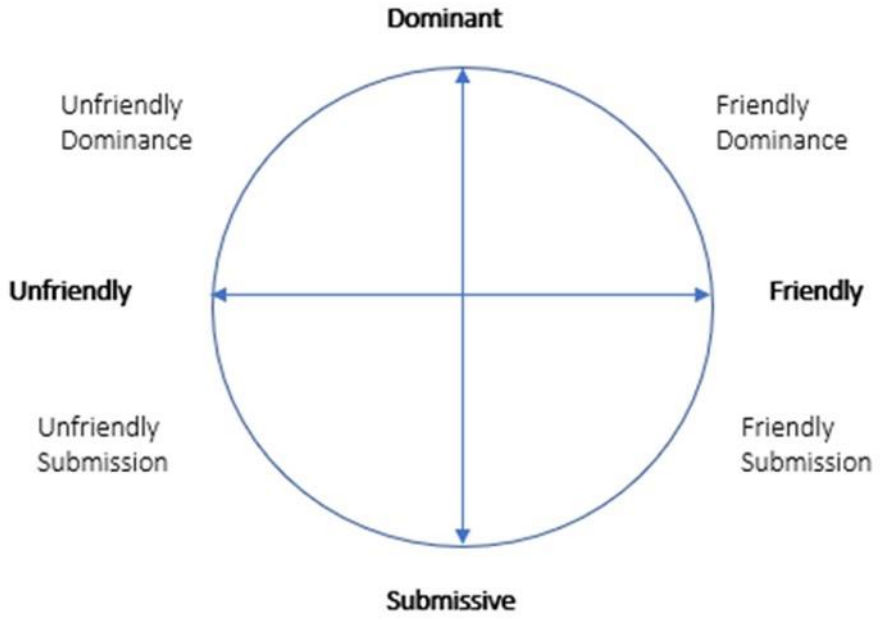

Figure 2.1: Keiser's interpersonal cycle 1983

Drawing on studies that address conflict in supervision, Grant, Schofield & Crawford (2012) used mixed methods, including in-depth interviews of sixteen 'experts', whilst Nelson et al. (2008) used grounded theory and Consensual Qualitative Research (CQR). Each supports the value of attending to supervisor and supervisee interpersonal processes to deal with conflict. Also of relevance is a dyadic study by Burke, Goodyear & Guzzard (1998) that examined weakening and repair in supervisory alliance, and in common with the former two studies, the perception of conflict as an expected phenomenon that should routinely be addressed in supervision.

With foundations in Bowlby's attachment theory, interpersonal therapy (Klerman, Weissman, Rounsaville, & Chevron 1996) emphasises relationships with others (Constantino et al. 2008). Studies indicate that interpersonal therapy training for therapists has a positive impact on treatment outcomes (Constantino et al. 2008; Crits-Christoph et al. 2006). Collaborative engagement in the context of a positive attachment relationship has been found to predict positive treatment outcomes (Constonguay, Constatino & Holforth 2006). Indeed, Safran and colleagues (2008) relate interpersonal theory to clinical supervision, with the supervisor providing a context that facilitates consideration of the quality of the relationship. Addressing interpersonal processes that are central to ruptures enables a shift away from blaming the other party whilst absolving oneself from any responsibility, as can be the case if conceptualised through the traditional parallel processes model (Safran et al. 2008).

Alliance-focused training (AFT) in supervision recognises the importance of supervisory alliance and the use of interpersonal skills to recognise, tolerate and manage alliance ruptures. Training focuses on increasing self-awareness, affect regulation and management of emotions (Eubanks-Carter, Muran & Safran (2015) in the context of group supervision within which supervisory alliance,

group cohesion and safety and impact are examined. A study by Urmanche et al. (2021) also examined supervisory alliance ruptures, cohesion and safety of trainee undertaking AFT within group supervision. The study involved 83 trainee psychologists and psychiatry residents, with 38 participants in the CBT group and 45 in the AFT group. There was a high level of SA in both groups, but the AFT group reported less safety and smoothness and more conflict. The level of engagement in the AFT group was deeper, leading to the conclusion that AFT fosters discomfort and risk-taking, which is conducive to facilitating deeper learning. A study limitation is that whilst the AFT group saw several different AFT supervisors, the CBT group had the same supervisor throughout, thus firm conclusions cannot be drawn.

2.5.1 Reflective Practice

The role of reflection in professional development has long been advocated (Schon 1983; Kolb 1984). Personal therapy for CBT therapists is not a requirement in the UK, which Prasko et al. (2021), argues strengthens the need for emphasis on self-awareness and self-reflection in supervision. In the last two decades, Bennett-Levy and colleagues (e.g. Bennet-Levy et al. 2003; Bennett-Levy 2006; Bennett-Levy & Thwaites 2009) have emphasised the centrality of reflective practice. The original model (Bennett-Levy 2006) represents three systems relevant to knowledge and skills development: *Declarative* knowledge is acquired through reading or formal teaching; *Procedural* knowledge (how to...) is acquired through practice, such as roleplay; *Reflection* is necessary for the refinement of skills. Self-Practice Self-Reflection (SP/SR) (Bennett-Levy et al. 2003; Bennett-Levy & Thwaites 2007) entails the application of CBT strategies to oneself (self-practice) and reflecting on our personal selves and how this impacts our practice (self-reflection). The original SP/SR model was revised Bennet-Levy & Thwaites et al. (2009) and privileged reflection as the '*engine*' propelling lifelong learning.

There is growing evidence that SP/SR, is instrumental in developing procedural, particularly relational skills, in developing CBT therapists. A study involving 120 experienced CBT therapists sought to gain insight into what training and supervision methods were effective in developing knowledge and skills (Bennett-Levy et al. 2009). Whilst lectures, reading and roleplay were valuable in learning technical knowledge and skills, roleplay was less effective for conceptual skills. For development of interpersonal skills, reflective practice including self-experiential work and roleplay, were more effective. A study using a quasi-experimental design, by Davis et al. (2015) quantifies the benefits of SP/SR for experienced therapists. It was found that SP/SR enhances self-perceived skills in interpersonal empathy and technical CBT. A study limitation is the sample size of

7 (following dropout of 3 participants), which limits generalisability. The sample were self-selected and may have attracted those who were reflective in nature. Lastly, in the absence of objective measures, self-reports were used, which Haarhoff & Farrand (2012) acknowledge, have been over-used in SP/SR research. Results are supported by a meta-synthesis conducted by Gale & Schroder (2014) involving 378 papers which found that SP/SR allows the therapist to experience therapy from a patient's perspective, thus enhancing empathy.

It appears that specificity of self-reflection is relevant. In a study by Ho-Wai So et al. (2018) a theory-based measure of reflection, called the self-reflective writing scale (SRWS) was developed, which encompasses personal self-reflection and therapist self-reflection. Using the scale to measure depth of reflection, a positive correlation was found between the level of therapist self-reflection and interpersonal skills. However, when reflection was focused on personal self-reflection, there was no benefit to the therapeutic relationship. This suggests the need for a supportive framework such as clinical supervision to guide therapists' reflection and subsequent transition to problem-solving, rather than fixating on negative thoughts. The authors recommend a reflective bridge between personal, therapeutic and reflection self (elaborated below).

The role of clinical supervision in supporting the transition to HI therapist cannot be underestimated (Thwaites & Haarhoff 2016), as is apparent in a grounded theory study by Wilcockson (2020). The study explored the transition of Mental Health Nurses (MHN), Counsellors and KSA (Key skills & Attitude) entrants (without a formal 'Core Profession') to High Intensity CBT. The trajectory from the core profession was found to influence therapists' approach to integrating CBT during training. Mental health nurses who previously used emotional avoidance or superficial adherence to manage emotional experiences had to adapt to the integration of SP/SR.

Trainee CBT therapists' experience of acquiring skills was examined by Roscoe, Bates & Blackley (2022) who drew on components of Bennet-Levy's DPR model (2006) to conceptualise the transition to CBT from other mental health professions. The '*previous professional self*' recognises the role and influence of previous training which can be in conflict with current learning and identity. The '*personal self*' represents self-schema which can present barriers to integrating CBT skills such as guided discovery, that contrast with more didactic behaviours consistent with previous learning and experiences, (such as mental health nursing). Finally, a study by Scott et al. (2021) supports the role of a personal practice (PP) model (Bennett-Levy and Finlay-Jones 2018) in developing therapists' personal attributes and confidence. Cohort control groups were used to evaluate the impact of SP/SR. The authors acknowledge the small sample (n=17) as a limitation, and only 50% of the groups completed outcome measures.

In my role as researcher. Reflective practice was critical and was a strategy which I used frequently to manage episodes of feeling overwhelmed emotionally and unsure of whether my motives were too concerned by the study and less focused on doing the best for the individuals involved in the study. Articulating my thoughts to a fellow researcher assisted me to work through my thoughts and recognise that my emotions (mainly anxiety) were feeing my overthinking. The use of a journal provided the opportunity to process my emotions and move on accordingly. Extracts are available in Appendix X.

2.6 CBT Supervision Models and frameworks

The concluding section of this literature review explores supervision models and frameworks that relate to the aforementioned literature, to establish the extent to which evidence-based practice is represented in models and framework used in CBT supervision. CBT is often regarded as a therapy that neglects the therapeutic relationship, and the historical emphasis on use of techniques and formulation may be partly to blame (Sanders, 2010). There is a misconception that CBT pays little regard to emotions (Liese & Beck 1997). Despite the growing emphasis on the importance of supervisors encouraging those new to CBT to reflect on their beliefs about CBT (Corrie & Lane (2015) and their perceptions regarding their core profession (Wilcockson 2018; 2021) and how these might impact their clinical practice and their experiences within CS.

In CBT, the cognitive behavioural formulation is recognised as the root cause of emotional distress (Haarhoff & Thwaites 2016), which contrasts with other psychotherapies that view the relationship as a key aspect of change (Rogers, 1957). The last two decades however, mark a greater recognition of the centrality of the relationship in therapy (Moorey & Lavender 2019; Safran 2014; Safran & Kraus 2014; Gilbert & Leahy 2007; Bennett-Levy & Thwaites 2009) and this is translating to clinical supervision. A variation in how much emphasis the relationship is afforded within CBT supervision models is apparent however.

Liese & Beck (1997) & Padesky (1996) advocate a supervision structure reflective of a CBT session, which serves as a means of socialising the supervisee to the structure of a CBT session. Features of supervision include the setting of an agenda, use of a Socratic style to guide discovery, setting homework tasks and using direct observation (video recording or 'live' therapy). Such a framework may feed the myth that CBT supervision focuses more on structure than process. Indeed, Bernard & Goodyear (2014) and Beinart (2014) argue that clinical

supervision and therapy are essentially different, with the former having an educative and governance function, and therefore reflexive models are unlikely to fulfil supervision outcomes and the SR may well be neglected. Reflexive models have been identified as fundamentally flawed by Milne & Reiser (2017), on the grounds that there is an absence of evidence-base and that CS is regarded as an extension of therapy rather than a specialist in its own right.

The IAPT supervision framework (Roth & Pilling 2008) has generated a culture of directly observing supervisee practice in order to measure competence. Generic competencies focus on fundamental skills such as building alliance, reflecting on one's own supervisory skills and experiential learning through roleplay, whilst specific competencies home in on the need to apply standards (the IAPT standard being the application of disorder-specific evidence-based treatment models). The use of a supervision framework reduces variability (Milne & Reiser 2012) and encourages standardisation of clinical supervision, thus enabling regulation of supervisors. Indeed, Falender et al. (2004) present a generic framework that focuses on attainment of knowledge (psychotherapy theory and research), skills (such as interpersonal effectiveness), values and social context. Also included is the means by which competencies are assessed. In their drive for a more rigorous approach to CBT supervision, Milne et al. (2011) have developed a supervision competence rating tool called SAGE (Supervision: Adherence and Guidance Evaluation) to support the Roth & Pilling supervision competency framework. However, Beckman & Alfonsson (2020) found that inter-rater reliability for the majority of the 14 items was in the fair to poor range.

Reiser & Milne (2017) assert that as clinical psychologists with '*a strong preference for methods and findings of applied science*' (p.104), methods of CS are given precedence ahead of the quality of the supervisory relationship. This, they posit, contrasts with those of a 'humanistic orientation,' possibly

contributing to the view that CBT supervision does not prioritise the SR. Given that IAPT CBT therapists have a variety of backgrounds and are likely to impart their own style and focus to CBT supervision (Wilcockson 2020; 2022; Townend 2005), the relational aspect may be prioritised differently. Nevertheless, a review of supervision literature conveys that the SR is acknowledged as a highly important component of CBT supervision. Indeed Reiser & Milne (2017) identify that the most common theme identified in narrative accounts of harmful supervision is difficulties in the supervisory alliance, with managing the alliance seen as an important role of the clinical supervisor.

Models of CBT CS attend to the SR to varying degrees. The Newcastle 'cake-stand' model (Armstrong & Freeston 2007) is widely used by CBT therapists and inherent within this is the need to attend to the SR. The SR, however, is recognised as a means of achieving the end goal of experiential learning, thus is situated below the upper 'layer' represented by Kolb's cycle of experiential learning (Kolb et al. 2014). The model offers a framework for conceptualising what factors influence CS but does not detail *how* such issues can be addressed (Gilbert 2020; Duquette 2010).

Milne and colleagues have drawn on their extensive CS research from which the evidence-based clinical supervision (EBCS) framework (Milne 2009) was developed. This describes 12 key principles of supervision, largely centring on learning and drawing on Kolb's cycle, which has been adapted to include five stages: experiencing, reflecting, conceptualising, planning and experimenting. The addition of *experiencing* is in response to criticism that Kolb's cycle is too cognitively focused (Milne 2009) and is intended to enhance reflection and self-reflection skills. The tandem model (Milne & James 2005) is based on the EBCS and depicts the active roles of the supervisor and supervisee in supervision. Supervision is a wheel of activities, with the front wheel controlled by the

supervisor who establishes learning needs and encourages the development of learning outcomes. The bicycle frame represents scaffolding to support learning, as advocated by Vygotsky's zone of proximal development (Vygotsky 1978) and finally the back wheel depicts the learning cycle, propelled by the supervisor and supervisee working together. The framework focuses on activities that can be employed within CS to enhance learning and development, for which a sound relationship is required. However, the SR is not suggested as a vehicle for change.

As discussed above (2.5.1), the six-stage process model (Bennett-Levy 2009) emphasises the role of each of the systems to optimise CBT skill development. There is recognition of the uniqueness of individual therapists learning style, thus the need for use of diverse methods in order to develop. Originally developed to address problems in the therapeutic relationship (Thwaites & Haarhoff 2016) it allows issues in the therapeutic or supervisory relationship to be addressed explicitly. Developments to the model (Thwaites, Bennett-Levy, Davis & Chaddock 2014), add emphasis on the role of reflection (focused attention) in order to resolve issues. With a growing body of evidence (Bennett-Levy & Lee 2014; Bennett-Levy et al. 2009; Bennett-Levy, Richards & Farrand 2010), the model provides a clear framework for self-reflection and reflection within supervision. The model is increasingly being used on CBT training courses, which is likely to propel the status of the relationship in therapy and supervision. As highlighted by Roscoe et al. 2022 above (2.5.1), SP/SR and clinical supervision were identified as useful for assimilating and integrating guided discovery in their practice.

The context of CS is ripe for addressing interpersonal issues in the therapeutic and supervisory relationship as is reflected in the cognitive-interpersonal supervision model (Safran & Muran 2000). This builds on Safran and Segal's (1990) seminal work on interpersonal processes in the therapy

relationship which provides a means of conceptualising the TR in CBT. Safran & Muran's model has been developed to resolve ruptures in the TR and involves the therapist 'disembedding from the relational matrix' (Safran et al. 2008 p.139) and adopting an 'observational stance' to reflect on the moment-to-moment dyadic interactions in a non-judgemental way. This focus enables awareness of own emotions and consideration of what has fuelled these. The model has more recently been applied to impasses in the supervisory relationship also. In common with Bennett-Levy's work is the centrality of reflection in therapist/supervisor development. Each of these models provide a framework for self-reflection in order to establish their part in the rupture. This is supported by a study by North (2013) in which a thematic analysis of supervisees experience of listening to an audio-recording of their latest supervision session, identified this as a means of facilitating challenge of negative automatic thoughts and in doing so, strengthening the SWA.

2.7 Summary of literature review (pre-analysis)

The last decade has seen the introduction of more CBT-specific supervision models, and a growing evidence-base for clinical supervision, in which the centrality of the SR is emphasised to varying degrees. There is an evident shift from procedural models (such as those of Liese & Beck 1997) to models that give due regard to interpersonal process, and this echoes a growing emphasis on the role of the SR, in the context of developing psychotherapy practice. Whilst credit is given to researchers who have built upon clinical supervision theory and evidence, particularly in the field of CBT supervision, namely Reiser & Milne (2016; 2017), Culloty, Milne & Sheikh (2010) and Milne & Dunkerley (2010), there remains a paucity of British studies that focus on relational processes in supervision. This is surprising given the introduction of IAPT, which not only

represents a radical new model of psychological treatment executed by a young, inexperienced workforce but is delivered in the context of key performance targets and pressure to move patients to recovery (Griffiths & Steen 2013). Working within an IAPT service introduces different challenges, many of which are likely to be carried into clinical supervision.

A review of the literature has uncovered many good studies that relate to the SR. However, the majority of studies undertaken in the last couple of decades are deemed to be of poor quality. The studies that have contributed to CS have, in the main, been quantitative and thus the 'voice' of IAPT supervisors and supervisees remains muted. I started my journey in search of literature that provides insights into the SR in CBT and particularly IAPT supervision. Given the dearth of studies in this area, this thesis will address this gap by focusing on IAPT supervisors' and supervisees' experiences of the supervisory relationship.
This study aims to address the question:

How do IAPT supervisors and supervisees make sense of their experiences of interpersonal processes in the supervisory relationship?

2.8 Significance of proposed research

Many of the studies referred to within this review have used quantitative research methods (commonly questionnaires) to elicit data. Watkins's (2014) review of literature relating to the SR observes that studies are, in the main, retrospective and from a supervisee perspective, within which single sessions of supervision are reflected upon. The need for studies carried out in the clinical context (rather than university-based) and from supervisors' perspectives is highlighted. The proposed study addresses an area deserving further exploration, in that supervisors and supervisees will be interviewed with a view to gaining insight into interpersonal processes in clinical supervision over a longer timeframe. This study will enable an in-depth multiple-perspective account of the SR in CS that will explore weakening and rupture (as an expected phenomenon) in addition to the repair of conflicts. The study will be specific to the IAPT context, which needs investigation, given the myriad of challenges faced by CBT therapists. Although the focus is on IAPT supervision, it is anticipated that findings will be relevant to other modalities of psychotherapy supervision in offering insight into what happens interpersonally within the SR. To this end, the findings can inform clinical supervision training and development.

2.9 Post-analysis literature review

In keeping with IPA studies as advocated by Smith et al. (2009 p.112), the study findings presented in Chapter four remain close to the participants' narratives. Within Chapter 5, findings are discussed in a wider context and theoretical frameworks are drawn upon to support the discussion.

The following theories are related to the study findings and are discussed in the post-analysis literature review below: S*elf-concept and self-concept clarity Social-identity theory; Emotional labour and burnout; Stress reduction and the quiet ego; Organizational cultures; Belonging* and P*ower.*

2.9.1 Self-concept and self-concept clarity

The theoretical framework of self-concept is drawn upon in Chapter 5 to support discussion of how participants perception of the self-appeared to play a role in their experiences of being in the supervisory relationship. Here a review of literature pertaining to self-concept and associated constructs, is presented.

Self-concept is a rich and complex multi-faceted phenomenon that influences how one thinks, feels and behaves in social situations (Corte 2007; Suszek 2007). Described as a cognitive schema that enables people to organise and process information about the self (Campbell et al. 1996), self-concept is a memory structure storing patterns of activation based on contexts, goals and moment to moment experiences. Self-concept comprises one's self-knowledge, self-beliefs (Baumeister 1998) and, derived from these ideas, self-evaluation (Guerrettaz & Arkin 2016). Self-concept is malleable and sensitive to life events (Markus 1986). Historically, theories supporting self-concept have been largely abstract (e.g., Epstein 1973) but the situation has improved somewhat in the last two decades. It has long been suggested that vulnerabilities in self-concept contribute to the development of psychological problems (Teasdale 1988; Marsh & Richards 1988). More recent studies of self-concept have enhanced

understanding of the onset of psychosocial pathologies such as eating disorders (Vartanian 2009; Stein 1996), alcohol dependence (Corte 2007) and even romantic break-up (Slotter Gardner & Finkel 2010). Whilst a review of literature suggests that self-concept has not previously been studied in relation to clinical supervision, I contend that the theory has much to offer in terms of conceptualising interpersonal processes within the context of clinical supervision.

Studies of the self-concept have increased and tend to involve the education or work contexts which provide insights into how self-concept influences experiences, perception and behaviour. A study by Weary, Marsh & McCormick (1994) found that those less confident in their own judgements and opinions engage more in social comparisons. This reflects Butzer & Kuiper's (2006) study of intolerance of uncertainty, a feature of low confidence, which also found that this negatively relates to upward social comparison (making unfavourable comparisons with others believed to be better than oneself). Those without a clearly defined sense of self may seek external sources to self-validate and potentially put pressure on themselves to excel (Vartanian 2009).

Self-concept clarity (SCC) is the extent to which an individual has a clearly defined, consistent and stable self-concept (Campbell et al. 1996; Ellison et al. 2020), and higher SCC is associated with adaptive emotional regulation and a greater sense of self that influences responses to self-relevant information (Guerrettaz & Arkin 2016). Studies suggest that SCC can moderate how an individual perceives feedback by acting as a buffer and therefore either maintaining self-esteem or confirming negative self-beliefs (Ellison et al. 2020; Guerettaz & Arkin 2015; Campbell 1990). Indeed, Swann et al. (2007) assert that those with SCC are more likely to resist feedback that doesn't fit their beliefs whilst behaving in a self-consistent and stable way.

The significance of SCC is apparent in a study by Boucher (2021), who investigated the relationship between socio-economic class (SES), SCC and subjective wellbeing (SWB). There was evidence of a relationship between SES (defined by income, educational attainment and occupational prestige), and psychological processes such as attention, memory, reasoning and emotional experiences. Using multiple regression with SWB as an outcome variable, SES and self-concept consistency were found to significantly predict SWB. This is consistent with the work of Kraus et al. (2012), whose social cognitive theory of class suggests that having access to resources and opportunities allows individuals to chase their goals. In contrast, those with lower SES face environmental limitations such as lack of education and experience and tend to want to 'fit in', while those with greater SES individuals have greater orientation to the self and prioritise autonomy. Given the broad socio-economic background of IAPT staff, it seems likely that psychological processes that impact individuals' experience of supervision are at play and may benefit from being addressed.

The relationship between SCC and management of social conflict was examined by Bechtoldt, Dreu, Nijstad & Zapf (2010). It was found that people with high SCC have greater problem-solving skills, which they draw upon to manage conflict. Furthermore, those with high SCC are less preoccupied with negative self-relevant information and experience less ego threat in social conflict than those with low SCC. High SCC participants were less likely to engage in rumination, which Lyubomirsky et al. (1999) associate with poor problem-solving. This may account for high SCC participants having superior ability to problem-solve, as highlighted by Bechtoldt et al. This supports a study involving dyads by Parise et al. (2019), which also provides evidence that having a clear understanding of oneself contributes positively to relationships and the functioning of the dyad. SCC was found to predict one's own and one's partners'

relationship satisfaction in romantic relationships and the use of coping behaviours (such as problem-solving) to maintain relationship satisfaction.

Intrinsic motivation is defined as the degree of positive affect of an activity (Spinath & Steinmayr 2012) and a study by Weidinger, Spinath & Steinmayr (2016) investigated why this reduces following negative feedback. The study examined the relationship between ability self-concept (ASC), defined as a cognitive representation of one's academic ability (Eccles & Wigfield 2002), formed through external comparison of ability to others (Morse & Gergen 1970; Marsh 1986) and internal comparison of self (comparing one's abilities in various domains (Skaalvik & Skaalvik 2002). It was found that the lower one's ability self-concept was, the greater this influenced intrinsic motivation. However, the effect was fully mediated by ability self-concept.

These studies provide insights into factors that potentially influence the experience of clinical supervision. Being cognizant of the need for adjustment, such as providing moderate feedback tentatively within clinical supervision and ensuring that the level of learning is within the individuals' zone of proximal development, is essential.

The impact of transitioning to higher status roles is apparent in a study conducted by Fletcher & French (2021), which examined change over time. A transition into a leadership role was found to have a positive impact on wellbeing and self-concept. However, the transition caused tension and a drop in self-esteem. The authors acknowledge that the effects found are small but ripe for further research.

2.9.2 Social identity theory

Social identity theory (Taijel & Turner 1986) suggests that individuals define their identity based on social groups that they identify with, and which bolster their self-identity, and thus can be related to participants experience of adapting to membership of a social group and integrating one's self-identity to reflect this. This impacts positively on wellbeing, thus enhancing self-concept (ibid.). However, Banas & Smith (2021) point out that self-identity mapping can include self-perceptions that are not linked to social groups. Their observational, survey-based study investigated self-concept structure, self-aspect attributes, perceived stress, life balance and satisfaction, which involved a sample of 640 members of the general population. The self-aspects that rated above midpoint on the scale of desired attributes were labelled as 'super aspects': positive, representative, and were found to be indicators of subjective wellbeing (SWB).

The Multiple Self-Aspects Framework by McConnell (2011) proposes that self-concept is a collection of context-dependent self-aspects, filtering life events and producing invisible context that determines the level of affect produced and the behavioural response. A study by Brown et al. (2016) suggests that people's movement between self-aspects is determined by the level of importance, with movement being slower between aspects of more importance to less. Consequently, people can compartmentalise parts of their identity that they are less comfortable with.

These studies provide insights into factors that potentially influence the experience of clinical supervision. Being cognizant of the need for adjustment, such as providing moderate feedback tentatively within clinical supervision and ensuring that the level of learning is within the individuals' zone of proximal development, is essential.

2.9.3 Emotional labour and burnout

To contextualise issues that arise in the SR, I draw on the concept of *burnout*. Defined as a psychological state resulting from emotional stress, burnout consists of emotional exhaustion, depersonalisation and a reduced perception of personal accomplishment (Maslach 1982; Maslach, Schaufel & Leiter 2001). Emotional labour is recognised as a forced affective performance which is associated with burnout (Hochschild 1983). IAPT therapists referred to the emotional impact of their work yet were in roles which required them to have emotional control. Whilst supervisors are required to undertake emotional labour for their work with patients, their role extends to containing the emotions of their supervisees. Within the study, there was evidence of both supervisor and supervisee work-related negative emotion.

Emotional exhaustion is associated with a perceived need to hide negative emotions (Brotheridge & Gradney 2002) and a Dutch study (Taris & Sehreurs 2009) highlights the implications of emotional exhaustion on performance, which, related to the IAPT context, translates to potentially poorer recovery rates. As discussed in the literature review (part 1), receiving higher levels of supervision is associated with lower levels of disengagement and burnout. Indeed, studies suggest that *better* supervision that provides relational depth, therapeutic quality and is supportive, correlates negatively with burnout (Ost et al. 2012; Sodeke-Gregson et al. 2013; Zarzycka, Jankowski & Krasiczynska 2021).

Emotional regulation theory contributes to understanding participants response to distress. Gross's (2002) model of emotional processing proposes that emotions are regulated through cognitive means, such as reappraisal. The forum of clinical supervision is conducive to such a process, whereby the supervisee is encouraged to discuss the relevant emotional experience, which in the short-

term heightens the emotion. However, once processed, emotions lose potency and are no longer distressing.

2.9.4 Stress reduction: The Quiet Ego

Within 'self' literature, one of the best predictors of stress reduction is self-control (Baumeister & Vohs (2007) and being able to manage conflict between social belonging goals and self-focused goals whilst attending to 'enlightened self-interest' (p.120). Wayment & Bauer's (2008) notion of a self-identity, referred to as '*the quiet ego',* represents an alternative means of construing the self and draws from humanistic and eudaemonic perspectives. This involves balance between concern for the self and others, thus transcending egotism. The quiet ego strives to facilitate four compassion-based characteristics. The first, *perspective-taking* (Davis 1983), involves understanding other perspectives. The second, *inclusive identity,* refers to the extent to which one involves others in their psychosocial space and emotionally connects with them (Leary et al. 2008). In turn, psychosocial growth is facilitated by identifying with and emotionally connecting to others. The final two characteristics, *detached awareness* and *growth mindedness* (Wayment & Bauer 2018 p.882) have similarities to mindfulness and involve paying self-relevant attention in the moment (Kabat-Zinn, 1994). *Growth mindfulness* also recognises and facilitates the opportunity for growth, not just of oneself but for others.

In a study of compassion fatigue and management interventions in a sample of 37 healthcare staff by Wayment et al. (2019), participants attended four bi-weekly sessions that facilitated the management of negative emotions, self-criticism and criticism from others using quiet ego interventions. Compassion fatigue and compassion satisfaction were inversely correlated. Cognitive appraisal was positively associated with compassion satisfaction. A further study by Wayment & Cavolo (2019) examined self-control, which was found to fully

mediate the relationship between quiet ego and less perceived stress in college students. The study, which involved 1,117 college students, also showed a relation between quiet ego characteristics and coping in stressful situations.

As a relatively new psychological construct, the theoretical relationship between the quiet ego and self-concept clarity has been examined by Lui, Isbell & Leidner (2021) using mediation analysis. Emotional intelligence (EI) is a construct made up of ability EI (understood as cognitive ability) and trait EI (understood as a self-perception) and results suggest that the quiet ego is positively associated with both. Furthermore, EI was found to mediate the relationship between the quiet ego, enhanced subjective wellbeing (SWB) and reduced stress. Serial mediation analysis found that trait EI (self-perception) was mediated by mindfulness, but there was no evidence that EI mediated the relationship between the quiet ego and SWB or stress.

In more recent studies, Lui, Isbell & Leidner (2022) used a confirmatory factor analysis approach involving 1,099 university students and the quiet ego was found to be positively associated with self-concept clarity. A second study investigated its associations with psychological well-being and self-esteem from the perspective of self-concept clarity, involving a sample of 500. Positive associations were found between the quiet ego and SCC. Furthermore, the quiet ego predicted psychological wellbeing and SCC through the associations with PWB and self-esteem from the perspective of SCC. Caveats to the study are acknowledged; as this is a correlation study, causal claims relating to results cannot be made. Furthermore, the study was theoretically driven, with results in line with Lui, Isbell & Leidner (2021). These findings explain the centrality of self-concept and the importance of considering this as a construct that plays out in the SR. Greater awareness of one's self concept would enable quiet ego interventions to be applied. This is likely to enhance clinical supervision.

2.9.5 The Influence of IAPT Culture on the SR

Culture refers to a collection of shared practices and beliefs that define a group of people (May 2013): shared events, practices, roles, values, myths, rules, beliefs, habits, symbols, illusions and realities (Eleftheriadou 1994). Mannion & Davies's (2018) Organisational Culture framework enables a nuanced perspective of cultures, with three levels: *visible manifestation of culture, shared beliefs and values*, and *everyday practices* that can be conscious or unconscious.

Bendall & McGrath (2020) argue that the trajectory to recovery within IAPT is not necessarily so clear-cut and unidirectional in reality. Their thematic analysis of patients who had received therapy within an IAPT service highlighted patients manipulating MDS to access further sessions; moreover, patient reports of MDS scores not being an accurate reflection of how they felt are concerning. By implication, measurement of therapist performance based on MDS may not be accurate. Consequently, therapists may deliver effective therapy without patient improvement being captured numerically, which reflects negatively on their recovery rates.

According to Tateo & Iannaccone (2012) social life is the context within which individuals learn to critique the world, thus broaden their knowledge through an ongoing cyclical process. Firstly, a culture of development occurs through the appearance of 'genius' or scientific knowledge, and through turning experiences of the world into discoveries (p.59). Following on from this, social practices become more detached from academic debates, and address fundamental issues. This is consistent with Jovchelovitch's (2001) view of social representations developing over time, meeting other representations and changing. Social representations theory is related to participants experience of clinical supervision, within the Discussion chapter in order to explore the integration of IAPT and explore cultures that have evolved since its inauguration.

2.9.6 Belonging

Theories relating to belonging offer a window into the dynamic and complex nature of participation (May 2012) and provide justification for promoting shared representations amongst the IAPT community. Described as a '*fundamental human motivation that guides behaviour'* (Marksteiner Janke & Dickhauser 2019 p.42), belonging serves an evolutionary function, as is observed in studies of people under threat of death from predators remaining in groups to increase the chance of survival (Baumeister & Leary 1995). Belonging provides the ontological security that comes with fitting into our surroundings (Giddins 1991), which Baumeister & Leary view as distinct from the attachment relationship hypothesised by Bowlby (1969), in which a specific person meets security needs.

A study of 1269 survivors of Hurricane Irma (Bruggs et al. 2021) found that a sense of belonging and perceived support moderated the effects of perseveration and distress intolerance, whilst reducing symptoms of anxiety and depression. Belonging provides a sense of wellbeing from 'being-in-the-world' (Miller 2003 p.218) and is not merely a feeling of belonging, but a state of being connected to particular people and having geographical and historical connections. This suggests the importance of IAPT therapists having a tangible team base and being part of a team, despite remote working and pressure to prioritise patient contacts over staff integration.

Miller (2003) refers to Kierkegaard's notion of *'correct relation*' which represents a mode of being perfectly integrated in oneself, having the ability to self-synthesise and consequently know oneself (Miller 2003). Thus, the individual is able to present the self in a true and authentic way. In a study of sense of belonging and perceived stress in nursing students on clinical placement, conducted by Grobecker (2016), a statistically significant low inverse relationship

was found, leading to the conclusion that a sense of belonging has a positive influence on student learning.

In interpretating the work of the philosopher Gadamer (1961), Palmer (1969) acknowledges the significance of belonging to the hermeneutical experience, for which shared language is required to enable conscious participation in the world. Absence of sense of belonging, however, predicts emotional exhaustion (Skaalvic & Staalvic 2011). On this theme, a psychological intervention study by Walton and Cohen (2007 p.82) found that in domains of achievement such as academic and professional settings, certain socially stigmatised groups are more sensitive to their state of belonging, which can manifest as a belief such as "*I don't fit in*". Walton and Cohen (2007) found that acknowledging and normalising the experience of having doubts about belonging, and conveying the message that all students endure some hardship (not just those from particular ethnic groups), had a positive impact on minority students. Indeed, their belief in their ability to succeed increased by 20 percentile points. The researchers conclude that majority students who showed little or no response to the intervention may have an assumed sense of belonging and so do not require acknowledgement of the difficulties of fitting in.

The '*Zone of Proximal Development*' theory of learning (Vygotsky's 1978) recognises the social aspect of learning. Indeed, studies suggest that socio-cognitive interventions (such as team discussion and checking wellbeing) has a lasting positive impact on health (Marksteiner et al. 2019). Whilst the study participants were not ethnically diverse, it seems important to consider *unseen* difference. Some participants expressed doubts about fitting in, which may originate from unseen disadvantage associated with socio-economic status, as highlighted by Tibbetts et al. (2018). The authors draw on Stephens et al. (2012) Cultural Mismatch theory to describe the discrepancy between norms implicit

within higher education, such as independent learning, that immediately disadvantage those from working-class backgrounds. In their study of students from a first-generation higher education background, it was found that they experienced peaks in cortisol (indicating stress) when they received an introductory letter implying an expectation of independent learning. An unseen advantage associated with middle-class norms was noted. First-generation students understand themselves and their behaviours as interdependent with others and their social context. This is common in working-class environments where people are subjected to material constraints and less autonomy (Stephens et al. 2012). In his work on the influence of socio-economic status, Manstead (2018) concludes that in the UK, material circumstances in childhood have a lasting effect on how people construe themselves.

It seems imperative that we consider what unspoken message is conveyed through the current systems for recruiting, appointing and training High Intensity CBT trainees, and whether these may contribute to therapists having a sense of not being good enough or of not belonging. In the spirit of diversity, there is a need to contemplate current systems and whether these reinforce the privilege or disadvantage that individuals have been subjected to in their formative years. Whilst not specific to IAPT, a study conducted by Scior, Williams & King (2015) highlights an unfair advantage that exists in the field of psychological services for those who have been privately educated and attended prestigious universities.

IAPT's commitment to fairness and equality is laid out in the BAME Service user positive practice guide (Beck et al.,2019) which recognises that engagement with minority groups must increase, and that the IAPT workforce should reflect the community served. Indeed, figures from the Equality Trust (2017) highlight that the division between social classes in the UK is widening, with a fifth of households earning 40% of the national income and the bottom fifth earning just

8% (Manstead 2018). This strengthens the argument for pragmatic consideration of difference at a more 'local' level, and creatively addressing how to ensure fair representation of social backgrounds, educational backgrounds, and ethnic groups within the IAPT workforce.

2.9.7 Power, IAPT and the Supervisory Relationship

Critical thinking entails the examination of assumptions and opening these up to change (Roberts 2016). For this, the work of Michel Foucault (Gordon 1991) is drawn upon to support analytical discussion of power in IAPT and the supervisory relationship. Various conceptualisations of power are presented within literature: traditional models such as that presented by Dahl (1957) conceive power as a form of domination, whereby one can influence others behaviours regardless of the person's desire to do so, with the consequence that others are constrained (Sadan 1997). The model has been criticised as too narrow and failing to elaborate on power relations and mechanisms (Lukes 2015).

The three-dimensional model of power presented by Lukes (2005) elaborates on Dahl's concern with social actions, adding a second dimension to reflect power implicit in not only decision-making but also non-decision-making. The more recently added third dimension (Lukes 2005) acknowledges power through domination; however, unlike his previous work, here he recognises that power can be positive, productive, and transformational (Swartz 2007), clearly reflecting the influence of Foucault.

Referred to as a '*triangle of power'* (Dean 2010 p.122), Foucault's work centres on disciplinary power and biopower, which Singer & Wear (2006) assert is *'lacking analytic specificity*' (p.444). Modern power is not owned by anyone (Foucault 1980) but *'traverses and produces things, it induces pleasure, forms knowledge, produces discourses'* (Foucault 1984 p.61). The Foucauldian notion of

power is concerned with how this plays out relationally, from the bottom up as much as the top down, as has been apparent within participant narratives. This entails examination of the relationship between knowledge, power, and human relationships, for which analysis is required (Gallagher 2008). Critics such as Lupton (1997) suggests that Foucault's propensity to refer to power negatively, for instance, as subjugating and instrumental in producing *'docile bodies'* implies ambivalence towards it. Indeed, feminist writers such as Allen (2008) disapprove of Foucault's depiction of power as associated with helplessness and passivity and his failure to emphasise individual agency. In his defence, Borg (2015) argues that Foucault's work has been misinterpreted in translation and must be considered alongside his annual lectures at the College De France, which offer further context. Indeed, Foucault refers to the positive aspects of power in *Discipline & Punish* (1977 p.194)

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production.

In response to assertions that his work lacks method and is '*discourse in the abstract*' (Hacking 2004 p.278), Foucault argues that his intention is not to create a theory, because '*the question of power'* is of no interest to him (1996, p.360). His concern is power and '*What happens when individuals exert…power over others?*' (Foucault 1982 p.728). This reflects his refusal to see power as uniform. Foucault believed that power is all around us and exists in all relationships. It is precisely this power '*as a mode of action'* (1983 p.220), that is analysed in relation to IAPT supervisors and supervisees. Analysis of power within IAPT, from the top down and the bottom up, adds context to power relations in supervision. Such reflexivity is central to Foucault's idea of freedom:

He asserts that one is not truly free unless, through self-reflection, they make a choice to either resist or subjugate (Foucault 1982). This is elaborated upon in Chapter 5.

2.10 Chapter Summary

Within this section, a review of literature that supports analysis of themes emerging from the study findings, is presented. These theoretical connections have been driven by emerging analysis however, I accept that my interpretation is likely to be influenced by my own experiences of the supervisory relationship. Heidegger (1962/1927) refers to '*fore-structures*', that is; prior experiences, preconceptions and assumptions, that can impact one's interpretation. Rather than deny their relevance these can be used to make the scientific theme secure by understanding how they may influence interpretation.

The following chapter outlines the methodology used to explore the research question.

How do IAPT supervisors and supervisees make sense of their experiences of interpersonal processes in the supervisory relationship?

Justification for the choice of qualitative methodology and specifically interpretative phenomenological analysis, is presented.

CHAPTER 3. METHODOLOGY

3.1 Introduction

In this chapter, the ontological and epistemological stance of this study is discussed, leading on to justification of the use of qualitative research methods to address the research question: *How do IAPT supervisors and supervisees make sense of their experiences of interpersonal processes in the supervisory relationship?*

I present a rationale for selecting IPA as a methodology over a stable of phenomenological methodologies advances to discussion around the founding principles and philosophical influences of IPA, mainly Husserl (1970), Heidegger (1962) and Schleiermacher (1998). The use of social representations to explore the social construction of mental illness and the role of IAPT is justified. My role as researcher is considered, following which the process of collection and analysing data collection (including ethical considerations) is discussed.

3.2 Researcher's Philosophical Stance

In considering my philosophical perspective, I draw upon Braun and Clarke's ontological continuum (2013), which places realism at one end, associated with positivism and assumes a direct relationship between what is observed and the nature of reality (Green & Thorogood 2004). Relativism, at the other end of the continuum, posits that there is no objective reality, but multiple realities have been constructed by humankind (Krauss 2005). Situated between is critical realist ontology, described by Losch (2009) as the 'most encompassing' (p.86) perspective, which acknowledges that an independent reality exists, which we can only partially access (Braun & Clarke 2013).

Bhaskar's critical realism ontology posits that the nature of reality is not confined to one view (Fletcher 2017) but is stratified into three domains that the critical realist researcher investigates. The *empirical* domain represents what is experienced, directly or indirectly, and can be explained by common sense, mediated through human experience and interpretation (Blom & Morén 2015). Within the domain of the *actual,* there is no filter of human experiences and indeed the real experience may differ to that observed (Fletcher 2017). The third level is the *real*, and at this level generative mechanisms exist. Described by Blom & Morén (2011 p.60) as concepts and phenomenon within the metatheoretical perspective of critical realism, generative mechanisms explain how and why events happen and can be identified through analysis of these three domains of reality. Whilst these are part of the social world and are contextually contingent, they are regarded as tentative (Blom & Morén 2011). Through analysis and interpretation of participants' narratives, generative mechanisms that relate to the SR and interpersonal processes are accessed. Reality is independent of the knowledge generation process (Dobson 2002) and is no less real for not being observable (Blom & Morén 2011).

Critical realist research tries to reconcile what we know in terms of 'context bound and emergent descriptions' (Scott 2005 p.3) with the ontological dimension that is independent of attempts to uncover. Indeed, critical realism enables a scientific approach within 'a climate of epistemic relativism in which knowledge is open to challenge' (Parker 1998 p.3) thus marrying constructivist epistemology whereby the researcher attempts to create meaning from an individual narrative with a realist ontology (Raskin 2008).

I am drawn to critical realist research as it enables me to embrace my subjectivity and use my knowledge of social, biological, and psychological factors to enhance analysis, rather than restricting analysis to knowledge made apparent through discursive means (Nightingale & Cromby 2002). Further consideration will be given to my role as researcher in an IPA study under section 3.4.

3.3 Why a Qualitative Paradigm?

The focus in this research is the supervisory relationship within IAPT and I specifically wish to gain insight into what is happening interpersonally between the IAPT supervisor and supervisee. Quantitative approaches are more suited to the numerical presentation of data in to carry out statistical analysis (Smith 2015) and to generalise findings to others, beyond the study subjects (Bryman 1988). Consistent with modernism is the belief that the model of '*good*' science is objective observation (Bryman 1988) of phenomena in order to generate a hypothesis, with studies focused on producing data consistent with the hypothesis (Fife-Schaw 2012). Indeed, Sharrock, Hughes & Wesley (2016) argue that the hypothetico-deductive characteristic of positivism, whilst driving the search for *explanation*, neglects the importance of *understanding,* which is sought in this study. For this reason, quantitative methodology was deemed unsuitable to address the research question. Qualitative research methodology allows the researcher to attend to the complexity of context (Coyle 2007) and

'the tangled, messy and multifaceted aspects of experience' (Eatough 2012 p.326). Qualitative research enables a flexible design that is particularly useful for answering 'why' questions (Green & Thorogood 2004) about experiences, meaning, and questions that allow the researcher to relate data to content. Furthermore, qualitative research is consistent with gaining in-depth information from a smaller sample (Harding 2013) and allows me as researcher to be fully engaged with the process. Qualitative research enables me to attune the interview to the specificity of the supervisory relationship and to exercise a degree of flexibility in order to access an account of participants' experiences.

3.4 Interpretative Phenomenological Analysis

IPA involves highly intense and analytical study of a small number of participants and a standard thematic analysis in the first instance. It then provides detailed interpretative analysis of the themes (Brocki & Wearden 2006). The influence of idiography is fundamental to IPA (Smith, 1995) and represents the researcher's concern with the particular, as opposed to groups (Smith & Osborn 2008). IPA aims to generate data enabling claims to be made tentatively at group level (Smith, Flowers & Larkin 2009); indeed, Smith & Osborn (2008) propose that IPA is consistent with theoretical generalisability, in that study findings can be related to other studies, personal and professional experiences and extant literature.

In the spirit of idiography, IPA achieves an in-depth insight into the perspectives of a specific group of people in a particular context, whilst remaining mindful of the individual and their narrative. Unlike nomothetic studies, where analysis is at group level, IPA entails detailed analysis of data on a case-by-case basis; one case is analysed in depth before the researcher moves on to the next, to carry out an equally intensive analysis.

There are concerns that IPA research lacks definition around levels of interpretation (Brocki & Weardon 2006). Indeed, Hefferon & Gil-Rodriguez (2011) suggest that IPA has become the default for inexperienced researchers, resulting in descriptive projects that do not reach the required level of interpretation consistent with IPA. Proponents of IPA acknowledge the propensity for insufficient depth of analysis (see Larkin et al. 2006); indeed, Smith (2011), in response to findings that 18% of 'illness experience studies' were of unacceptable quality, developed of an IPA quality evaluation guide in an attempt to enhance the quality of IPA studies. Whilst Smith et al. (2009) recognise the importance of quality in IPA research, they point at possible implications of the use of 'simplistic and prescriptive' quality checklists (p.179) that may detract from the work. They advocate more sophisticated guidance such as that of Elliot et al. (1999) and provide guidance themselves on how Yardley 's (2008) criteria for qualitative research can be applied to IPA.

As a relatively new research methodology, IPA has not escaped criticism, with Giorgi (2010) pointing out a failure to relate methods to phenomenology. On a similar theme, van Manen (2017) argues that IPA does not explore the phenomenological meanings and instead approaches these in a psychological way (through reflection) and thus cannot offer phenomenological insights 'of evidential quality' (p.778). In response, Smith (2018) reasons that sense-making is inherent in us as humans and the role of researcher is to encourage the articulation of participants' sense-making through reflection, which he views as part of the analytical process of making sense of the interpretation. In answer to claims of IPA not being sufficiently scientific, Smith (2011) acknowledges the long-standing debate in qualitative research on how to evaluate validity but methods such as replication do not sit with human science research.

3.4.1 Why IPA?

IPA was chosen as the research method best suited to answering the research question. Exploration of the lived experience and of the personal meaning attributed to this (Smith & Osborn 2015) is integral to this method and is conducive to answering the research question. IPA embraces my involvement in, and experiences of, the phenomenon. As the researcher, I have robust involvement in data collection and analysis. Whilst participants provide the first-order account of the phenomenon, I provide a second-order analysis to provide theoretical insights (Smith et al. 2009). Whilst mindful of IPA limitations, the methodology provides a means of capturing the lived experiences of supervisory dyads in context-rich detail, enabling in-depth insight into the phenomenon of being in a supervisory dyad, within IAPT. Discussion of measures taken to enhance validity is presented in section 3.6.1

3.4.2 IPA: Philosophical and theoretical influences.

The phenomenological influence of early twentieth-century philosophers Husserl and his student Heidegger is central to IPA. It was Husserl's (1970) belief that human experiences have value and only through deliberate critical reflection upon these experiences can a scientific study of the taken-for-granted, human experiences (Lopez and Willis 2004) or '*lifeworld*' (Smith, Flowers & Larkin 2009) be achieved. For the researcher, this involves stepping outside the everyday experience and adopting a phenomenological attitude by turning the gaze inwards, enabling reflection on perceptions of the phenomenon (Smith et al. 2009). The unique component of Husserl's philosophy was his insistence that the researcher is required to shed all prior knowledge of the phenomenon in order to examine the experience as it occurred. Husserlian phenomenology entails *reducing back* to the phenomenon itself (Larkin et al. 2011), enabling the study of a phenomenon devoid of any judgements or misconceptions, through

'bracketing' i.e., putting aside the knowledge of the world that is taken for granted and instead focusing on our perception of the world (Smith et al. 2009) This represents the difference between phenomenological research and IPA, which in contrast embraces the relationship of the researcher to their lifeworld as a central tenet of the research.

Heidegger used the term *Dasein* to depict one's situatedness, and the influence of *'being-in-the-world'* (Smith et al. 2009 p.18). This '*Person-in-context'* (Smith et al. 2009 p.17) is consistent with symbolic interactionism, which emphasises the social context of *Dasein* and the relevance of language, culture relationships and objects to our perspectives, in addition to the meaning we attach to a phenomenon (Chapman & Smith 2002). The researcher is involved in a dynamic process of understanding the participants' perspective of the phenomenon (Smith & Osborn 2015) whilst drawing on their own contextual position in relation to the phenomenon in order to inform their interpretation.

Heidegger was strongly influenced by Schleiermacher (1998), a major theorist in the early nineteenth century who sought to move away from specific means of interpreting texts to developing '*an art of understanding'* all texts. Interpretation, he posited, is an art involving skill and if analysed holistically enables 'grammatical' and 'psychological' interpretation; whilst the former relates to the actual text, the latter relates to the person being studied (Schleiermacher 1998). Sound analysis enables the researcher to have greater understanding than the participant (Smith 2007) and their motives, which requires a combination of an empathic and suspicious hermeneutic. The hermeneutic process (Palmer 1969) starts with a general question and is followed by attempts to make sense of the utterances from which meaning is established through the art of hearing. We build understanding by comparing new knowledge to something we already understand, and in turn our knowledge forms itself into

unities or circles made up of parts known as the 'hermeneutic circle'. To understand a part, there is a need to look at the whole; and to understand the whole, individual parts (words) need to be analysed (Smith et al. 2009). The meaning applied to words is dependent on how these are written or spoken, and to skilfully interpret these, the context within which the words are produced is most relevant (Smith et al. 2009). Although a complex dynamic, this double hermeneutic is integral to IPA (Smith & Eatough 2012); indeed Smith & Osborn (2015) refer to the researcher 'making sense of how the participant is trying to make sense' of the phenomenon (p.53).

In considering the ontological and epistemological assumptions associated with IPA, Larkin et al. (2006) describe contextualism (as presented by Madill et al. 2000) as 'a convenient shorthand' for an integration of their ontological position of minimal hermeneutic realism and an epistemological emphasis of learning about persons-in-context, in which

> [w]e *commit ourselves to exploring, describing, interpreting, and situating the means by which our participants make sense of their experiences.* (Larkin et al. 2006 p.110).

3.4.3 Heidegger's Ontology and Relevance to the Researcher and Research area

In contrast to the Cartesian view of the person that focuses on epistemological debate and whether knowledge is real and reflective of reality (Leonard 1994), Heidegger considers ontology at length (Wrathall 2013) and argues against the dualistic separation of egos and the world, which differentiates between subjective and objective truth.

Heidegger's notion of '*Being-in-the-world'* encompasses a person's position within the world in which they are shaped by relationships (Leonard 1994) and influenced by linguistics, culture, family traditions etc. (Orbanic 1999). To uncover what life is like for an individual or what it means to an individual to

be in their world, hermeneutic inquiry entails the researcher going beyond description and accessing the essence of the human experience and what it means to the individual (Lopez & Willis 2004). The Heideggerian exploration of *Dasein* represents my quest as researcher to access and increase my understanding of the participants' worlds through hermeneutic enquiry. Heideggerian enquiry calls for questions that promote depth of reflection on the phenomenological experience of being in a supervisory relationship. Heidegger used the term *'thrownness'* (Leonard 1994 p.47) to describe the position of the person as being-in-the-world and part of 'cultural, familial and situational practices and meanings' (p.54) and therefore not always at liberty to judge meaning objectively. Central to *Dasein* is that things matter (Dreyfus 1987) and are (as described by Heidegger) repositories of 'meaningfulness' that evoke emotion. Researcher reflexivity is discussed in section 3.6.

3.4.4 Social representations theory

Social representations theory (SRT) formulated by Moscovici (1984; 1988) provides a social psychological framework for hypothesising how culture, society and behaviour are dynamically linked. SRT was developed to study the cultural integration of psychoanalysis (Moscovici 1961), implying that the framework can offer insight into how supervisors and supervisees have adapted to the introduction and integration of IAPT. SRT is concerned with how a cultural phenomenon enters everyday life and becomes 'common sense' (Bauer & Gaskell 2008), which Moscovici (1963 p.251) describes as an elaboration *'of a social object by the community for the purpose of behaving and communicatin*g'. Representations are implicit images that influence meaning, interpretation, and classification of events (Jodelet 1991) and create a shared social reality for a particular social group (Burr 2002). They provide a theory supporting the

expression of thoughts and feelings into verbal and overt behaviours within a social group (Wagner et al. 1999), in this case IAPT clinical supervision. It is proposed that shared social representations are acquired through dialogue and the development of routines and goals within an organisation. In doing so, a sense of belonging is promoted (Jodelet 2012) and interpersonal relationships are established and maintained (Baumeister & Leary 1995).

Representations are generated by people's desire to know the world, thus making the unfamiliar familiar (Moscovici 2008). Because they are a form of knowledge based on a constructed reality, they do not represent the whole of reality (Jovchelovitch 2001). Whilst there are commonalities between SRT and Durkheim's Collective Representatives, each presents a distinct theory. The focus of the latter is on forces and strengths that hold society together and is consistent with the traditional view that the authority of the few dictates legitimacy and constrains access (Jovchelovitch 2001). In contrast, Moscovici perceives society to be in a constant state of negotiation (Marková 2010), and his interest lies in innovations, diversity, and unequal distribution of power. Analysis centres on changes in society, how new innovations (in this case IAPT) become part of social life (Marková 2010) and the subsequent influence of the minority. In contrast, Durkheim's collective representatives are criticised as too static for modern society (Hoijer 2011). Discourse analysis has similarities with social representations, in that each aims to open up group-based representations, the latter viewing representations as '*discursive objects*' such as descriptions or accounts, and analysis focuses upon gaining insight into how precisely these descriptions are built (Potter 2019 p.411). In contrast, social representations are informed by themes, and indeed have been criticised for lacking the detail of discursive analysis. Analysis using SRT comprises consideration of characteristics of communication systems relating to IAPT therapists, including content,

processes, consequences and subsequent segmentation of social groups. This provides insight into participants' behaviours, cognitions, formal and informal communication.

Tateo & Iannaccone (2012) propose that social life is the context within which individuals learn to critique the world, thus broadening their knowledge through an ongoing cyclical process. Firstly, a culture of development occurs through the appearance of 'genius' or scientific knowledge, and through turning experiences of the world into discoveries (p.59). Following this, social practices become more detached from academic debates, and address fundamental issues. This is consistent with Jovchelovitch's (2001) view of social representations developing over time, meeting other representations and changing. Social representations will be used as a theoretical framework to explore the cultural phenomenon of IAPT and the SR (Chapter 5).

3.4.5 Alternative Phenomenological Methodologies

Consideration was given to other phenomenological methodologies. Discourse Analysis (DA) views language as a means of constructing reality and functioning in the world, and the research emphasis is on 'what people do with their talk' (Potter & Wetherell 1995 p.81). Analysis of language in DA is conducted in a more structured way than IPA, using 'building tasks' (significance, activities, identities, relationships, politics, connections, sign systems and knowledge (Gee 2005)). This provides insight into the formation, creation, and maintenance of social norms (Starks & Brown Trinidad 2007). DA, however, challenges the assumption that verbal statements relate to underlying cognitions (Smith 1996); instead, discourse is viewed as a means of social interaction and achievement of interpersonal goals (Georgace & Avdi 2012). The use of language is highly relevant to this study; however, a focus solely on the *role* of language to describe

the experience, as is consistent with DA (Biggerstaff & Thompson 2008) would not answer the research question and so was discounted.

3.4.5.1. Grounded theory (GT)

Grounded theory is an interpretative method that offers flexibility, in that the research can be conducted from various theoretical perspectives. For instance, Glaser (1992) takes a more positivist stance, whilst Corbin & Strauss (1990) and Charmaz (2014) adopt post-positivist and constructivist stances respectively. Like IPA, GT is rooted in social interactionism that recognises the social context to meaning-making (Blumer 1986) and aims to explore the participants' experiences in the context of their world. Unlike IPA, GT seeks to produce theory. For this, analysis of interviews plays a large part, while several other sources of material are drawn upon, such as diaries, reports and other research. GT research offers a broader remit than IPA and because the focus is on social and psychological processes, it is better suited to questions that address influencing factors (Braun & Clarke 2013). GT was discounted for this reason as I wished to gain a nuanced account of a specific experience that would be compromised through using GT. The focus of GT methods is to *generate* data that is generalisable and although the process may lead to a better understanding, this isn't the central aim of this methodology.

3.5 Method

3.5.1 Recruitment of supervisory dyads

The goal of this research was to gain an understanding of interpersonal processes in the supervisory relationship of IAPT supervisory dyads. Specifically, I sought to gain access to the '*pushes and pulls*' (Safran et al. 2008 p.138) that are inherent in all relationships which are negotiated between the individuals.

It was acknowledged that recruiting supervisory dyads may limit participants' level of openness, given that a power imbalance is likely to exist. This would have the potential to make it difficult for supervisees to be authentic about their experiences of supervision. It was envisaged that interviewing the supervisory dyads separately would be more conducive to participants providing a nuanced perspective of interpersonal dynamics, and their means of making sense of and manage such dynamics. Interviewing a non-dyadic supervisor and supervisee would not provide the same depth of information relating to interpersonal behaviours that a supervisory dyad has the potential to provide. Non-dyadic participants', whilst likely to offer insights into participants experiences and perspectives of the SR, provide a one-sided perspective only.

Ethical approval was granted by the University of Derby College of Health and Social Care Research Ethics Committee (Appendix III) and relevant permission was obtained from NHS (Appendices III.i-III.iv) and non-NHS IAPT services, to conduct a study involving supervisory dyads. I emailed the Service Managers/Clinical Leads of five IAPT services in the north of England and provided details of the study, to formally request permission to recruit supervisory dyads. Once permitted to recruit, I requested that the Clinical Leads forward a cover letter and Participant Information Sheet (PIS: Appendix IV) to CBT supervisors and supervisees within their IAPT service. The PIS outlined the inclusion criteria that required that both the clinical supervisor and their supervisee (who had completed HIT training within the timeframe of six months to two years prior)

consent to be interviewed. The timeframe was intended to exclude newly-qualified therapists who were less likely be established in their role as qualified CBT therapists. Having a minimum of six months experience ensured that supervisees had the opportunity to settle into their High Intensity CBT position and to have sufficient experience of clinical supervision as a qualified CBT therapist to inform the study. Clinical supervisors were required to have full accreditation as a CBT therapist with the professional body BABCP and to work within an IAPT service as a CBT therapist or CBT supervisor. Those interested were directed to discuss the research with their supervisory partner in the first instance and, if both wished to participate, to contact me by email. Five supervisory dyads asked to be involved.

3.5.2 Pilot study

Interviews were piloted on the first supervisory dyad recruited, who were interviewed separately following which data was analysed using IPA. As a less experienced researcher, the pilot provided an opportunity to develop a questioning style that flowed logically, and that promoted reflective discussion. Pilot studies are recognised as a crucial means of identifying issues that may interfere with the quality of data (Harding 2013; Breakwell 2012). However, their role in assessing quality in qualitative and quantitative studies tends to be under-reported in scientific literature (Van Teijlingen & Hindley 2002), which Malmqvist et al. (2019) attribute to publishers' reluctance to draw on small-scale studies. Through transcribing and analysing the first two interviews, I developed a deeper connection with the study, which I believe enhanced the quality of subsequent interviews and analysis. To ensure adherence to the IPA principle of remaining close to participants transcripts, a more experienced researcher read the

transcripts. Themes identified by the researcher were consistent across analysis, which added to the credibility of findings.

3.5.3 Sample

A total of five supervisory dyads were recruited from four IAPT services, representing a purposive *'information rich*' sample (Patton 2002 p.46; Marshall 1996). In deciding on the size of the sample, time available to interview participants and analyse data was considered. I was aware that the desired depth and richness of data analysis might be compromised should the sample size be larger, and that '*rich understanding'* comes from a few rather than many (O'Leary, 2005 p.104). The sample size was consistent with the guidance from Smith (2004) of 5-10 participants in an IPA study. The pilot study provided useful insights into the quantity of data generated by just two interviews, and, on this basis, it was deemed appropriate to recruit a further 4 dyads. Ideally, I would have asked participants to identify their ethnicity on the consent form, but this was an oversight. I recognise that the question does have relevance, and indeed some themes highlighted in the study could be impacted by participants' ethnicity or background. Study participants are presented in Table 3.1. below.

The extent to which the findings are transferable is important in qualitative research (Lincoln & Gupa 2011; Lincoln, Lynham & Guba 2011). Furthermore, Green & Thorogood (2004) argue that whilst thick description is the aim of qualitative research, the theoretical import of the findings is also important. Transferability is enhanced through description of the specific contexts, settings and participants (Braun & Clarke (2013), enabling the reader to decide whether findings are relevant. Professional background and age range were deemed relevant, based on the literature review finding that age and experience correlate with an ability to manage stress (Briggs and Munley 2008; Lawson 2007).

Table 3.1 Study Participants

Participant	Gender	SPVR (supervisor) SPVE (supervisee)	Age range	Practice context	Professional background
Joe	M	SPVE	20-30	IAPT	PWP
Mia	F	SPVE	20-30	IAPT	PWP
Dan	M	SPVE	20-30	IAPT	PWP
Liz	F	SPVE	40-50	IAPT	Counsellor
Kate	F	SPVE	20-30	IAPT	PWP
Lily	F	SPVR	30-40	IAPT	MHN
Michael	M	SPVR	30-40	IAPT	Counselling Psychologist
Emily	F	SPVR	40-50	IAPT	Counsellor
Jenny	F	SPVR	50-60	IAPT	MHN
Cath	F	SPVR	40-50	IAPT & Secondary Care	MHN

3.5.4 Data collection

Prior to interview, participants were invited to ask questions about PIS, and a verbal summary of the interview and research process was provided, including information on storing confidential material, such as the interview recordings and transcripts. Wilcockson (2020) suggests that previous professional background can impact one's trajectory to CBT therapist. Participants were then invited to sign a consent form. Participants were interviewed separately in a location of their choice, which for all but one was their workplace (one participant chose to be interviewed at my workplace for practical reasons). After the interviews, feedback on the process was invited and participants were given the opportunity to debrief. Each interview was audio recorded.

Semi-structured interviews are, by design, flexible and do not need to be followed rigidly (Smith & Eatough 2012); indeed, Braun & Clarke (2013) suggest that it is acceptable to make changes to the schedule and not to treat it as fixed in the quest to ensure that the relevant data is accessed. The interview schedule

(Appendix V) was used flexibly and adapted to consider factors such as participants' personalities and level of comfort. This fits with Smith and Eatough's (2007) view that interviews are *guided* rather than dictated by a semi-structured schedule. This allows the research question to be answered whilst enabling flexibility to probe areas of interest, essential for an IPA study (Smith & Eatough 2012; Smith et al. 2009). The interview schedule was used as a guide and whilst warm-up questions tended to be similar for all participants, questioning style and subsequent discussions evolved from what participants said (or did not say).

To support audio recordings, field notes were used to record non-verbal cues. Participants were advised that each interview would be approximately an hour in duration, which proved to be the case (the shortest was just over 50 minutes, and the longest 80 minutes). Shorter interviews tended to be with participants who were less reflective but provided rich information nonetheless. For the lengthier interviews, we negotiated additional time, as the discussion was highly relevant. Interviews were fully transcribed, and notes added to provide context (such as facial expression being inconsistent with what participant had said; long pauses; expressed emotions). Participants were sent a copy of the transcribed interview and invited to identify material they wished to have removed (no participant asked for data to be removed). The Data Protection Act (1998) and The University of Derby Policy and Code of Practice on Research Ethics (2011) were adhered to, ensuring secure storage and destruction of recordings, and relating paperwork following completion of my doctoral studies.

3.5.5 Data Analysis

In the first instance a six-step process presented by Smith et al. (2009a) was utilised to analyse the individual transcripts as described below. Following on from this, a framework (Smith et al. 2009b) depicting the stages of analysis across all participants was utilised to guide the process of analysing across each participants' narratives. Below is a description of the how the six stages of IPA analysis were undertaken for each transcript.

Table 3.2 Analytic process (Smith et al. 2009: 79)

Analysis across participants' transcripts
Line-by-line analysis of experiential claims, concerns and understanding of each participant.
Identification of emerging patterns, emphasizing convergence and divergence, commonality and nuance
Dialogue between researchers around coded data, discussion in relation to psychological theories. Development of an interpretative account
Development of a structure that illustrates the relationship between themes.
Organisation of themes enabling analysed data to be traced through all stages of the process.
The use of supervision and collaboration to develop coherence and plausibility of the interpretation.
Development of a narrative supported by a commentary on data that lays out interpretation, theme by theme.
Reflection on one's own perceptions, conceptions, and processes.

3.5.5.1 Reading and re-reading

This entailed being fully immersed in the transcript as advocated by Pietkiewicz & Smith (2014). Listening to the audio recording whilst reading the script and making notes enabled me to connect with participants' accounts of their lived experiences of being in a SR. Hearing and seeing what participants said enabled me to consider the unspoken, and extensive annotations were added each time that the script was read. This process required time and psychological space to read beyond the script and reflect deeply. Each time the transcript was re-read, further observations were made, and more questions generated. The second stage (described below) occurred naturally as I read and re-read transcripts and generated more notes. The process allowed me to become more connected with the data gradually. Transcripts were analysed separately as there may be one of a pattern of case outliers, which may further contribute to the research question.

3.5.5.2 Initial notes

Using a three-column Microsoft Word document, the transcript was copied to the central column (Appendix VIII: Initial noting (Cath)). Each line of each page of the transcript was numbered and the column on the right used to make exploratory comments on the content. Linguistic comments are the second level of exploratory noting and involved exploration of the use of metaphor, emphasis, repetition of words and anything else that stood out. An example of this relates to supervisor Cath (Cath 4:33), who stated that she tells her supervisees that they don't need to know everything. When asked if the same applies to herself, she states, "*I'm alright with that … I'm alright with that; I don't feel at all under pressure to know everything*" (Cath 5:6). A note of the repetition is made on the right-hand column with the comment "*is she trying to convince the researcher?*" Further analysis on a conceptual level leading to the third level of annotation when I added the comment *"Does she feel under pressure to know everything?"* I

tentatively suspected that Cath over-invests in being knowledgeable and tried to convey her knowledge to me. This was strengthened when she stated "*She [her supervisee Kate] thinks I don't know enough about it"* (Cath 15:26).

Smith et al. (2009) draw on Gadamer (1990) to illustrate how the preconceptions we hold can project a meaning (p.26), emphasising the need for reflection upon our own experiences and perceptions of a phenomenon and being aware of how these could influence our interpretation. The process involved reflective engagement, critically questioning the text, and considering the relevance of my views and emotions to how the text was interpreted.

3.5.5.3 Developing emergent themes.

From the exploratory comments, emergent themes were identified and listed in the left-hand column (see transcripts for supervisor Cath (Appendix VIII) and supervisee Mia (Appendix IX). These were more analytical and psychologically informed. Text was highlighted in places to draw my attention to examples.

3.5.5.4 Searching for connections across emergent themes.

It was useful to number the exploratory comments chronologically in a Word document and 'clump' related comments together to form tentative themes. Drawing on the transcript of Mia (transcript 4) to demonstrate the process, all exploratory comments were listed in a numbered Microsoft word document. Exploratory comments at lines 22, 24, 26, 31, 33, 34, 35, 37, 38 and 42 all linked to the theme 'Vulnerability'. An additional theme, 'Self-perception', emerged from lines 33, 67, 74, 75, 78 and 101 (Appendix VII: Participant 4, connecting themes). For each theme identified, related extracts from the text were identified to ensure that themes remained close to the text. Some comments related to more than one theme and were listed as such, on the understanding that themes were likely to connect with other themes to generate superordinate themes.

3.5.5.5 Moving to each of the transcripts.

The same process was followed for each transcript, which were treated as separate to the others. I remained attentive to the ease with which I could be influenced by other transcript themes throughout and was careful to ensure that every transcript was analysed in its own right. Each theme was supported by extracts from the transcript, which ensured that themes emerged from the individual transcript. Such a strategy was conducive to identifying case outliers, which may enhance my understanding of participants experience of being in an IAPT supervisory relationship further.

3.5.5.6 Looking for patterns and themes across cases.

Various methods were tried to select themes across each of the transcripts. Initially, themes from all ten interviews were listed, in an attempt to organise these into superordinate and sub-themes. Eventually all themes were written on pieces of card, which I provisionally organised into piles. The number of themes was reduced through abstraction, a process involving the identification of patterns and developing superordinate themes that incorporate a number of themes. This was a fluid process to which I returned several times until I was satisfied that the superordinate and sub-themes reflected the essence of how supervisors and supervisees described being in a SR. The three superordinate themes and sub-themes emerged when I embarked upon the write-up.

3.6 Researcher reflexivity

In recognition of Heideggerian philosophy on intersubjectivity and our inability to disengage from the world, a reflective journal was used to attend to various concerns and dilemmas that arose during the process of analysis. Rather than denying personal biases or prejudices, Rubin & Rubin (2005) perceive the ability to empathise with participants as a strength that encourages openness. The process of examining and understanding my reactions has been conducive to considering participants' experiences. My goal was to enter the *lifeworld* of each participant (Smith et al. 2009) and developing the interview schedule started this process. The phenomenon of the SR matters to the participants and to me as researcher, and through hermeneutic enquiry, I seek to gain greater understanding and to uncover meaning through interpretation. The Heideggerian notion of the person as embodied acknowledges that I, as researcher, am influenced by my background experiences (Leonard 1994). In order to make sense of how IAPT supervisors and supervisors make sense of being in a supervisory relationship, I have immersed myself in the world of IAPT supervision. However, the need to be objective is vital in qualitative research and I remain alert to the possibility that my experiences and beliefs, as a supervisor and indeed a supervisee, could inadvertently influence the study findings. Reflective writing was used as a means of making sense of my emotional responses and ensuring that analysis would not be contaminated.

My concern at the outset was that, as a dyadic study, participants might be less likely to discuss tensions in the relationship, particularly since I was known to many in a professional capacity. In the context of supervisory relationships that were described positively by each participant, the interview and analytical process facilitated reflection and appeared to have brought tensions and

vulnerabilities within the dyads into their consciousness This is a strength of qualitative research and IPA in particular.

Whilst I have never worked within an IAPT service, my experiences of being in supervisor relationships assisted in the development of questions that were likely to enhance participant reflection and provide greater insights into their lived experiences, however I was aware that my role as course leader of an IAPT clinical supervision training module could lead to an idealised perceptions of CS. The potential for participants to experience strong emotions during interviews was anticipated, indeed Lewis & Graham (2007) in their study of fifty people who had taken part in a social policy study, found that participants were not adverse to discussing their own painful issues if was useful for the study. My response to hearing the accounts of participants experiencing was unexpected. Reflexivity served as a means of processing my emotions and subsequently shifting from feeling critical of what I perceived to be a lack of support in a participant's workplace to exploring the situation through a more objective lens (see Appendix X) for samples from my reflective journal).

The power inherent in my role as researcher was a source of discomfort and led to some reluctance to identify themes, which then became a protracted affair. Reflection on the analysis processes illuminated the use of safety behaviours, mainly procrastination, in an effort to avoid getting the analysis wrong and consequently misrepresenting what participants had said. Recognising my difficulty in tolerating uncertainty and accepting, firstly, that some discomfort was inevitable, and secondly that my professional credentials validated my interpretations to some extent, was helpful. It was also helpful to reflect that I had shared analysis of the pilot interviews and each participant agreed with the themes identified. Having an awareness of how easy it would be to inadvertently ask leading questions to support themes that had emerged from

earlier interviews was a concern. An extensive electronic and hand search of literature did not yield a protocol specific to my situation; however, Smith & Osborn (2015) emphasise the importance of starting each transcript analysis afresh to avoid being overly influenced, a principle which I applied thereon. My reflexivity extended to considering the validity of the study, detailed below.

3.6.1 Ensuring validity

The issue of quality in IPA studies has been questioned, and Smith (2010) in his review of studies using IPA between 1996 and 2008 found that 27% were good and 55% acceptable, whilst 18% were unacceptable. This was assessed on the strength of the following: focus, data, level of discussion and interpretation of themes and analysis of convergence and divergence. Rigour was evaluated on the inclusion of extracts of themes with the recommendation that, in small samples (1-3), each theme is supported by extracts; samples between 4-8 should include extracts from half, whilst larger samples (greater than 8) should include 3-4 participants per theme. Following Hefferon and Gil-Rodriguez (2011), I examined exemplars of high-quality studies (highlighted by Smith 2010) and accessed several papers written by those renowned in IPA research (Eatough & Smith 2006a; Eatough & Smith 2006b; Flowers et al. 1997; Larkin & Griffiths 2004; Dickson et al. 2008). These publications provided insight into the depth of analysis conducive to the reader being able to truly engage with participants' lived world.

The four guiding principles presented in Yardley's (2008) framework for validity were applied while conducting and writing up my research as a means of enhancing the quality of my study. The first, *sensitivity to context,* is apparent in my knowledge of literature and empirical data relating to clinical supervision and indeed IAPT culture. This is helped by my background as a CBT therapist and course leader of an IAPT-commissioned CBT programme, enabling engagement

with study participants and empathic understanding of their lived experience. Whilst I do not work within IAPT, I have regular contact with IAPT clinical leads and managers and have good insight into the demands and challenges experienced by those working within this milieu. Being familiar and comfortable with the interview schedule enabled me to tune into participants' narratives and emerging themes; indeed, Yardley (2015) postulates that qualitative research is about allowing patterns and meanings to emerge. The questions asked were open, to encourage participant discussion of what they felt was important. Participants were viewed as experts, and I have tried to convey this by expressing an interest in their role and the cultural context of their workplace. Finally, in the study analysis, I was mindful that supervisory dyads were aware that their counterpart was also being interviewed and that this could affect what they said (and did not say) during the interview.

The second principle of *commitment and rigour* has been applied through attending to the needs of participants and considering their physical and psychological wellbeing. Participants were recruited purposefully as ideally placed to answer the research question. My commitment to methodological competence is apparent in my robust use of doctoral supervision, in addition to accessing the regional IPA group for additional support and guidance. Data collection and analysis adhered to recommended practice for IPA (Smith 2009). Rigour is apparent in how themes have been selected and each theme is supported by verbatim statements from at least half of the participants. In my write-up, I have strived to demonstrate the application of the third principle, *transparency and coherence,* by clearly describing each stage of the research process, from recruitment to analysis. I have proofread my work several times to ensure it provides a coherent account of the research process that I believe reflects IPA principles, phenomenology and hermeneutics. Interpretation of data

has been carried out tentatively. I chose the subject of IAPT clinical supervision as my area of research as I believe it reflects the final principle, *impact and importance*. There is a well-documented dearth of literature in clinical supervision and particularly the IAPT supervisory relationship (as highlighted earlier in the review of literature; see Chapter 2).

3.7 Ethical considerations

Moral principles and philosophical positions are drawn upon and related to my experiences and practice as the researcher. The theories most commonly discussed in relation to ethics are deontology and consequentialism, each of which threads through my practice as researcher. Deontology draws on the work of Immanuel Kant (1724-1804) and emphasises the morality of an action at a given time, regardless of consequences. The rule of deontology is associated with the principle of universalizability, which posits that fundamental rules and principles must be applied consistently (Hendrick 2004). Within research, there are blanket rules such as the need for confidentiality, but these alone are not sufficient to guarantee ethical practice. Act deontology provides a more flexible framework by formulating rules that consider the situation as a whole (Kingdon et al. 2017), reflected in professional codes of practice. The BABCP Standards of Conduct, Performance and Ethics (2021) have informed my practice as a researcher as much as a therapist and I have strived to act in the best interests of participants, to maintain high standards in my work and personal conduct and behave with honesty and integrity.

Consequentialist theory or utilitarianism emphasises the importance of action having a favourable outcome (Thompson & Russo 2012) 'for the good of the greatest number' (Hendrick 2004 p.9) and stems from the work of John Stuart Mill (1863). This takes the consequence of actions into account and advocates decision-making on the grounds of what is morally right for the greatest number.

By implication, the minority group may be disadvantaged by such an approach (Kingdon et al. 2017) and indeed I would not be comfortable conducting research in the knowledge that it was likely to be distressing for some, regardless of the potential gains for the greater good.

In exploring the concept of ethical research in the context of 'vulnerable' participants, Mkandawire-Valhmu et al. (2009) draw on a definition of vulnerability offered by Flaskerud & Winslow (1998) as 'social groups who have an increased relative risk or susceptibility to adverse health outcomes' (p.69). Whilst this did not seem to reflect my study participants, I remained mindful that vulnerability is not always visible. In interview, I offered the same level of sensitivity and attentiveness to wellbeing as I would to those classed as 'vulnerable'. Furthermore, participants volunteered to be interviewed and were not pressurised during the interviews. They were willing to discuss their experiences of supervision in order to contribute to CS research.

3.7.1 Addressing power differentials in the research relationship.

I have adopted principles consistent with egalitarianism, in line with my practice as a CBT therapist and educator. Egalitarian research addresses power disparities inherent in research by using feminist guidelines that attempt to de-emphasise power and ensure that participants have their say (Mkandawire-Valhmu et al. 2009). Thus, participants' opinions were respected and valued as contributing to the study, even if they challenged my own. Consistent with IPA principles, I sought to capture the voice of the researched by allowing participants to lead the interviews, and by being flexible with the sequence and wording of questions. Transcripts were shared with each participant, who was given the opportunity to remove text, as advocated by Grbich (2013). The expertise of participants and my comparable lack of experience of working in an IAPT service was acknowledged.

Emphasis was on developing a rapport and making participants comfortable. The importance of developing trust and rapport in interview is emphasised by Smith et al. (2009b), as it gives rise to 'richer and more detailed sections, or indeed contradictions and paradox' (p.82). Similarly, Braun & Clarke (2013) recognise the ability to establish rapport and trust as core skills of a good qualitative researcher; however, the misuse of rapport (perhaps inadvertently) to create bias (Harding 2013) was also considered. Feminist research suggests that a non-hierarchical relationship can be promoted through an interviewer disclosing personal information (Miller 1998), but it is argued that participants could disclose too much and regret it later (Harding 2013; Clarke 2006). Although I knew some of the participants, our relationship wasn't personal, and I took the same professional approach that I would in other work.

3.8 Ethical principles

Ethical practice is intrinsic to my status as a Registered Mental Health Nurse (RMN) and CBT therapist. Throughout the research process, the Code (NMC 2015) and BABCP Standards of Conduct, Performance and Ethics in the practice of behavioural and cognitive psychotherapies (2009) have been adhered to. Ethical research is based on the principles of respect for autonomy, justice, fidelity, beneficence, and non-maleficence (Hendrick 2004), which have underpinned each stage of the study and served as a guide to ethical decision-making. Examples of areas considered are provided below.

3.8.1 Avoidance of harm

A key issue in practicing ethically is avoiding harm to participants (Thompson & Chambers 2012; Flick 2009; Hendrick 2004). Research Ethics Committees (REC) and National Research Ethics Services (NRES) have been set up to protect the rights and safety of research participants (Health Research Authority 2013) and the study did not commence until permission was granted by the University of Derby REC. Ethical approval was obtained from Research and Development departments of the relevant NHS Trusts and independent organisations.

Within the interviews, as advocated by Punch (2005), participants' motives for taking part in the study were checked. Almark et al. (2009) highlight the difficulties of dyadic studies when confidentiality can be threatened if one individual reveal more than the other is comfortable to disclose, potentiating the risk of harm. As advocated by Davison (2011), I was mindful of an acceptable balance between potential harm and tangible gains for those participating in the study and remained alert to their wellbeing, as advised by Smith et al. (2009). Although the PIS included details of how participants could access support post-interview, I was mindful of the need to check individuals' psychological wellbeing during the interview if sensitive information had been discussed. Indeed, participants' wellbeing was deliberately checked as part of the debrief following the interviews. Data from the study were not used in any way likely to cause damage or distress, and care will be taken to ensure that participants are not identifiable in any publication relating to the study.

3.8.2 Informed Consent

I ensured that that information provided was clearly written and understandable, enabling each person to make an informed decision on whether they wished to participate (Kingdon et al. 2017). Details of the IPA Institute Birkbeck University, was provided to participants. Time was set aside before interviews to give an overview of the study, the interview process and to answer any questions. Furthermore, participants received a copy of the fully transcribed interview and were invited to read this and indicate if there were any areas they wished to have removed prior to data analysis. Participants were aware that they could withdraw from the study up to the point of data analysis.

3.8.3 Confidentiality

Participants were sought from a wide geographical area spanning several counties so as to ensure institutional confidentiality. In the formal write-up of the study, quotes and discussion of interview content is presented in such a way that the individuals are not identifiable. In considering confidentiality in research, Parker (2005) argues that there can be no such thing, as the aim of research is to make discoveries and share these with others; therefore, a quest for *'anonymity'* is more accurate (p.17). Throughout the process of recruitment, interviewing and analysis, issues of confidentiality were carefully considered, and attempts made to maintain this through the use of coding, anonymising personal details and securing sensitive material. The interviewing of dyads presented an added dimension to confidentiality; participants were informed that I would do my utmost to ensure that quotes or information provided did not make them identifiable as individuals. Participants were made aware of the process for secure storage of consent forms and recordings, and allocation of pseudonyms to prevent individuals from being identifiable. For this, the Data Protection Act (1988) was considered. Any data relating to the study was stored on university

devices, which offers enhanced security, and emails to participants were sent via university email accounts.

3.8.4 Participant wellbeing

As discussed in section 3.6, reflexivity played a critical role in understanding participants' experiences and responding empathically. Care was taken to prevent people from feeling coerced into participation. Letters were sent inviting people who met the criteria for inclusion to contact the researcher and information about the study was included. In planning the interviews, additional time was allocated, in the event that the participant wished to discuss issues. A debriefing exercise immediately following the interview gave study participants the opportunity to provide feedback on the interview process and ask questions. They were reminded that they had access to an independent therapist should they require additional support and that contact details were provided in the PIS. Some of the information disclosed within the interviews was highly sensitive and some participants were upset when they shared it. In these situations, it felt important to allow the participant to lead and to tell their story at their own pace, rather than feeling coerced into sharing sensitive information.

My concerns for the wellbeing of a participant following the interview are noted in Appendix X. Reflection was an integral part of ensuring that I responded appropriately. Indeed, a study by Lajoie, Fortin & Rachine (2022) points to study participants perceiving the role of interviewee positively. They reported that taking part made them feel respected, valued and listened to.

3.8.5 The potential impact of dual roles

Whilst dual relationships are acceptable in qualitative research, Braun & Clarke (2013) caution that the pre-existing relationship is not used to pressure people into participating or to disclose information they are uncomfortable with. Consideration was given to potential participant discomfort in relation to my multiple roles and the fact that some participants were known to me in a professional capacity. As discussed in section 3.6, reflexivity played a key part in preparing me for the role of researcher. Whilst distinct from my professional roles, how I was perceived by participants was likely to impact how they responded within the interview. A systematic review of clinical-researcher dual-role experiences by Hay-Smith et al. (2016) highlights the potential for ethical dilemmas, as clinicians may experience tension within their research role relating to practice issues. Of relevance is a study by Chew-Graham et al. (2002) involving General Practitioners (GP) who were interviewed by either a GP researcher or a non-clinical researcher. When participants were interviewed by non-clinicians, they had a narrow and less emotionally charged discussion. In contrast, when the interviewer was viewed as clinical, participants were open to providing insight into attitudes and activities; furthermore, as a confidante, the interviewer was privy to a more in-depth and personal account.

3.8.6 The Ethics of Interpretation

The power inherent in my role as interpreter was given much consideration. Having responsibility for analysing data and organising my interpretations of data into themes has been challenging, due to concerns about misrepresenting participants. The ethical complexities of interpretation are acknowledged by Willig (2013; 2017), who emphasises that, in phenomenological research, interpretation is driven by the information provided by the participants and not the researcher's theoretical framework. Ricoeur (1996) recommends a

combination of suspicious hermeneutic and emphatic hermeneutic to gain insight; indeed, Willig (2012) suggests that in the search for understanding, *'empathy'* and *'suspicion'* propel the hermeneutic cycle required for interpretation. This inevitably occurred at various stages: during the interviews, whilst listening to the interview recordings or recalling what participants had said, at other times, and during the formal process of data analysis.

The literature presents differing views on participant validation. Whilst Willig (2013) recognises that suspicious interpretations of data may not be shared by participants, participant endorsement is advocated if the aim of the research is to explore what a phenomenon has meant for the individual. In contrast, Braun & Clarke (2013) argue that checking the validity of interpretations is fraught with practical issues, such as split views from participants, a reluctance of participants to engage in the process, and time constraints. It has been useful to consider this from an ontological and epistemological perspective consistent with IPA. Larkin et al. (2006) highlight that for researchers,

> *access to the experience is partial and the analytic process will never provide a genuinely first-person account, the account is always constructed by participant and researcher.* (p.104)

From an ontological perspective, IPA recognises that scientific observation is fallible, and reality is contingent on human perspective. Applied to my study, I concluded that participant validation of themes could potentially result in ethical dilemmas and complexity, with little added value. It seemed likely that participants' perspectives on my interpretation would vary, which would pose the question *whose view do I go along with?* For this reason, I made the decision to send a copy of the transcribed interview to each participant to check. They were informed prior to interview that IPA involves interpretation of data, which would be informed by my interpretation of what they had said during interview. They were made aware of the experiential emphasis of IPA with my commitment to

stay as close to the data as possible. For this, verbatim extracts would be included in the write-up to support themes.

3.9 Chapter Summary

This chapter provides a detailed account of the research methodology used to address the research question. The methodological underpinnings of the study are presented and justification for conducting critical realist research is provided. The philosophical and theoretical influences of IPA are elaborated upon, namely Schleiermacher's interpretation; Husserl's phenomenology, and Heidegger's 'Daesin' or state of 'being-in-the-world'. A critique of IPA as the methodology and a rationale for its use is presented. Alternative phenomenological methodologies are presented, and I provide a rationale for choosing IPA.

Following on from this, a discussion of the methods used to recruit participants, collect data and analyse transcripts is provided. The process of developing emergent themes, is presented. Inherent within this, is consideration of ethical principles, researcher reflexivity and ensuring validity. The following chapter will present the findings from this IPA study.

CHAPTER 4. FINDINGS

4.1 Introduction

Within this chapter, the results of an IPA study which centred on the experiences of 10 CBT therapists in a supervisory relationship, are explored. Consistent with IPA (Larkin et al. 2006), a psychologically informed narrative account of IAPT supervisors' and supervisees' experiences is presented, which provides a rich and detailed description of CBT therapists' professional world and an insight into their experiences of the supervisory relationship. The resultant emotions and the ways in which therapists make sense of their experiences of the SR are explored. Verbatim extracts from each participant are presented throughout the chapter.

Table 4.1 Superordinate, subordinate themes and participants

Superordinate Theme*	Subordinate Theme	Supervisees					Supervisors				
		Joe	Mia	Dan	Liz	Kate	Lily	Micha	Emily	Jenny	Cath
Being in the SR	The back story	√	√	√	√	√	√	√	√	√	√
	Comfort vs. constraint	√	√	√	√	√	√	√	√	√	√
Playing the part	Role vulnerability	√	√	√	√	√	√	√	√		√
	Proving oneself	√	√			√	√			√	√
Dancing around interpersonally	The spoken and unspoken.	√	√	√	√	√	√	√	√	√	√

*Colour coding representing superordinate (green) and subordinate (blue) themes is continued throughout Chapter 4 and 5

4.2 Introduction to themes

Themes represent the most powerful, recurrent, and interrelated ideas raised across the ten participants. 'Powerful' themes are those believed to embody the 'life-world' of being in a SR and provide insight into cultural, historical factors and social norms. Eatough & Smith (2006) emphasise the importance of exploring not only the narrative but also the goals of the individual and what they wish to achieve through their narrative; for instance, how they may wish to present themselves to the researcher. Initial analysis of individual transcripts was achieved by reading and re-reading the material several times and highlighting narratives that were of interest. This led to identification of initial themes through aligning concepts or ideas that had similarities. A process of reduction through clustering these initial themes together in order to generate higher order themes, followed. Through this process of analysing transcripts one by one, fidelity to the IPA principle of idiography was maintained. Themes consistent across the transcripts were classed as recurrent if found in over half of the interviews. Whilst superordinate themes are related, each is distinct and represents separate clusters of meaning conveyed by participants across the study. Initial themes were aligned to a connecting theme and there were no outlying themes.

The use of a closely defined group, as is typical of IPA (Smith & Eatough 2012), provides an information-rich sample, and in-depth interviews with 10 participants generated rich data. Saturation in qualitative research refers to the point at which a complete and truthful picture of the object of study is reached (Braun & Clarke 2013 p.56). Sampling in IPA differs from other methodologies such as grounded theory and tends to be purposeful and broadly homogenous. Rather than aiming for saturation, researchers select participants based on their ability to contribute to answering the research question, thus enabling a robust interpretation of the data (Brocki & Wearden 2006). The interviews have

provided a detailed understanding of the phenomenological experience of being in a SR. Furthermore, themes were recurring, indicating that saturation had been reached. Superordinate and subordinate themes presented in this chapter capture the essence of the participants' narratives. Table 4.2 (below) presents the first superordinate theme, *Being in the SR.*

4.3 'Being' in the Supervisory Relationship

Superordinate Theme 1 Being in the supervisory relationship
Subordinate themes - The back story - Comfort versus constraint

Table 4.2 Superordinate theme 1 & subordinate theme 1

This superordinate theme represents the highest order superordinate theme, which reflects the situated-ness of supervisors and supervisees in a supervisory relationship, encompassing behaviours, cultures, and relatedness to others (Plager 1994). Two subordinate themes, "The back story" and "Comfort versus Constraint" capture the essence of participants' narrative which contextualise their current experiences of IAPT CS. In doing so, participants refer to previous experiences which they connect with the present. These are discussed in turn.

4.3.1 Subordinate Theme 1: The Back Stories

The subordinate theme of *'back story'* represents how participants draw on past experiences as an associated layer of consciousness to contextualise their current experiences of IAPT clinical supervision and the supervisory relationship. In doing so, a window into their cultures within IAPT supervision, relatedness to others and their emotional experiences, is opened. Participants' back stories contextualise their transition to the IAPT SR in which they are positioned. Thus the theme embodies their previous emotional experiences of clinical supervision, and expounds their perspective of the SR. The subordinate theme will be discussed in relation to, firstly, each supervisee, followed by the supervisors, in order to provide context pertinent to the present.

4.3.1.1 Supervisee Mia's Back Story

Mia recently completed CBT training, prior to which she was a PWP. She works within the IAPT service in which she trained. Asked her perspective of being in a supervisory relationship, she replies;

> I find it really useful. I guess I've had experiences in the past that I haven't found useful, and it hasn't felt comfortable but with Michael, I do. (Mia, 1:13)

From the outset, she conveys her satisfaction with her current supervision, but makes it known that this has not always been the case:

> I think that's the most important thing to me, that I feel comfortable to talk to him [her current supervisor] whereas other supervisors in the past I haven't, and that has really affected how I used the supervision, and maybe not brought everything that I should have brought because I didn't feel comfortable with them, or I worried about being judged. (Mia, 1.16)

Mia's use of the phrase "*I think*" hints at her doubting her own opinion, though she emphasises the importance of feeling comfortable to open up to her supervisor as she does with her current supervisor. Her sensitivity to being judged is apparent and provides context for why she has not been open previously. Her account of using avoidant behaviour for fear of negative judgement, suggests

vulnerability. She reflects that she was unable to open up with a previous supervisor, which she acknowledges impacted her development.

> I think I probably avoided for a while … showing tapes 'til I kind of got to know the supervisor. And the same with the group supervision that we had at uni. That probably took me a while to bring a tape, whereas other people were maybe, straight in there. So, yeah confidence-wise, I think it just puts you back down a bit. (Mia, 6.11)

A repeat of this hesitancy "*I think*" is apparent when Mia recounts her discomfort in previous supervision. Mia describes having difficulty as a trainee in exposing her practice within supervision which further eroded her confidence. She refers to "*the supervisor"* and "*the other people"* (i.e., her fellow supervisees) in a detached way devoid of any reference to being part of a group herself, thus emphasising the *aloneness* of her situation. She compares herself negatively to "*the other people"* who are able to show recordings in their therapy sessions. Below, Mia conveys unease within the CBT culture of recording sessions and having her practice scrutinised in clinical supervision.

> I didn't feel comfortable, and I felt like the way the feedback was given was quite critical I guess, and not very helpful, but I hadn't said anything to them. I find that really difficult to … confront. I find that difficult anyway but bringing it up in that relationship where you feel, I guess almost inferior to that person and they're intimidating … and I think it is really difficult. (Mia, 8.12)

The statement above suggests that in her discomfort, Mia had taken rather a passive stance. Whilst she describes her experience, it seems that she is holding back on detail; for instance, the feedback is described in broad terms as "*quite"* critical and "*not very helpful",* suggesting some ambivalence. Similarly, she conveys a sense of inferiority without fully owning it ("*almost inferior").* Grammatically, she changes from first to second person ("*you feel, I guess, almost inferior to that person"*), as if to distance herself from an emotional experience. Her use of present tense however, suggests the ongoing presence of a sense of inferiority within a power relationship. We know from an earlier statement that

she is uncomfortable with being judged and, coupled with a propensity to feel inferior, this provides insight into why she didn't address difficulties in her previous supervision.

4.3.1.2 Supervisee Kate's back story

Kate completed her CBT training a year ago. When asked about the transition to the role of qualified CBT therapist, she described this as "peaceful" (Kate, 13.1).

> It felt like quite a nice transition because as you get further through the course, your confidence is developing. So even though you might be working with the same complexity, you're seeing more of what you can do for them (Kate, 2.12)

Kate's back story is marked by negative supervisory experiences during her CBT training.

> I was brand new here, [had a] brand new supervisor on the course and I didn't feel like I could go to anyone and go "*this isn't working*." I just assumed it was, ... I was being a bit crap. (Kate,7.10)

> I was going to go back to the wards as a nursing assistant. It was awful. I think at the time I wasn't seeing the supervision as awful, I just thought I was really terrible. (Kate, 30.4)

Kate conveys her aloneness and 'stuckness', recognising "*this isn't working"* but feeling powerless to do anything about it. In an unfamiliar new world, she assumes the fault lies with her. Her reflections of the time ("*I just thought I was really terrible"*; "*I was being a bit crap"*; "*it must just be me not being kind of good enough"*) provide insight into her lack of confidence at that time and illustrate the potentially destructive impact of a problematic supervisory relationship. The nonchalance of the phrase "*I just thought*" contrasts with "*I was really terrible"* and suggests detachment from the awfulness of that time. Although she was that person, she no longer identifies with herself as she was. This is in contrast to Mia does not communicate a sense of distance or indeed closure from such emotions.

Kate compares her experiences of clinical supervision with her previous supervisor and Cath.

> I think my first supervisor when I came here as a trainee, wasn't a good match and Cath has actually supervised me since I was a trainee PWP, so I feel we have a very good relationship and that's really important to me; that someone kind of gets me and understands what I'm like and how I work…. Kind of knows my limitations and strengths….and uses those to help supervise me really. (Kate, 4.4)

In the extract above, Kate expands on features of a good SR, and it seems that her experience of having been in a poor SR has empowered her to know what she wants within the relationship. She uses strong terminology; Cath "gets" her and "knows" her limitations and strengths, which she uses to evidence a sound and fulfilling relationship.

4.3.1.3 Supervisee Joe's back story

Joe completed his CBT training two years prior and describes a positive relationship with his current supervisor. He draws on previous experiences of supervision and what he perceived to be "*ongoing scrutiny"* of his work due to a lack of trust (Joe 15.7). This, he states, conflicts with his personality and how he likes to work. It seems that Joe isn't suited to the expected boundaries of clinical supervision in which clients are discussed collaboratively and clinical practice, particularly for developing therapists is closely monitored. His desire for autonomy created tension in a previous supervision.

> I do tend to be quite an autonomous person and I like to do my own study and my own thing and ask for help when I feel that I need it, and I think early on Lily [his supervisor] did challenge me on that, so it's not as if we're kind of mates or anything, it's just a more pleasant experience, I think. It's (kind of) more the boundaries and when someone needs to be challenged. They can be trusted. (Joe, 5.3)

Joe suggests that, within the supervisory relationship, he is given the independence that he desires, reflecting that he has "a *lot more autonomy"* since he completed training (Joe, 1:27) and that his supervisor watches recordings of his sessions "*every now and again"* (Joe, 2:20) which is inconsistent with his stage of development. This contrasts with his previous negative experiences:

> ...in the past, erm, again, just in the way that things are (kind of) handled when you present a case that maybe you're struggling with, or it's identified that you haven't done something in accordance with the treatment model or something like that. I don't think that it's anything that's been mentioned but sometimes you get the impression that you're kind of not doing your best or you are (kind of) failing someone and I think there sometimes can be a (kind of) element of (kind of) shame that comes along with that. (Joe, 15:25)

Here Joe draws on non-specific situations that have occurred in CS, when he feels *a "kind of"* shame. His use of "kind of" suggests some discomfort at disclosing this. The extract illustrates the lifeworld of a "struggling" supervisee (15:27) experiencing a sense of having done something wrong and feeling shame.

4.3.1.4 Supervisee Dan's back story

Supervisee Dan, a CBT therapist who qualified a year previously, works within the same organisation as he trained. He tends not to expand on his answers to questions and answers tentatively ("*I think I found it more interesting*" (Dan, 2:13), *"I think so"* (Dan, 2:20). This changes when he is asked whether CS provides the context to discuss his patients: he describes feeling supported in the SR and has the opportunity to discuss patients "*without a doubt, and the learning is also…is good"* Dan, 2:26). Asked about the ingredients for a good SR, he replies,

> Having the knowledge, I guess that's important. Erm, being personable, like being able to get on, be able to speak to them if there are any issues. Not being concerned to tell them about any problems you might be having or feel embarrassed to tell them about any problems. So, they need to feel comfortable talking about (I don't know), confidential things, whether that's personal or with clients. (Dan, 6:27)

Whilst he acknowledges the role of knowledge, here is an emphasis on feeling comfortable within the relationship. Dan also prioritises confidentiality and the ability to discuss personal matters.

Transition from the role of PWP to CBT therapist was smooth and Dan was able to choose his supervisor Emily. On being asked why, he states:

> Experience really, she's got quite a lot of knowledge of different areas, so rather than just being CBT, she's kind of drawing on other areas that I'm.. with me just being pure CBT, she would be able to help with that learning and that kind of stuff. But also, she's.. like.. easy to talk and get on with, and quite a warm person and understanding (Dan, 10.5)

Dan's response indicates that his desired ingredients are present in a SR that has facilitated his professional growth.

4.3.1.5 Supervisee Liz's back story

Supervisee Liz completed her CBT training a year ago and described the transition from trainee to CBT therapist as a "baptism of fire" (Liz, 1:23). In relation to her transition to qualified, she reflects:

> I always felt incredibly supported with supervision. I think as a trainee, there's more dependence, from my perspective, on the supervisor. Like I would go to them with a lot of …well not a lot of things, but I'd be more likely to go to the supervisor, erm, and I guess once you qualify, that kind of dissipates a bit, and I guess for me, I was a bit more savvy about what really warranted a supervisor and what I should deal with myself, or be able to deal with myself (Liz, 2:10).

Liz conveys an exponential growth of confidence and ability to make clinical decisions. This she defined as "less of a kneejerk kind of mentality" (Liz, 3:21). She describes a readiness to embrace the transition and recognised the challenge of

> going from text book training…and having a very clear IAPT model in my head of the stepped care model.. [then recognising] people are people and they're not necessarily going to fit into the GAD model. (Liz, 4:22)

She communicates an acceptance of the uncertainty of being qualified, which was helped by..

> a very positive supervisory relationship, I feel for want of a better expression 'she's got my back'. (Liz, 5:26)

In contemplating the ingredients of a good SR, Liz reflects as follows:

> I think it's about rapport, I think it's about respect, I think it's about… It's that transparency. (Liz, 6:13)

Liz conveys her recognition of the importance of being open in the SR and that she was more guarded in previous supervision. She reflects on her journey:

> that's come with experience, and I think that's come with working through and processing things myself, that to really benefit from supervision, I have to be transparent, I have to be honest, and she is with me. (Liz, 6:22)

Liz describes how she felt when her previous supervisor left his position suddenly.

> I took that quite personally and I felt like I'd been left high and dry and, "*Oh my God, what am I going to do*?" Interestingly, had that have been now, I would've felt very differently about it. But I don't know whether at that point, I kind of, had him on some kind of pedestal, some kind of guru status, you know. And now I was like left high and dry and what was I going to do?, and you know, if it happened now, it wouldn't have that impact, which is quite interesting. (Liz, 7:14).

It seems that Liz's previous experiences of perceiving her supervisor as having 'guru status' and later being let down by him, has led to her having a more balanced view of her supervisor and in turn, there is a less defined power dynamic within the SR. For Liz, supervisors no longer have 'guru status'. "It's more equal" (Liz, 8:16). Should her supervisor withdraw again, she wouldn't take it personally, demonstrating her development as a supervisee who is less dependent on her supervisor.

4.3.1.6 Supervisor Michael's back story

From a supervisor perspective, Michael discloses that, soon after completing CBT training, he was asked to complete supervisor training, as there were insufficient CBT supervisors within the service.

> I remember when I first started doing therapy, and I thought "no one's going to trust me, I look like a kid" and now I'm doing supervision and I had that same whole experience initially, you know … so if you're challenging someone and saying … "Are you giving me the full picture?" or, "Can we just kind of look at this and see what's going on?" (Michael, 35.30)

Michael recalls having concerns that his persona wasn't consistent with that of a clinical supervisor and doubted his credibility in challenging supervisees' clinical

practice. There appear to be two areas he is conscious of in relation to his therapist/supervisor roles: his youthful appearance and his demeanour. Michael reflects on similar insecurities when he first began supervising Mia:

> I felt a little bit intimidated when I first started supervising Mia, and there was nothing that Mia had done or said, but her previous supervisor, erm, was a good friend of mine at the time and I knew that, that person was very, very CBT [in approach]. Now I come from a counselling psychology background, and CBT I think is fantastic … [but] I'm a lot less structured in my sessions than this person was, and I'm a lot less … I would say educated than this person, and I think this person could go, "*ah yeah, you're talking about this guy*" and he would be like "*that's Wells 2012* [author], *go and read this article."* (Michael, 15.13)

His concerns relating to his ability to be a credible supervisor mirror the anxieties he experienced when he began his therapist role, suggesting a lack of confidence and a belief that he is doing *less* than others ("*I'm a lot less structured"; "I'm a lot less educated"*). He states, "I feel comfortable enough to say if I don't know" (Michael, 6:5), but later concedes:

> The closest that someone's experience is to mine, the more I start to feel uncomfortable (Michael, 7:2)… I think my confidence there struggles a little bit because our experiences aren't that different. (Michael, 7:5)

Whilst he refers to *previous* anxieties in his role of supervisor, there is evidence of current anxieties. In uncertain situations within supervision (when he doesn't know the answer), "*I'd maybe start to kick myself a bit more*" (Michael, 7:17). His propensity to compare himself negatively to others (15:13), suggests that intrusive thoughts that he isn't good enough in the role, are at play. Although he denies feeling the need to be an expert (Michael, 12:7), he hasn't showed his supervisee a recording of his clinical practice as he felt it wasn't good enough.

4.3.1.7 Supervisor Cath's back story

Cath is an experienced CBT supervisor who has supervised Kate for approximately 18 months. Early in the interview it became apparent that, in relation to 'knowing'

within supervision, she has mixed feelings. Whilst she values being very knowledgeable in her role as supervisor, she realises that it isn't necessary.

> I'm not there to know the answers all of the time. (1.17) I think sometimes I put pressure on myself, I think there is an expectation that I need to know and keep on top of current research and things like that. (Cath, 1.25)

When asked what it would mean to her to not know everything, she replies:

> I've never had a problem with people because a lot of the students … a lot of the supervisees that I've had over the last 5 to 6 years have gone on to the doctorate, the clinical doctorate. So, a lot of the supervisees I've had have been brilliant in terms of their tenacity, their ability to kind of work their way around things, the way they connect things, their intelligence levels. They've always been really, really good in that respect, so it has never really worried me that at some point they are going to know more than me … that's fine but I think there is an expectation from myself to myself that I have to keep on top of things, otherwise I don't feel like the supervision would be worthwhile. (Cath, 2.17)

Here, Cath seems to convey that she is comfortable with her supervisees' being knowledgeable and possibly knowing more than her at some point. She draws on her experience of previous supervisees who eventually studied for a Clinical Psychology Doctorate. Reflecting on culture within IAPT services, there is an implicit hierarchy of professional backgrounds, for those completing IAPT CBT training, and indeed PWP's as the largest proportion of CBT trainees, are deemed to not have a core profession (despite often having completed PWP training) and must demonstrating equivalence through prior Knowledge, Skills and Attitude (KSA) in order to access training. Furthermore, Clinical Psychologists (regardless of experience) receive higher pay than other mental health professionals.

It is conceivable that Cath draws on her experience of supervising those whom she implicitly views as more learned, as evidence that she is comfortable with not knowing everything and potentially not knowing as much as her supervisee. She does, however, expect to "keep on top of things", or supervision wouldn't be "worthwhile". This, coupled with an earlier comment that she puts

pressure on herself to know, alerts us to the possibility that knowledge holds significant meaning for her.

4.3.1.8. Supervisor Emily's back story

Emily has been a supervisor within IAPT for 5 years and has been supervising Dan since he completed his CBT training a year prior. She describes her journey to her role as supervisor below:

> I did the [IAPT supervision] course when I started doing supervision as a CBT therapist, it was really because of the demands of IAPT, so very quickly, after qualifying as therapists, we went into supervision, there was a bit of learning curve for me, but that was about five years ago, so I've kind of grown into that, and I really enjoy supervision, I enjoy the guiding, I enjoy the developing of people, I enjoy, I suppose helping people to sit back and reflect and trying to help them with a different perspective and also looking at their CBT skills and helping them to develop those. So I like the role. It's different from therapy but similar. It's a bit of a different stance so it gives you a break from therapy as well, and it's still about development, just in a different way. (Emily, 1:12)

Emily's passion for the role of supervisor is evident in her use of the word 'enjoy' multiple times in quick succession. She isn't alone in stating that she enjoys the role, but she is very specific about what she likes i.e., 'guiding 'and 'developing'. In contrast to other participants who recalled having concerns about their readiness to be in a supervisor role, Emily is confident in her ability, and recognises her contribution to supervisees' development. For her, being a supervisor is a "break from therapy" which is not surprising given that IAPT therapists see up to five patients a day. In contrast to other participants, she does not have concerns about not being good enough or not knowing enough.

In contrast to her positive experiences as a supervisor, Emily describes what she perceived to be a negative experience of CS as a trainee therapist. She recognises this as pivotal in her development as a supervisor in that it taught her not to discourage people. She received what she believed was an exaggerated response from her supervisor suggesting that she had done something wrong.

> She went 'ooh!' She reacted like that! So I immediately (because I was new), I thought 'oh my God, what have I done?' And what was interesting is, then for the next week when I was working with clients, I felt shaky, I really internally felt shaky, very shaky. (Emily, 5:17).

Here, Emily draws on what she perceived to be critical feedback in supervision and the deleterious effect it had on her. She uses her experience this to be mindful of the vulnerability of supervisees, who may experience a similar emotional response. Her experience enables her to take an empathic stance that informs her practice as a supervisor.

4.3.1.9 Supervisor Jenny's back story

Jenny is an experienced CBT therapist and supervisor and has supervised Liz during and since she completed her IAPT CBT training. Jenny completed a 3-day supervision training course, which preceded IAPT supervisor training. She also receives supervision of her supervision. Jenny describes how her practice as a supervisor has been influenced by her experiences of good and bad supervision. She states that she does not ever feeling uncomfortable about supervision:

> I guess if you follow the framework of CBT, the agenda setting and the…you know, the interpersonal effectiveness stuff then actually it's not that different (Jenny, 1:4)

She describes drawing on the wisdom of previous supervisors:

> It's quite scary actually because when I'm acting as a supervisor I can literally hear things that my supervisor said to me, and it's almost like having a mini (previous supervisor's name), I suppose in the room….him saying to you, "*Explicit empathy!*". So yeah, I do very much follow the framework that I was supervised with. (Jenny, 2:23)

She perceives her relationship with Liz as "warm and mutually respectful" (3:21) and has been told by her supervisee that she feels that "I have got her back" (3:27). When asked for clarification of the meaning of the phrase, Jenny replies "I'm here for her" (3:28). Jenny draws on her negative experience of clinical

supervision as a trainee and the deleterious impact on her experience of the SR and indeed her development.

> I sort of had it on a plate on how to not be in supervision, and yet compared to my work place supervisor it was just complete polar opposites. It was quite interesting. So I knew exactly what to avoid and I knew what wasn't helpful for me and you just kind of think, well it wasn't helpful for me, so is it going to be helpful for anyone else? (Jenny, 3:5)

Jenny also demonstrates how she has used her negative experiences of CS as a supervisee to develop her practice as a supervisor. It seems that her own experiences (as a supervisee) have amplified her ability to reflect and ensure the supervision experience is positive and meaningful.

4.3.1.10 Supervisor Lily's back story

Lily has a senior role within the service, in which she supervises Joe. She completed her CBT training in the first wave of IAPT and soon after completed IAPT clinical supervision training. She progressed to a management role within the same organisation. Lily has supervised Joe for much of his training. She describes her style of supervision:

> I always start the supervision by seeing how they are… so it's always you know… how are you? How's things? How's work? Very informal type of…erm just checking in on them.. Checking in because you know it's so busy, it's so…it can be stressful working where we work, fast paced…you know they have management supervision with the managers as well and there's lots of demands on them, so I always check in how they're doing, and then we set our agenda. (Lily, 1:24)

Lily demonstrates an appreciation of the demands that her supervisees face. There is empathy for the "*lots of demands on them*"(Lily, 2:2) and checking their wellbeing is prioritised. Asked about her perspective on the SR, Lily states:

> I do think it's really important, and as a supervisor it's easy to…it's easier to deliver supervision to someone you can work interpersonally with. Erm, because you know I've delivered supervision to people where it's really…that interpersonal process isn't there…the relationship isn't there, and it can be a hard slog. (Lily, 3:22)

Her reference to supervision being *delivered* by her emphasises the power dynamic. This is in conflict with her statement above in which she recognises the importance on interpersonal processes. This contrasts with Jenny's description of the SR as "warm and mutually respectful" (3:21). Lily compares caseload supervision and clinical supervision below:

> as a supervisor because IAPT is so driven in principle by the idea of…of erm performance…"*get them [clients] in, get them out*", and they [supervisees] have supervision or they have caseload management from there managers so I… everybody who works in the service, all the therapists they all have caseload management, they go see there manager and they are…they present the cases and they [the managers] say "*right get them in* [clients]*, and get them out*", you know, "*let's talk about recovery scores*". I then give….we have clinical supervision. They present the same case, and the focus is very different. You know we look at engagement skills, we look at therapeutic processes, we look at what's going on in the therapy room, erm but they can't sometimes…they are very focused on, erm on recovery…erm you know it can be really stressful, so sometimes when they're stressed by (you know), these demands that they have in the service, so they're not willing to give as much in the supervision room. It can feel that the information that they give is restrictive; you know they're a bit pissed off with the managers, and they can be a bit narked because of that, by association with me, because I'm senior management as well. (Lily, 3:28)

Lily provides insight into her lifeworld as a supervisor with a management role within the service with the expectation that recovery targets are met. Supervisees' performance as therapist is measured on their recovery rates, and there is ongoing pressure to move patients to recovery; "*get them in and get them out*". This plays out in CS with therapists focusing more on recovery rates than development. She also reflects that "*the information that they give is restrictive*". It is not unlikely that supervisees may focus on recovery to avoid discussing the intricacies of their clinical practice with management.

Whilst she earlier expressed empathy for her supervisees, her frustration that her supervisees can be reluctant to share information seeps out. There is a suggestion of discomfort with her role, evidenced by her correction of "*I then*

give" to "*we have clinical supervision".* Lily reflects on how she manages the tensions below:

> So I suppose I try and improve the relationship by being honest and open, by making sure that they're aware it's a totally confidential environment…that (you know) "*I'm not going to go tell-tailing to the manager or to this that and the other*, *unless there is very specific concerns in which is already set out in the contract to start off"*. Erm but really just (you know), really listen to their anxieties, their concerns that they possibly have about suitability in the cases, and just slowing it down. (Lily, 4:27)

In doing so, she conveys her frustration at the blurring of roles between clinical supervision and case management supervision and her sense that supervisees are being restrictive as a consequence. Lily vacillates between conveying empathy "*really just [you know]), really listen to their anxieties*" to expressing annoyance that information given is restrictive. On one level she has taken her dual role into account as she reflects on the supervision process; However it seems that she hasn't really considered that trust issues may be restricting supervision.

4.3.1.11 Summary of supervisees' back stories

Supervisees drew on previous experiences of supervision to compare with their current practice. Each participant offered a 'story' of their journey to the present, and their position within a SR in which they felt comfortable and supported. That journey for some involved navigating difficult (previous) supervisory relationships. Those who described positive past and present experiences of CS regarded supervisor feedback as part of the experience. For instance, Dan recognises the importance of having a warm and understanding supervisor with whom he can share difficulties; Liz strives to grow in knowledge in the context of a SR within which she knows the supervisor has 'got [her] back'.

Whilst all supervisees evaluated their current SR positively, 3 of the 5 drew upon negative experiences with previous supervisors. These related to feeling judged, receiving overly critical feedback, or having their work scrutinised. In the

context of their current (positively evaluated) supervision, some spoke nonchalantly of withholding information or dismissing supervisors' advice. Supervisees' back stories highlighted their level of sensitivity to verbal and non-verbal communication (as recounted by Emily). There was evidence of vulnerability in their account of difficulties in past supervision. Participants appeared to be mindful of the role of the SR in maintaining their wellbeing.

4.3.1.12 Summary of supervisors' back stories

Supervisors reflected on their journeys, which contextualised their current experiences of being in the supervisory relationship. Past experiences of dysfunctional supervision were implicitly used as a guide on *how not to be a supervisor*. For some supervisors a discord was apparent between their self-identity as supervisors, and their implicit perception of how supervisors should be. Some supervisors provided insights into their earlier life experiences, giving a greater understanding of their current experience of being a supervisor. What follows is discussion of the second subordinate theme *Comfort versus Constraint,* which relates to the superordinate theme *Being in the supervisory Relationship.* This subordinate theme reflects participants' discussion of factors that enhanced or constrained their experience of supervision. Analysis of participants' narratives relating to the theme is discussed.

4.3.2 Subordinate Theme 2: Comfort versus constraint

Superordinate Theme 1. Being in the supervisory relationship
Subordinate themes - The back story - Comfort versus constraint

Table 4.3 Superordinate theme 1 & subordinate theme 2

The subordinate theme *Comfort versus Constraint* is the second of two subordinate themes relating to the Superordinate theme *Being in The Supervisory Relationship*. This represents a continuation of supervisors' and supervisees' phenomenological experience of 'Being'. Participants, in discussing their experiences, draw on aspects of the SR that enhance or constrain their level of comfort. A continuum of comfort factors and constraint factors is apparent. Comfort factors such as a dynamic match within the dyad, described as an '*ease*', '*a fit'*, being *compatible* and *complementing* one another, each enhance the experience of the SR. '*Constrain*t' however, represents factors that had a negative impact on 'being' in relationship and that created tensions. The detrimental impact of power being misappropriated is discernible. Participants draw on their current and previous experiences of CS and the theme is apparent within some participants' narrative. Discussion of the emergence of this theme from supervisors' narrative, as follows. For example, supervisor Emily's positive regard for her supervisee Dan is palpable:

> I like Dan, we get on, there's a kind of ease in communication between us. (Emily, 4:3); I like his sense of humour, he's quite humorous and light, you know. (Emily, 4:10)

Emily conveys her respect for Dan. We hear that he is "*empathic"*, "*reflective"* and "*conscientious"* (Emily, 12:11). Notably, she refers to "*an ease"* in her description of the relationship. The familiarity and pride that Emily conveys, can be likened to that of a parent, indeed this pride is demonstrated by Emily later as

she reflects that Dan is "*developing brilliantly".* This parental-like pride emerges in Lily's narrative, and her pride in her supervisees' development appears to take on a competitive edge.

> I kind of want them [her supervisees] to be better than the other therapists' [supervisees], probably. You know, I want them to be good therapists. (Lily, 9:6)

Similarly, Cath conveys a sense of pride in Kate's professional growth:

> I've watched her develop, I've watched her grow, I've kind of nurtured her along the way and I just feel she's a really excellent therapist, so it's a bit of a privilege really, I think, to supervise Kate. (Cath, 7:4)

The word "*privileg*e" suggests that this relationship is *more* special than other SR's and there is a sense that Cath feels fortunate that Kate has been so receptive to developing. Cath's parental-like pride is evident; she has "*nurtured her"* (Kate's) growth into "*an excellent therapist".* She provides further insights below:

> I think we both complement each other and she's able to adapt and she's able to meet me halfway, even though we are quite different people, and I can imagine she's like that in therapy as well. (Cath, 9:23)

Cath's use of the phrase "*meeting halfway*" conjures up an image of a graceful coming together of supervisor and supervisee; they are different people, but they work well together. Indeed this reflects supervisee Kate's ideal within the SR:

> That someone kind of gets me and understands what I'm like and how I work…kind of knows my limitations and strengths and uses these to help supervise me. (Kate, 4:3)

Participants thus far have referred to "*compatibility"* and "*ease*" to describe a straightforward relationship. This ease is evident also in Michael's words:

> I think that Mia has a way of working and I think it fits very much with my own … it's a relaxed kind of supervision. (Michael, 9:8)

He speaks of compatibility or "*fit*" in how he and supervisee Mia work. Supervisor Jenny also evaluates the SR positively:

> I think I have a warm and mutually respectful relationship with Liz. I certainly feel comfortable, and I think she does. (Jenny, 3:21)

In contrast to other participants who describe experiencing a "*fit"* or a *mismatch* from the outset, supervisee Liz alludes to a *"journey"* of development, eventually leading to openness and transparency within supervision. Here Liz articulates, what she considers is her role within the SR;

> I think it's about respect, I think it's about … It's that transparency … and I think that's come with experience and I think that's come with working through and processing things myself, that to really benefit from supervision, I have to be transparent, I have to be honest, and she is with me. (Liz, 6:10)

She acknowledges her duty to be transparent, honest and prepared to *work through* issues, a term that originates from Freud (1914), in order to maximise the benefits of supervision. The inference here is that she has responsibilities; she must be transparent, however difficult this may be. There isn't the expectation that supervision will be effortless, and she conveys comfort with needing to experience discomfort, in order to develop as a therapist. Her experience of 'being' is summed up in Liz's words that, "I feel, for want of a better expression that she's got my back" (Liz, 5:26). This metaphor '*she's got my back'* illustrates her sense of safety in the SR and suggests that Liz perceives her supervisor as someone who cares and looks out for her. Her safety within the SR provides the milieu for her to 'work through' and optimise supervision. Liz accepts the professional boundaries of the relationship, and she considers factors that may constrain her journey of development;

> If I've got somebody who I feel is a wise owl and knows everything …. I might feel… I felt in the past ... more guarded and less willing to share. But I do see Jenny as an equal in one sense, but in another sense, I do respect that, like I say, she's forgotten more than I know. (Liz, 9:2)

Reflecting on the dynamics of the relationship, power is considered, implicitly and explicitly. Liz states that they are "equal" and notably suggests that excessive wisdom may adversely impact power dynamics. It seems that the power that

comes with 'wise owl' status may hold her back and make her reticent about opening up. Liz distinguishes between her relationship with Jenny as a peer and their relationship within the supervision.

> There's a distinct difference in being in the room in the supervisory relationship and being outside the room in the non-supervisory capacity, but it's not a bad thing … I do respect her in a different way in a supervision room, as opposed to being my colleague and my peer. (Liz, 27:7)

Here Liz differentiates between her relationship with Jenny as a colleague and as her supervisee and recognises that the dynamics of each differ. In contrast, her supervisor Jenny is of the opinion that the SR can be equal:

> I think as long as you've got a mutually respectful relationship and I mean supervision is also a learning curve for the supervisor so it should be equal. I don't see why there needs to be a power dynamic and I think it could be an issue, but it's not been in my experience. (Jenny, 7:5)

On this subject, supervisee Dan describes his SR as devoid of contagions (such as power) that might detract from the intended function.

> So just to be able to speak freely I guess, so that kind of comfort, just to be able to say what I want … so it's not an authority kind of thing, she's not authoritarian. (Dan, 10:31)

Consequently, he doesn't need to concern himself with behaving in a certain way and can "*speak freely*". For him, the authority inherent in supervision could supress the process of supervision and prevent him from being open. Mia's narrative confirms that it is important for her to feel comfortable within a 'good relationship' (Mia, 1:15) and she draws on a previous difficult SR:

> [It] really affected how I used supervision and maybe not brought everything because I didn't feel comfortable, and I worried about being judged. (Mia, 1:19)

The impact of being in a dysfunctional SR for Mia is apparent; she didn't feel comfortable, and she worried about being judged. Consequently she held back relevant information relating to her wellbeing. As discussed in the literature

review, non-disclosure is common particularly in power relationships, which is implied by Mia's concerns about being judged.

To understand the participants' experience from a relational perspective, I draw on Interpersonal Theory (Safran & Muran 2000; Keiser 1996; 1983; Safran & Segal 1990) and Keiser's (1983) interpersonal circle. We see how supervisor and supervisee affirmative behaviours (Emily and Dan; Cath and Kate) are reciprocated and subsequently form the basis of a functional SR. Conversely, dominance, such as that reported by supervisees Mia and Kate (in previous supervisory relationships) were met with submission and in turn, constrained supervision. Indeed, their accounts of their predicament conveyed a deep sense of helplessness that impacted their wellbeing. Kate describes her discomfort within a previous SR and indicates that her supervisor may have felt similar.

> I think it was critical … me feeling criticised and under pressure to get it right. (Kate, 6:10)

Within the context of CS, Kate described feeling under pressure to get things right. This was inconsistent with her stage of development, as a trainee therapist, early in her development and learning:

> I kept taking tapes [to supervision] and nothing passed, and it put my anxiety through the roof … I would literally come out of every supervision crying. It wasn't a very good experience. (Kate, 6:9)

Kate conveys her sense of hopelessness; her focus was on achieving benchmarks, but her work wasn't deemed to be of the standard required. The situation eventually reached a conclusion as conveyed by Kate:

> The supervisor said they were no longer able to supervise me. So, I wonder whether they were picking up on it not really working. (Kate, 7:33)

To return to Keiser's (1983) interpersonal circle, on the affirmative scale, Kate appeared to perceive her previous supervisor's interpersonal communication as veering towards hostility and responded accordingly ("It felt very rigid and very '*stick to this and don't move on 'til you've got this'*"). Kate's description suggests that

her (previous) supervisor was dominant on the control axis and her power as supervisor was played out within the SR. Kate reciprocated by being submissive, the impact of which is apparent, and within her narrative, she refers to "*feeling criticised*" (Kate, 6:9) and having "*anxiety through the roof*.

The power inherent in the role of supervisor is much discussed in literature and evident from the interviews is that supervisees value feeling comfortable and safe. Also apparent however, is that supervisors also, are subject to constraint through supervisees' behaviours. Supervisor Michael recalls his *"very, very difficult"* experience with a previous "*very confrontational"* supervisee (26:10).

> I got a 'phone call just saying, "*We've moved this person onto another supervisor"*, which was fine, it needed to happen, but I'd have liked to have been involved in the process a little bit more, to say, *"it's not working"* but she went straight, like that to her line manager and got it shifted, which was fine, it was just that was very difficult to work with. (Michael, 27:15)

Michael's sense of powerlessness is apparent, indeed the impact of supervisee power being misappropriated is rarely noted. Here, there is a suggestion of dominance being met with submission (this time from a supervisor). Michael's friendliness is met with hostility, an anti-complementary behaviour viewed as deleterious in a relationship (Tracey et al. 1999).

It is apparent from participants' narratives that subtle nuances dictate the comfort of the relationship, and the required ingredients are personal to the individual. Although all participants described being in a positive SR, indications that their current supervision was not perfect, punctuate the interviews. Indeed, the process of reflecting on supervision whilst being interviewed for this study, appeared to highlight issues. This is most apparent for Cath, who reflects:

> she [Kate] thought I was barking up the wrong tree about this client because I said he [the patient] was quite narcissistic and she said after that, that she was going to go speak to her manager; he is a counselling psychologist; So she said she takes transference issues and relationship issues to him now. (Cath, 15:4)

Cath previously had stated that there was no power differential (Cath, 12:7). Here she discloses that, following a disagreement regarding a client, she discovered that Kate was now taking that client to another supervisor. Kate had asserted her power as supervisee to 'dismiss' Cath without consulting her.

Lily also discusses frustration at supervisees withholding information:

> Sometimes … they are very focused on recovery … It can feel that the information that they give is restrictive, that they're a bit pissed off with the managers, and they can be a bit narked because of that association with me, because I have a management role as well. (Lily, 4:3)

Here Lily articulates her resigned acceptance of supervisees' power to restrict what they share with her. It seems that her management role, restricts supervisees' level of engagement, thus limiting the scope of supervision, and in turn, their development. Interestingly, Joe her supervisee, alludes to a sensitivity to power dynamics in his clinical work:

> I've worked with quite a few older gentlemen, ex-miners, like that kind of background and there does tend to be a dynamic of erm, like a bit of a power struggle and the clients, erm, trying to belittle you, using words like 'son' and kind of things like that. (Joe, 17:2)

He describes the SR with Lily, however, as strong ("She puts trust in you" (Joe, 5:16)) and he adds "It's the best supervision I've had" (Joe, 5:5), illustrating the importance of 'fit' in the SR. Joe acknowledges that he likes to work autonomously, and values that this is available to him within the SR. He feels trusted and therefore secure in the relationship to share his clinical practice and has thrived professionally as a consequence.

To conclude, so far Section 4.3. has provided an analytical account of the first superordinate theme *Being in the supervisory relationship.* Two subordinate themes, The Back Story and *Comfort versus constraint,* represent participants prior emotional experiences which influence their current experiences of CS.

Analytical discussion of the superordinate and sub-themes has been supported by quotations from the participants.

4.3.2.1. Summary of subordinate theme 2. Comfort versus Constraint (Supervisors)

Supervisors, in evaluating their supervisory relationship, referred to an 'ease' (Emily, 4:3), compatibility (Michael, 9:8), and being comfortable (Jenny, 3:21). Jenny acknowledges supervision as 'a journey of development leading to transparency within supervision. Supervisor's pride in their supervisees, was evident with Lily stating that she wanted Joe to be better than other therapists (9:6). Cath expressed pride that she had 'nurtured' Kate into 'an excellent therapist'(Cath, 7:4)

Beneath the surface, however, there was evidence of constraints in the SR. Whilst power differentials in their current supervisory relationships were not acknowledged, there was discussion of supervisees bypassing their supervisors advice. Lily expressed resigned acceptance of supervisee power to restrict the information shared in supervision. Supervisee Kate exercised their power to seek supervision elsewhere, when she disagreed with the advice offered by Cath. Mia also bypassed Michael to discuss her symptoms of vicarious trauma with her manager. Divergences were not addressed within the dyad.

4.3.2.2. Summary of subordinate theme 2. Comfort versus Constraint (Supervisees)

Factors that constrained CS were identified, with supervisee Liz expressing the view that a 'wise owl' supervisor may constrain the journey of development by leading to the supervisee being more guarded about what they share. Supervisees felt constrained by supervisors who were 'rigid 'in their approach to CBT and who discouraged digressions from treatment protocols. Participant narratives provided insights into how criticism led to heightened anxiety. Supervisees highlighted the detrimental impact of power in the SR, and this was recognised as a factor that reduced the likelihood of discussing problems in supervision (Joe, 29:19). Conversely, feeling trusted led to comfort in the SR, which increased the likelihood of disclosure.

Section 4.4 presents the second superordinate theme *Playing the part.* From this two subordinate themes; *Role vulnerability* and *Proving oneself*, have emerged. Analytical discussion of the themes and how these related to study participants, is provided. Highlighted in Table 4.4 (below), what follows is discussion of the second superordinate theme, *Playing the Part* is discussed.

4.4 Superordinate Theme 2: Playing the Part.

Superordinate theme 2. **Playing the Part**
Subordinate themes - **Role vulnerability** - Proving oneself

Table 4.4 Superordinate theme 2 & subordinate theme 1

The second superordinate theme *Playing the Part* represents participants' narratives relating to the intricacies of 'being' in the SR and how they have navigated their role accordingly. Whilst some participants conveyed an implicit identity (as supervisor or supervisee), it seems that others were 'playing the part', rather than behaving in an authentic way. Subordinate themes, 'Role vulnerability' and Proving Oneself' are discussed below.

4.4.1 Subordinate Theme 1: Role vulnerability

This subordinate theme addresses vulnerability amongst the participants in relation to their role. Whilst clinical supervision is recognised as an essential forum for discussion of clinical cases and professional development, an interesting and unexpected finding was that therapists referred to experiences of supervision-related distress more often than therapy-related distress. All therapists evaluated supervision positively and supervision-related issues tended to emerge from general conversation rather than through direct questioning. This seems indicative of the complexity of the SR.

It was apparent across the interviews was that some therapists were not only grappling with the demands of working within an IAPT service, but also presented with psychological vulnerabilities that impacts on their experiences in the SR. Participants referred to current and previous supervisory experiences and some inferred that past traumatic memories have been reignited through their experiences of providing therapy and/or being in supervision.

On one level Cath conveys self-awareness, recognising that she puts pressure on herself to 'know'; however, her conflicting narrative suggests a dissonance between how she feels and how she portrays herself. Asked if her belief that she should know more than her supervisees puts her under pressure, she replies:

> It can do sometimes, but I'm compassionate to myself ... because I used to have quite a lot of hang-ups, I was criticised quite a lot as a kid, so I always felt very self-motivated to always know the answers or always kind of be on top of things or always know that little bit more, so I never had to be in that position where I didn't know or was criticised. (Cath, 3:21)

Her reply provides a window into her vulnerability. An understanding of why it is important for Cath to *'know'* is gained and there is a suspicion that strategies used to avoid criticism as a child may be used in her role as a supervisor. Note Cath's use of past tense to convey that her issues are resolved. Her repetition of *"always"* (four times in quick succession), although presented in the past tense, arouses suspicion that these are in fact 'rules for living'; That is, her need to *always* be self-motivated, to *always* be on top of things, to *always* know in order to prevent criticism. Cath reflects further on her journey:

> providing therapy has given me an opportunity to be able to almost get some kind of self-healing as well. I've had CAT therapy myself anyway, so I've worked on that, and I do know that my core pain is around, erm, being … not looking … I don't know how I would say this, but kind of ... not knowing enough or not doing well enough or not being good enough at something. (Cath, 4:15)

'*Core Pain'* is a concept relating to Cognitive Analytic Therapy (CAT), which refers to painful and largely unexpressed attachment needs (Jellema 1999). Cath's tone and rate of speech changes and she grapples to find words to describe what specifically her "core pain" is. She states that it relates to her "*not being good enough at something"*. She reflects that she has become more compassionate with herself and has allowed herself to lower her standards.

Like Cath, supervisee Joe presents tension. He emphasises a positive and enriching SR with Lily, but it appears there are aspects of his personality that set him apart as vulnerable in the context of clinical supervision. On one level, he expresses confidence in his clinical ability:

> There's been times where sometimes I'll always be more inclined to saying I'm quite confident that I can get good outcomes out of working with this person and sometimes again, Lily's had to reign us in. (Joe, 13:16)

He recognises that at times, his confidence exceeds his ability and Lily has intervened. This misplaced believe in his clinical ability, coupled with a desire for autonomy is perhaps inconsistent with his stage of development and has the potential to play out negatively. It seems that for Joe, to be trusted holds great importance, and not being trusted has negative connotations.

> Personally, for me, it is feeling like someone has got the trust in you, like decisions aren't being micro managed or overly analysed. So, having that kind of freedom and I think (kind of) on a personal development level as well. (Joe, 5:25)

Joe conveys an awareness of his own vulnerabilities in the context of "*core beliefs"*, identifying that he is "*quite a guarded person"* who doesn't share freely (Joe, 6:23) and that the SR, which he describes as "*the best I've ever had"* (Joe, 5:5), is containing these. There is a sense that If the SR 'match' was different, this could have detrimental consequences:

> I know there's been times in the past where I potentially haven't disclosed things because it wouldn't be handled in a supportive way and it would be quite critical and more pressure would be put on us in the therapeutic sense, so I definitely think having that relationship in place, it does make me much more likely to disclose things. (Joe, 14:21)

Worth noting is Joe's ambiguous use of "*it"* in the extract above, which points at the objectification of his (previous) supervisor, replaced by supervision as a process ("*it would be quite critical"*). Joe's vulnerability is evident. His words suggest that trust holds a particular salience. Also implied is that, for him, being

given autonomy means he is trusted. Considering the governance role of clinical supervision and Joe's status as a recently qualified therapist uncomfortable having his work scrutinised, the context of CS is potentially threatening.

Joe makes further reference to trust and compares his current supervision with past experiences that led to his reluctant to disclose thereafter. He describes opening up in a previous supervision, and linguistically moves from speaking in the first person to second person, as he speaks of feeling shame. He appears uncomfortable when he recalls an incident when he disclosed a clinical error in (previous) supervision:

> Some learning needs have come out of it, but from that, there's been increased, and ongoing scrutiny of my work and I think sometimes you get the impression there's kind of trust issues developing in terms of your practise, and I think that can be more detrimental to the supervisory relationship. (Joe, 15:9)

He alludes to trust having an emotional resonance for him. It seems that he associates scrutiny of his work with not being trusted and strives for autonomy as he equates this to being trusted. Supervisors, however, require evidence before assuming supervisee competence and this is likely to create tension. Interestingly, in discussing his current supervision, he justifies the occasions when Lily has taken a more didactic role in response to his dubious clinical decisions.

> Lily would pull me up if I was being a little bit too dismissive or confident in my risk-decision making. (Joe, 12:19)

The extract above conveys Joe's recognition of the need to be challenged within supervision and he implies that, within the context of a good SR, this is acceptable. He respects Lily's opinion and feels respected by her.

Is seems that Joe's fragility is impacted upon by criticism, both real and perceived. In common with supervisee Liz (Joe, 6:10), he has worked through this in supervision, demonstrating Joe's acceptance of his vulnerability and ability to address this positively within a SR that 'fits' with his needs.

Supervisor Lily's dual role as a manager and supervisor creates tension:

> if you're being told as a therapist by a manager, 'let's get them [patients] in and get them out' and then you have [a] supervision with them, they're not really willing … they see it as me being tokenistic, possibly with them, thinking "*you're not bothered anyway so why should I [be]?*" (Lily, 4:17)

She recognises that these roles conflict and she considers how supervisees may perceive her. In her management role she promotes the prompt throughput of patients within the service, which may be at odds with her role as clinical supervisor. Lily fears that supervisees will interpret her case management role as meaning that she "*isn't bothered"* about therapeutic or supervisory processes and is being "*tokenistic"*. She perceives that supervisees resent her somewhat for having a foot in both camps, as a clinical supervisor and also a clinical lead who provides case management supervision. She interprets supervisees' reluctance to disclose to be a consequence of her job title and role within the team.

> It can make you feel a bit rubbish … you can question yourself whether you're doing it right, or what you can do … but I've learnt over the years that I just need to continue working with them [supervisees], you know, give them the opportunity to bring cases and talk about them … being explicit and, kind of, say, you know, "is it going alright for you?" (Lily, 5:20)

Described by Scaife (2001) as a relationship in which one has the power to influence the progression of the other, dual roles within IAPT mean that power relationships are not uncommon. Supervision serves as a 'sounding board' for therapists, in recognition of the emotional challenges of being a therapist (Woolfe & Tholstrup 2010) with an overall function of enhancing therapy. The influence of dual roles is an important consideration given the deleterious impact of power misappropriated in the SR as highlighted in the literature review. However less attention is given to supervisees' power to choose what information to share within clinical supervision.

Lily conveys a resigned acceptance of supervisees' ability to choose what they disclose in CS. Her awareness of the dynamic leads her to question her effectiveness as a supervisor and her discomfort is palpable:

> I'd feel gutted if someone came to me and said, "*You know what Lily, it's not going too great"*, and I didn't know … and I thought it was all hunky-dory … I'd be absolutely gutted, and I'd see it as a reflection on myself. I would feel absolutely gutted. (Lily, 14:27)

Lily's reflections highlights her investment in the role of supervisor and the responsibility she places on herself to navigate this with her management position. This leaves her vulnerable to discord from others. She states that if there was to be a rupture in the SR, she would take responsibility: that she would feel '*gutted*' suggests an investment in being liked. Her desire to be liked may account for Joe being privileged more role autonomy than is consistent with his stage of development. Conversely, Lily's relaxed attitude has enabled Joe to flourish in the context of a relationship in which he feels trusted. This trust is reciprocated, enables him to disclose his practice to her, even in the event of a clinical error.

Supervisee Mia, in reflecting on her experiences of the SR, seems to set herself apart from others;

> Bringing tapes and everything. That was very different for me, erm, so that was really anxiety provoking to think you're going to have to show your whole session, it took quite a few weeks … I think I probably avoided for a while … till I kind of, got to know the supervisor and the same with the group supervision that we had at uni. That probably took me a while to bring a tape whereas other people may be straight in there. (Mia, 6;6)

It was "*very different"* for her. Her comment that "*maybe"* other people showed recordings right away implies that she was so pre-occupied with her own discomfort that she couldn't fully engage with others' experiences. Mia reflects on how she feels presently:

> I feel, like, safe and supported really, that he's [Michael] not going to judge me or tell me off or anything like that, and he's really understanding and empathetic and always checks out how I am and makes sure I'm not going home with

> anything on my mind that, you know, I've left, so yeah … really safe and really comfortable. (Mia, 6:30)

Her narrative intimates her vulnerability in the role of supervisee and her fear of being judged and/or admonished. Mia's emphasis on the restorative function of supervision also point at vulnerability and her need for empathy, support and for someone to look out for her. Her description of how her supervisor Michael supports her bring to mind the fundamental security needs in an attachment relationship (Bowlby 1988; 1969).

Within the context of a professional relationship, Mia's relief that Michael isn't going to "*tell [her] off*" stands out. She speaks of her previous supervisor being critical, and perhaps she experiences critical feedback as being admonished. Her sensitivity to judgement from others makes the context of the SR, which involves a degree of evaluation, more threatening. The following statement opens up discussion of her recent difficulties;

> I maybe struggled with stuff, and I've not told him, [her current supervisor] early on especially, when I didn't feel I knew him that well... (Mia, 13:8)

Although the right ingredients are apparent in her SR with Michael, in the early stage of the relationship Mia was unable to verbalise her need for support. Given her fear of negative appraisal, it is likely that she requires longer than others to establish trust. The implications of this become apparent when she discloses that she experienced vicarious trauma following a period in which she treated several PTSD cases in succession.

> I was just thrown into the deep end. After training and that, you pick up everything and anything [In terms of referrals], so I had some … sexual abuse trauma that … we don't really go into that on the course, so I just felt totally unprepared but just … dealt with it and then I had another one and another one all kind of in a week or so and I just … it just really affected me. (Mia, 14:13)

In the treatment of people with Post-Traumatic Stress Disorder, it is not uncommon for therapists to experience vicarious trauma (Chouliara, Hutchison

& Karatzias 2009). However, Mia did not feel able to discuss this with Michael, fuelled by her belief that she should be able to cope. It is interesting to compare her response to vicarious trauma to that of Kate, also recently qualified:

> I had a client not so long ago that was treated for child sexual abuse and for a week I woke up with her screams in my head because we had been doing the kind of narrative and I took that to Cath and she … helped, kind of supported me through what I was feeling but then helped me see how that could link with the client and how significant that might have been in terms of the transference and what we could do for her. And it was good for me but good for the client as well, to realise what that might have been about. (Kate, 20:30)

Kate describes how she experienced distressing symptoms of vicarious trauma following treatment of a client who had experienced sexual trauma. However, she recognised these as a consequence of working with trauma and reached out for clinical supervision. She was "helped" and "supported" to make links between her symptoms and her client's presentation. Her narrative illustrates the value of effective clinical supervision in managing vicarious trauma. Supervision provided the context in which to process her emotions ("*supported me through*") and she acknowledged that her subsequent development as a therapist benefitted her client. This highlights the importance of therapists feeling safe to discuss their emotional experiences within clinical supervision.

Scattered through supervisor Michael's discourse are references to his emotional experiences that he then minimises; for instance, he refers to "*mild"* anxiety (11:8), "*not a real fear"* (11:10) and feeling "*not uncomfortable"* (7:12). His "*confidence struggles a little"* (7:5) the closer someone is in terms of clinical experience. He refers to feeling intimidated when he began supervising Mia:

> knowing how, erm, qualified she is, and it is purely the CBT I am more qualified in … in other aspects she's more qualified than me, and I think that's probably what knocks my kind of confidence a little bit more. (Michael, 7:26)

He was conscious that Mia's previous supervisor was more *purist,* and that he couldn't live up to this:

> I knew that that person [her previous supervisor] was very, very CBT. Now I come from a counselling psychology background, and CBT I think is fantastic and I use it with people across the board, but I'm a lot less structured in my sessions than this person was, and I'm a lot less … I would say educated than this person. (Michael, 15:17)

Michael discloses a recent experience of a rupture in a SR with a previous supervisee, which may account for what appears to be, a lack of confidence in his ability as supervisor:

> I supervised someone before and I don't supervise them anymore, and she was quite confrontational in the supervision ... And she was very confrontational and that's how she was as a person as well and I think openness and honesty and critical (you know), feedback is absolutely fine. But I think that experience was very, very difficult, where someone would be, certainly not hostile, but just to say, "*I don't see why you're saying that!"* and "*I don't know what you expect me to get from that!"* and things like that. There was clearly an issue in the room, you know, we had to have a look. It was just a bad match right from the start. (Michael, 26:6)

Michael presents the information in a chain of staccato sentences devoid of emotion. He speaks quickly and factually ("*I supervised someone before and I don't supervise them anymore"*), hinting at emotional avoidance. Repetition of the phrase "*she was quite confrontational"* (26:11) suggests that he was on the receiving end of hostility, something he earlier denied. Then gradually he opens up to his emotional experience ("*that experience was very, very difficult"*). He reverts back to his earlier linguistic style in which he tends to minimise or undermine his own emotional experience. He gives an example of his supervisee undermining his advice and concludes "*it was a bad match right from the start"*. This he contradicts later in the conversation:

> It wasn't an enjoyable process, to be honest. It was absolutely fine for a long time and then something shifted and there was misinterpretation as to what I was kind of putting forward and it became quite uncomfortable, and I would not look forward to it. (Michael, 26:29)

Given the emphasis on the relationship in psychotherapy, a rupture in the therapeutic relationship can feel distressing for the therapist but can also provide a window into that person's interpersonal style, which is of therapeutic value (Safran & Seagal 1990). Ruptures in the supervisory relationship are hurtful and, the findings of this study suggest, often unresolved. Supervisors Emily and Jenny each drew on their experiences of ruptures in their SR as trainees that influenced their own practice and *how not to be a supervisor*. Whilst Grant et al. (2012) undermine the importance of supervisors using relational approaches to repair ruptures, it is less likely that supervisees who are experiencing tension in the SR feel able to instigate discussion of this. Michael, as supervisor, did not address such challenges in the SR and the situation intensified until finally his supervisee terminated the relationship. Consideration of ruptures is provided in Chapter 5.

To summarise: the second superordinate theme, *Playing the Part* represents participants' experiences in the SR. This theme covers two subordinate themes. The first, *Role Vulnerability*, draws upon participants' vulnerabilities in the context of the SR. Whilst clinical supervision is recognised as an essential forum for discussion of clinical cases and professional development, an interesting and unexpected finding was that participants referred to experiences of supervision-related distress more often than therapy-related distress. Whilst all therapists evaluated supervision positively, supervision-related issues tended to emerge from general conversation rather than direct questioning. This seems indicative of the complexity of the SR. Below, the second subordinate theme, *Proving oneself,* is discussed.

4.4.2 Subordinate theme 2: Proving Oneself

Superordinate theme 2. **Playing the Part**
Subordinate themes - Role vulnerability - **Proving oneself**

Table 4.5 Superordinate theme 2 & subordinate theme 2

Whilst the theme '*Role Vulnerability'* draws upon participants' vulnerabilities and how these play out within the SR, '*Proving oneself*' recognises how participants inadvertently or intentionally present themselves in their role as supervisor or supervisee. 'Proving oneself' represents implicit expectations and ideologies that participants hold about themselves, relating to their role. Analysis of the theme draws upon how, within IAPT supervisory relationships, participants managed their vulnerabilities. Each will be discussed in turn.

> Supervisor Jenny expresses confidence in her role as supervisor:
>
> I've never felt uncomfortable about supervision, I guess if you follow the framework of CBT, the agenda setting and the … you know, the interpersonal effectiveness stuff then actually it's not that different. (Jenny, 2:3)

Her transition to the role of supervisor was without issue. She conveys confidence as a supervisor and alludes to using a reflexive model ("*follow the framework of CBT*"). As discussed in Chapter 2, reflective supervision models have been identified as flawed as they assume that CS and therapy are the same, when in fact they are fundamentally different (Milne & Reiser2017; Beinart 2014). Jenny completed a clinical supervision course prior to the inauguration of IAPT at a time when reflexive models (Liese & Beck 1996) were commonly used in CS. Further evidence of the use of a reflexive model is conveyed:

> I work with a lot of people who have got personality issues as clients and there is absolutely no difference in how I would work with them and the relationship I

> would have. As long as the person I was supervising was acting in a safe, professional manner then I would have no problems with that. (Jenny, 9:25)

Here Jenny credits her positive experiences in CS to being 'straight' with her supervisees and having the ability to address personality issues as she would in the therapy relationship. She draws on her experiences of clinical supervision as a trainee therapist:

> I wasn't the only one actually [who found her supervisor difficult] …. There was three of us in the group and we all used to dread it and it was so predictable. (Jenny, 12:13).

She makes it known that others also had similar difficulties, possibly in an attempt to substantiate that the fault lay with her supervisor, who was 'difficult': others too had found this supervisor difficult. She doesn't acknowledge her responsibility for contributing to the supervision issue. A hesitancy to discuss any challenges as a supervisor is apparent. She provides little access to her emotional experience of 'being' in the SR. Questions are answered in a pragmatic way, devoid of reference to experiences. An open-ended question was used in an attempt to gain insights into these supervisory experiences; Jenny was asked how she deals with issues in supervision. She replied:

> I guess I would deal with issues the same way I would deal with any issues; I would be tabling it and discussing it and hopefully come to some sort of collaborative agreement. (Jenny, 6:10)

She is asked about her experiences of emotion in supervision and, similarly, whilst she acknowledges sadness at hearing the stories of others, gives a rather stilted answer: "I tend to keep my emotions upper level" (Jenny, 17:7). Consequently, insight into Jenny's *'Daesin'* (Heidegger 1962/1927) is superficial. She does not allude to vulnerability and there is a sense that she holds back. In contrast, Michael and Mia enter their SR having had recent negative experiences in their previous SR, which they readily reflect upon. Supervisor Michael discloses that when he began

supervising, he had concerns about being taken seriously and described a rupture in a recent SR in which he was supervisor. Subsequently he entered the relationship with Mia having concerns about being a good enough supervisor. Here, he reflects on the positive effect of their SR:

> I think that it's been … the relationship has been very key for Mia, because I think it's been a huge difference from the supervision that she had before. And it wasn't that it was a negative experience … the supervision, but I think there is a lot more focus this time in … you know … supporting Mia with different things. (Michael, 5:15)

Michael reflects that Mia's current experiences of supervision are more positive than her experiences with a previous supervisor, who he states did not provide the support she needed. Thus, he conveys his knowledge of Mia, her previous issues in CS and his awareness of her needs, for which "*there is a lot more focus*". His pride is apparent in his statement "*It's made a huge difference*" (Michael, 5:16) and he acknowledges that Mia previously felt intimidated in CS. He points out that, within CS, Mia has the opportunity to "*discuss how she is feeling about things"* (Michael, 5:21). "*Normalising a lot of her anxieties and a lot of her beliefs as a therapist"* (Michael, 5:26) has helped her. There is an inference that his focus on the restorative aspect of supervision and his concern for Mia's wellbeing has impacted positively. Michael feels accomplished in his role:

> So I don't feel there is any pressure in terms of…she expects…you know… there to be an answer. (Michael, 6:12)

Whilst he states that he doesn't feel pressure to know, a few moments later, he discloses that he "*struggles a bit*" (Michael, 7:5) when supervisees have similar clinical experience to him. He contends that supervising Mia (whom he perceived as more qualified in other modalities)) made him anxious:

> that's probably what knocks my (kind of) confidence a little bit more. (Michael, 7:27)

In considering his practice as supervisor, he recalls:

> Mia … brought it up.. she'd never seen a tape of (you know), my therapy. (Michael, 10:9)

He reflects that Mia commented that she had never seen recordings of his practice and shows a reluctant to expose his practice:

> There's always the mild anxiety, I think, where you think, like, is she going to watch this and then think, "*Oh Christ that guy's my supervisor!"* But it's not a real fear, it's just that negative thing that kind of pops up, erm, and I would feel mostly comfortable I would imagine, yeah. (Michael, 11:8)

Michael minimises and normalises his anxiety in the same sentence; he experiences 'mild' anxiety, and it seems that he shifts ownership of this by using second person: "You think; *is she going to watch it?"* (Michael, 11:9). He continues to justify his reluctance to show recordings of his clinical practice:

> There would need to be, erm … there would need to be something in that tape that was special that they took away from it … does that make sense? ... I'd rather give them a tape that was particularly good … does that make sense? (Michael, 11:17)

His repetition of "does that make sense?" hints at some discomfort in admitting his reluctance to reveal his every day practice. His concern that recordings should be something better than the norm suggests a lack of confidence; He wants to prove himself in his role as supervisor by having "*something in the tape that is special, that they take away from it*" (Michael, 11:19). It seems that Michael has concerns that his 'standard' work as a therapist isn't good enough to show his supervisees.

A similar dynamic is evident in Cath's narrative:

> Yeah, there are times [when] I have said "*I don't know the answer to that, what do you think it could be?*" or "*Should we just have a think about it and write it out and think about what it could be?*" … I'm alright with that. I am alright with that, I don't at all feel under pressure to know everything at all now but I'm very lucky with [the] supervisees I've got. (Cath, 5:1).

She recognises that she places pressure on herself to be knowledgeable, which she attributes to her experiences of being criticised as a child, leading to compensatory behaviours in order to avoid criticism, mainly ensuring that she is knowledgeable. This leads to a pressure to *'know'*. It seems that Cath '*plays the part'* of being her own therapist, having conceptualised and overcome issues stemming from her experiences of being criticised as a child (4.15). It seems that Cath tries to convey that her issues have been resolved and she is comfortable with not knowing everything. Her self-portrayal as comfortable with *not knowing* ("*I'm alright with that, I am alright with that*") has a paradoxical effect and rouses suspicion that, not only does she put pressure on herself to know, she also puts pressure on herself to be "*alright*" with that.

Supervisee Joe also identifies this tendency;

> touching back on the stuff that I was saying … about personal stuff, and about, kind of projecting as if, erm, you're always competent and, that kind of stuff, I think that's something I've always tried to do. (Joe, 9:7)

He demonstrates understanding of how his vulnerabilities are played out and his tendency to want to appear as competent. His movement from first person (*I was saying*') to second person, '*you're kind of projecting as if you're always competent'*, suggests that he is experiencing some discomfort in acknowledging defence mechanisms. Further context is provided:

> I know there's been times in the past where I potentially haven't disclosed things because it wouldn't be handled in a supportive way and it would be quite critical and more pressure would be put on us in the therapeutic sense, so I definitely think having that relationship in place, it does make me much more likely to disclose things. (Joe, 14:21)

We hear that he is uncomfortable with showing his weaknesses in terms of clinical practice and he acknowledges a tendency to portray himself as competent, suggestive of negative self-concept. Worth noting is Joe's ambiguous use of '*it'* in the extract above, which appears to relate to his supervisor ("*it would*

be quite critical"). An alternative explanation may be that Joe found the supervision context critical. He reflects further on the implications of being in an unsupportive SR:

> if the relationship isn't as strong and if it isn't as open and trusting, I think there can be that inclination to provide a slightly biased opinion of [clinical] performance and cases and maybe contain certain insecurities … so that's the main thing, [outcome of a weak SR], feeling like not necessarily giving the most representative, and open experience as a therapist, and I think that can be kind of restricting and quite limiting in terms of the growth that you can get out of that professionally. (Joe, 7:13)

His vulnerability within supervision is demonstrated in the extract above, in which he justifies hiding his insecurities. The inference is that, if there isn't trust, he cannot be open.

Supervisee Mia also alludes to fear of judgement and admonishment (Mia, 6:20) within supervision. Despite feeling positive about her relationship with Michael, she does not feel able to disclose distressing symptoms of vicarious trauma as a recently qualified therapist. She recalls thinking, "I'm actually qualified right now, and I should be able to do this" (15:8). Mia conjures an image of a deeply distressed therapist trying to hold herself together because, in her mind, she has to prove herself as a competent within the organisation. Such emotions are not consistent with her view of how a CBT therapist should be, so she tries to hide them. She recalls concerns that she had at the time:

> Is he going to have to tell somebody else that I'm not coping? So that's maybe made me hold back, I guess. And it's not that I didn't trust Michael … it was just, where is this going to go? … Is [sic] there going to be any implications for me and my job? (Mia, 13:28)
> ..you worry they're going to have expectations of you, I guess, and where you're at … that you're coming towards the end of the course, they might think you should be further on than you are. (Mia, 13:15)

Mia switches tense from first person "*Is he going to tell somebody I'm not coping?*" to using second person, "*You worry*", possibly as a means of avoiding

her emotional experience. Use of the phrase "*you worry"* could be interpreted as a means of normalising her response. It seems that she is not fully connecting with how she felt at that time. Referring to Michael as *"they"*, suggests she is distancing herself from him and hints at emotional dissonance. It appears that the meaning that Mia attaches to her emotional experience, dictates her ensuing behaviour (avoidance/non-disclosure), which in turn exacerbates her distress.

Continuing on the theme of participants relationship with knowledge and being knowledgeable, supervisee Liz need to prove themselves, often by being knowledgeable, paradoxically supervisee Liz acknowledges the deleterious effect of excessive knowledge in the SR. She reflects that *"a wise owl"* supervisor (Liz, 9:2) may impede her ability to be open. Mia expresses similar views on the delicate balance of supervisor knowledge;

> I guess it makes me feel better that [her current supervisor] doesn't know everything] because I don't. (Mia, 4:26)
> Whereas with the supervisor I had before who would literally ... know word for word an article ... or a model straight away … it can be quite intimidating when they expect you to know that as well, I guess. So, yeah, I find it better the way it is. (Mia, 5:6)

Both Liz and Mia allude to level of knowledge impacting the ability to be open within supervision. Interestingly Mia refers to a belief that "*they"* (her previous, knowledgeable supervisor) expected her to have the same level of knowledge. It isn't clear whether this was an accurate perception, however the discomfort and feeling of intimidation that she experienced at the time was conveyed in her narrative.

Cath also relates the subject of knowledge to her previous experience of supervising someone who was extremely knowledgeable;

> The awkwardness was about that person always being right, being quite supercilious and knowing everything, and I felt that came across to patients as being a power differential and quite patronising. But I felt it as the supervisor as well. I felt because the academic knowledge was so much, you know, well read, very educated, kind of "*All the gear and no idea"* kind of thing. (Cath, 29:26)

It is worth noting that despite Cath feeling compelled to '*know*', she recognises that knowledge can be used as a "*big smoke screen"* (30:1). Her use of metaphor conjures up the image of a therapist with all the "gear" (knowledge), which is misappropriated in order to gain power. Beyond this knowledge, there is a noticeable lack of interpersonal skills. Despite her status as supervisor, Cath felt uncomfortable. This reflects Mia and Liz's inference that the '*wise owl'* contributes to a power dynamic inherent in supervision. It seems that there is a delicate balance between sufficient and excessive use of knowledge within supervision. Participants alluded to excessive knowledge being intimidating and being misused within the SR.

To summarise: the subordinate theme *Proving oneself*' represents how participants' inadvertently or intentionally presented themselves in their supervisor or supervisee role. Implicit expectations and ideologies that they held about themselves, and how they related to their role, appeared to play out in the SR. Whilst some participants fulfilled the role of supervisor or supervisee in an authentic way, others strove to prove themselves through projecting themselves in a way that aligned with how they believed they should be, such as confident and/or knowledgeable. Analysis of the theme draws upon how, within IAPT supervisory relationships, participants managed their vulnerabilities.

4.5 Dancing around Interpersonally

Superordinate theme 3. Dancing around interpersonally
Subordinate theme The spoke and unspoken

Table 4.6 Superordinate theme 3 & subordinate theme 1

This superordinate theme *Dancing around interpersonally* represents the final superordinate theme and the subordinate theme '*The spoken and the unspoken'*. Reflected within this theme are the interpersonal and power dynamics that participants' narratives uncovered. Whilst discussion of themes thus far has categorised supervisors and supervisees narratives separately, this final theme entails analysis of each supervisory dyad as a unit. This enables the intricacies of what is happening interpersonally within each dyad to be analysed in order to address the central question: *"What are IAPT supervisors and supervisees experience of interpersonal processes in the SR?*"

The superordinate theme *Dancing around Interpersonally* shows how some dyads navigated being in an IAPT supervisory dyad. Participants within the dyad transversed around interpersonal obstacles without explicitly addressing these issues, and overt avoidance of issues manifested within the SR.

4.5.1 Subordinate theme: The spoken and the unspoken

This subordinate theme reflects interpersonal dynamics within the supervisory dyads, the analysis of which enables a greater understanding of participant's phenomenological experiences of the supervisory dyad. The theme is related to each of the five dyads below.

4.5.1.1 Cath and Kate

Cath and Kate each evaluate their relationship positively. Kate sums up the SR and indeed the quality of supervision positively.

> I feel we have a really good supervisory relationship and that's really important to me. That someone kind of gets me and understands what I'm like and how I work … kind of knows my limitations and strengths and kind of uses those to help supervise me, really. (Kate, 4:1)
> It's just having that check-in of your overall wellbeing and I do trust that she has got my interests at heart. (Kate, 5:16)

There is a suspicion that Cath compensates for a deep-rooted feeling of not being good enough by providing supervision "*of a much higher standard"* (Cath, 4:24) than needed, so it is testimony to their strong relationship that she is able to admit to not knowing within supervision as the extract below portrays:

> she's learnt my vulnerabilities, I guess, in supervision. Like GAD … you know, I'm rubbish with GAD, I'm not great with it at all, I'm willing to sit and try work through it, but I'm not well read in it or well experienced in it. (Cath, 7:28)

Cath conveys that she is comfortable with Kate knowing her vulnerabilities. However, the 'vulnerability' that she refers to ("*I'm rubbish with GAD")* seems to be her means of self-disclosing without actually providing insights into her own vulnerabilities. "*We laugh about it because she pulls a particular face*" (8:1). There is an impression of the 'realism' aspect of the Real Relationship (RR) first presented by Greenson (1967) and much addressed in psychotherapy literature (Gelso 2002; Gelso & Hayes 1899; Gelso & Carter 1985). Cath alludes to this realness below:

> So, in that respect, honesty and the ability to be able to say things to her without feeling there is going to be real devastation at what I'm saying. She understands that I understand that … she does have a penchant for dependent patients. (Cath, 8:9)

Cath projects the SR positively: they can be open and honest with one another Yet despite a mutual appreciation of each other's vulnerabilities, it is interesting that, following a difference of opinion, Kate chose to take a client to another supervisor. This is not discussed robustly within supervision, depriving Cath of any control over the decision. Although power is inherent in the role of the supervisor, here we have a further example of the supervisee having the power to withhold in supervision. Cath felt hurt:

> It made me doubt myself at first. I thought I was wrong about a lot of the stuff I said about the sense of people I'd got. But also, probably that it's one of two things; either I'm not giving her what she wants to hear … or she thinks I don't know enough about it … and that's maybe not my speciality so she goes elsewhere. It doesn't bother me as such, it's just an area that I'm kind of quietly observing and not … there's still enough to talk about in supervision, it just feels like there's a six-foot monkey that's not being talked about, and I did mention it a couple of weeks ago and I said, "*Oh have you thought about… (something)* and she said, "*Oh I take that to T [another supervisor]…anything like that I just take that to T"*. (Cath, 15:22)

She states that she doubted herself *"at first"* and "*it doesn't bother* [her] *as such"* but it seems she has not moved on from the hurt. Earlier Cath recognises her sensitivity to being perceived as lacking in knowledge or expertise leading to over-compensatory behaviours. The actions of her supervisee (bypassing her for specialist supervision), are likely to contribute to her insecurities, thus activating her *"core pain"*. Kate, she believes, *"thinks I don't know enough about it"*. Again, Cath's use of metaphor, *"six-foot monkey"* represents an interpersonal dynamic that is very evident to each party, however is not being addressed. This reflects Supervisee Liz's uses a similar metaphor of the "*elephant in the room"* to emphasise her belief that openness is essential in the SR (22:12). It is noteworthy

that, within a relationship positively evaluated by Cath and Kate, the '*six-foot monkey*' is never discussed. It seems that the process of being interviewed and thereby reflecting on clinical supervision has prompted Cath to analyse processes that she may previously have avoided.

Cath has a propensity to vacillate between acknowledging the great work that Kate is doing, to subtle cynicism ("it's almost like [she is saying] '*look at what I can do*!'" (Cath, 23:31)). She then seems to take an empathic stance, suggesting that "*she* (Kate) *does that for her own self-worth*" (23:21). We get Kate's perspective on honesty in supervision below.

> I feel I can be honest, but yeah, there are sometimes where I feel like … you skate across some information because you think they're going to say, *"Don't work with them!"* or your supervisor's going to say, *"That's secondary care!*" or maybe you've got a bit of a connection [with the client] and you think there's something you can do. It's not something I'm massively aware of but there are some times ... where I've gone out [of supervision] and been … [thinking] "*Maybe you didn't paint that picture great … What's that about?*" So maybe it's not been an intentional thing but when it's comes to sitting and doing my notes, I think "*Maybe I don't stress that as much as … and would that change things?*" (Kate, 16:1)

Kate changes from first person *"I feel I can be honest"* to second person, possibly in an attempt to normalise the process of withholding details ("*You skate across some information"*) is much less potent than use of first person "*I skated across some information*". She refers to Cath as '*your supervisor',* which creates a sense of her minimising a relationship that, up to now, has seemed strong. The perception of a more confident Kate wishing to assert some independence and "*fly the nest"* in order to work more creatively with clients continues an attachment theme. It is conceivable that Cath is struggling to adapt to Kate's enhanced confidence, reflective of her stage of development, and that Kate has an awareness of this and tries to appease her.

4.5.1.2. Lily and Joe

Lily and Joe illustrate a functional and respectful SR, within which each feels comfortable. In analysing the dyad, it seems that Lily and Joe meet each other's needs in relation to their vulnerabilities. Joe's need for autonomy is fulfilled and he feels trusted. Consequently, he feels able to disclose within supervision without being penalised for poor decision-making. Indeed, the following statement conveys how important it is for him to be vulnerable in supervision:

> I can freely demonstrate shortcomings and limitations that I've got, and vulnerability as a therapist and I feel comfortable doing that and I think because of that it is quite beneficial. (6:26)

He provides a sense of these benefits further in the interview, again mentioning the ability to be vulnerable:

> you can be kind of vulnerable and demonstrate kind of flaws in your practice, that kind of thing, and kind of, that's OK and you can be supported through that, and you can go beyond it. (Joe, 9:15)

Exposing his vulnerabilities in supervision has enabled Joe's practice to develop, and he identifies that his ability to understand interpersonal dynamics with clients has expanded through being able to articulate his thoughts and emotions in supervision. This contrasts with his reflections of past supervision in which he experienced "*a kind of element of shame"* (Joe, 15:33) when he disclosed errors. To explore the interaction between Joe and his supervisee Lily from an interpersonal perspective further, it seems possible that affiliative behaviours they pull from one another fit with their desire to avoid or overcompensate for their vulnerabilities. Lily appears sensitive to people's perception of her and arguably has allowed Joe a greater degree of autonomy than his stage of development might dictate. This may be an attempt to increase her likeability in a context within this this is compromised due to her job role. This works well for both of them; Joe feels valued and trusted, Lily feels liked and respected by Joe:

> I think if he dropped the ball, I would probably be the first person he'd ring. I think … I would hope he would think "*I need to ring Lily; she'll be able to help*". (Lily, 17:1)

This contrasts with her experiences of other supervisees; the extracts below suggest that Lily wants to have access to supervisees' experiences in the therapy room but (within supervision) isn't given full access which makes it difficult to fulfil her role as supervisor.

> I have delivered supervision to you know people who … it can be difficult; they can give you one-word answers and it's frustrating. (Lily, 3:22)

In contrast to her experience of the SR with Joe, she expressed frustration when other supervisees don't engage in supervision on a profound level. With Joe, however, it seems that the behaviours each pulls from the other are not only mutually advantageous but also developmentally enhancing, particularly for Joe. Joe provides personal insights, as we see below. He recognises his competitive edge and a desire to appear competent.

> touching back on … personal stuff, and about being kind of projecting as if, erm, you're always competent and, that kind of stuff, I think that's something I've always tried to do. (Joe, 9:4)
>
> ... like sports as well, I always do tend to be quite competitive so, I think if it [supervisor] was a man, there might subconsciously be … that element of putting that guard back up again and slightly demonstrating just how capable you are. (Joe, 9:23)

Based on his account of previous supervision, there appears to be a sensitivity to criticism; however, with Lily he lets his guard down and is comfortable being vulnerable. Within supervision Lily's affirmative manner has eradicated any power dynamics and consequently Joe doesn't feel the need to prove himself to or compete with his supervisor. Notably, we see from the extract above that her gender makes this easier. Feeling trusted makes him feel valued which facilitates openness and reflexivity in supervision. Lily observes how Joe has developed:

> he is a really technical therapist … he could fly through the CTS-r … those type[s] of things come very natural to him ... so we've been working on the vulnerable part of him as a therapist … you know, looking at cases that aren't going too well, exploring how he felt about a case. (Lily, 9:21)

Joe recognises his progress, and his sense of achievement is apparent:

> It's probably the thing I've been most uncomfortable with about supervision is probably the thing I value the most about it now. (20:22)

4.5.1.3. Michael and Mia

This supervisory dyad was formed at a time when Michael's relationship with a previous supervisee had ended. Mia was transitioning to working fulltime without the 'buffers' afforded to trainees, such as reduced caseload and less complex clients. There are indications that Michael's sense of self is fragile, apparent in his concerns about how he is perceived by others and how he compares himself to other supervisors, namely his friend, a fellow therapist. Indeed he earlier admitted to feeling threatened by Mia's level of knowledge. There is a sense of him asking "*Am I good enough?"* in relation to supervisory and clinical practice (see 15:13 to 16:23). This, and Michael's recent experience of being rejected by a previous supervisee, is likely to have made him more attentive to the quality of the SR. Michael describes his reflection of a previous supervision, ended by his supervisee:

> It's a real question of "*what do I need to do then? what was I not doing that I need to do?"* And I think that you then start to look to overcompensate a little bit. And, when she [previous supervisee] was saying "*This is what I want from supervision"*. And I was trying to jump through those hoops to be the supervisor that she wanted; it wasn't working. (Michael, 28:3)

There are vestiges of self-blame as he discusses his futile attempts to make it right. We know that Mia has chosen Michael over other potential supervisors because she admires his qualities and evidently they each hold the other in high regard. Yet, despite all the ingredients supposedly being in place, the SR does not provide the safe haven for Mia to disclose that she is experiencing psychological

problems. Why, in the context of a '*good*' SR, does Mia not open up to Michael, and why does he not recognise her emotional distress?

Worthy of consideration is the timing of these events, which took place several months prior to Mia and Michael participating in this study. She feels "*safe and supported"* in supervision *now* but at the time this may not have been so. A possible reason for this links with the previous superordinate theme of 'Playing the Part'. Subverted following recent negative supervisory experiences, Michael and Mia are focused on each playing their part. There are indications of fragile professional identity and doubts about worthiness for the role. Michael's experience of being rejected as a supervisor was likely to be shaming, and Mia recalled that she had felt "*almost inferior"* (8:17) to her previous supervisor, whom she found "*critical"*. It is conceivable that Michael may spurn parts of his role that that could destabilise Mia and indeed their relationship. 'Technical' supervision is possibly a more tangible default for both. Mia states:

> I knew I would get upset if I talked about it as well, (with Michael in supervision) so I was reluctant to … because I don't like to break down anywhere, never mind in supervision. (Mia, 18:17)

The culture of working in an IAPT service and the expectation of "*Get them [clients] in, get them out*" (as earlier quoted by Lily) in order to meet targets is aptly conveyed by Mia below:

> All of a suddenly [after completing training] it was five days a week, five clients a day, very complex clients, I think I just burned out to be honest. It was just too much. (Mia, 20:18)

Michael and Mia were contending with the demands of working within IAPT and it seems that the conflicting demands of their roles may have contributed to the difficulties that Mia has experienced:

> based on previous supervision, there was never ever any talk about how I felt, and there was nothing about what's going on with you, nothing about the relationship with the client, it was all "*This is the model you should be using"* and

> "*This is CBT"* and it was very *"This is the agenda, and you stick to* it" so I guess, I didn't know with Michael whether I could bring personal stuff or not. (Mia, 18:6)

It seems that there was a lack clarity around the role, function, and scope of clinical supervision. Mia's narrative introduces an additional variable that contributed to her lack of openness in supervision; furthermore, when asked directly what would have facilitated her disclosure in supervision, yet another variable becomes apparent:

> ... knowing that it would just stay within the supervision, and it wouldn't go any further than that but, yeah, I'm still even unsure about that to be honest, about where it goes because like I say, when I did speak to my manager she did take it further and it did go higher up. (Mia, 20:22)

Something as inherently central to clinical supervision as confidentiality remained unclear to Mia, despite the interview taking place several months after the event. Finally, when asked why she disclosed to her manager rather than her supervisor, Mia replies,

> My manager's female … I think I feel just that bit more comfortable with females than males, to be honest. (15:31)

In the context of what was deemed to be a positive SR, it seems that much has been left unsaid. Indeed, the unspoken remained unaddressed within the dyad. Mia remained unsure of the bounds of confidentiality; Michael is unaware of Mia's discomfort with males or her concerns about confidentiality, all of which impact the extent of her openness. Consequently, he is unaware of what Mia requires to feel safe in the relationship.

4.5.1.4. Dan and Emily

Emily and Dan describe a supervisory relationship that has functioned well from the outset, supporting Dan's smooth transition from completing his training to commencing as a CBT therapist.

> It's [supervision] always been kind of a support, and I think I noticed during times when there was a gap for whatever reason, whether it was a kind of holiday, or the supervisor was on holiday. (Dan, 4:17)

> You'd notice a kind of increase in stress build up from not (kind of) discussing some people in supervision. (Dan, 4:20)

> I think so yeah, even just to kind of check in to make sure everything's going okay. (Dan, 4:27)

Dan recognises the role that supervision has in maintaining his wellbeing and observes that his stress levels build when he hasn't had supervision for a while. Asked what he finds useful about supervision, he reflects:

> Obviously the discussion and kind of, the knowledge that can get more information, but the reassurance as well is useful. (Dan, 5:18)

He elaborates on this:

> Having the knowledge… I guess that's important. Erm (kind of), personable, like being able to get on to speak to them if there is any issues, not being concerned to tell them about any problems you might be having or embarrassed to tell them about any problems. So they need to feel comfortable talking to about, …like, confidential or what would be confidential things, whether that's personal or with clients, So being able to take things that you think might impact on the client or…(Dan, 6:31)

He expresses conditions specific to a 'good' supervisory relationship. His supervisor needs to be personable, trust is required, feeling comfortable with the person and knowing that confidentiality is maintained. He provides insights into his personality that are relevant to supervision:

> I mean I'm the type of person, I mean I'd probably wait until it got to the point where it was kind of quite bad, I'm more the type of person to put up with it if there is a problem, then say in the early stages of the problem, so make sure it's definitely an issue, I guess, before they're doing anything about it. (Dan, 8:8)

Dan recognises that, should he be experiencing difficulties in the SR, he is unlikely to share these within supervision unless they were particularly bad. He would wait until he was sure it was an issue. In terms of his clinical practice, he would be less reticent.

> I don't mind saying things that I haven't done right, erm, because I think it's a good opportunity for learning really and if I'm feeling as though I've not done something right (Dan, 8:21)

Dan's comfort in exposing clinical mistakes in supervision is evident and he recognises supervision as a context for discussing errors:

> I think so, yeah. 'Because it's an environment where it's okay to be doing something slightly wrong because I guess that's what supervision's for. Well, I think to help put you on the right track if you're slightly off. (Dan, 9:1)

Dan's level of comfort and indeed confidence is apparent; he recognises that clinical errors can occur. Indeed Emily identifies supervision as a context for building supervisee confidence (Emily, 3:1) and it is apparent that this message has been conveyed to Dan.

> Yeah, definitely. It's like human error, isn't it. You can't get them all right and I think part of that kind of encourages that as well, to be able to feel to say what you're doing and if it's okay or not. And I think my own view of supervision might help that as well because I think that's what it's for; I need to be able to spot those things if I'm doing something wrong. (Dan, 12:4)

In the context of a supportive supervisory relation Dan conveys a feeling of safety and ability to authentically share his clinical practice, in the knowledge that clinical mistakes can occur, and are part of his development as a therapist. His positive experiences of supervision are mirrored by Emily below.

> I really enjoy supervision, I enjoy the guiding, I enjoy the developing of people, I enjoy I suppose helping people to sit back and reflect and trying to help them with a different perspective and also looking at their CBT skills and helping them to develop those. So I like the role. It's different from therapy but similar. It's a bit of a different stance so it gives you a break from therapy as well, and it's still about development, just in a different way. (Emily, 1:17)

From an interpersonal perspective, Emily and Dan demonstrate an open and safe relationship. Asked whether Dan is more open than other supervisees, she replies:

> I feel that people are fairly open with me.. I try to make it okay when they bring something (you know), I (kind of) try to react in a certain way that I hope makes them feel that they can bring the worst to me and I'm not going to judge. (Emily, 16:10)

Emily's conditional positive regard for her supervisees is conveyed. It is *'massively important'* to her (Emily, 16:18) that people feel comfortable to bring everything to supervision. With regards to Dan she reflects:

> He has a lovely personality I feel, so I can't imagine [ruptures in the relationship].

4.5.1.5. Jenny and Liz

Jenny has been supervising Liz for 7 months since she completed her CBT training. Whilst Liz felt prepared on one level, she acknowledged that it was

> a bit of a baptism of fire. I had everything that I needed, but putting it into practice, I found that quite scary (Liz, 1:22).

On the SR, Jenny reflects:

> We often reflect together, what's been useful, what has went well, what has not went well, and she's always well prepared for supervision- there's always a supervision question which is quite interesting to explore. I *think* she feels supported. She has told me on occasions (Jenny, 3:21).

Jenny appears hesitant to state categorically that the relationship is good. From her perspective she evaluates the SR positively and she *thinks* that Liz would agree. She believes that the relationship should be equal in relation to power (Jenny, 5:10). In her supervisor role she recognises her need to be tolerant of uncertainty and sit with the unknown of what people are going to ask (Jenny, 5:25), then coming up with a "*shared answer*". Liz describes a "very positive" relationship:

> I have, at times, felt the need to contact Jenny between supervision[s] to run something past her. Jenny is always very responsive, very on the ball, always

> there. I guess, I feel, for want a better expression, that she's got my back. (Liz, 5:20).

Her repetition of "*very positive"* adds emphasis. She uses metaphor (*on the ball*) to depict a responsive supervisor who is aware of what is happening. Further, she uses the expression *"got my back"* which refers to feeling protected or defended by someone. The statement conveys an impression of a collaborative relationship within which Liz feels supported by Jenny. She acknowledges that, as a trainee there is dependence (Liz, 2.10), which gradually dissipates on qualifying. She recognises her own exponential growth of independence.

> I became a bit more savvy of what really warranted a supervisor and what I should deal with myself or able to deal with myself (Liz, 2:13).

Jenny reflects on her experiences as a supervisor:

> I think I've been fortunate to have good supervisees, but I am pretty straight with people. If I feel there is an issue, then I will tell them…I'll be honest. (Jenny, 7:31).

In reflecting on the relationship in clinical supervision, Jenny acknowledges:

> You can't get on with everyone and I would have no problems with the relationship as long as the person was acting in a safe, professional manner (Jenny, 9.25).

This is in contrast to other supervisory relationships in which members described a strong affiliation (such as Lily and Joe), Jenny and Liz describe a boundaried professional relationship.

The challenges of the role of supervisor are acknowledged particularly in relation having accountability; Jenny conveys her commitment to ensuring that her supervisees have the necessary skills to practice competently, and she acknowledges her accountability for their practice.

> if I'm supervising their practice then I've got some accountability for that too, and if people are doing things that actually I found unsafe I don't know how

> comfortable I would be about taking it further. I would be very comfortable about discussing it with them (Jenny, 9:16).

Whilst Jenny would be comfortable to discuss issues, she would find it difficult elevating the issues and informing the individual.

> I think it would be hard to do because I do tend to be pretty honest. I could do it. I mean I've worked with people who I found it quite difficult to work with, but they would never have known because I would have been professional to them and there would have been nothing to suggest that I felt that way about them. (Jenny, 9:10)

Liz discriminates between being in clinical supervision and being with a colleague:

> There's a job to be done in that room and it's important to me. Supervision is really important to me. And I guess you go out of being colleague a little bit, even though you've still got that really good rapport and things are, I guess, superficially the same, but then you're there for supervision. (Liz, 28:1)

Liz recognises the SR as a professional relationship, devoid of 'banter' which has an important role in her development as a therapist.

> If I feel like it's something that's affecting my practice, like something is blocking something or whatever, then supervision for me is a great way to kind of work that out a little bit. However, if it was something that was clearly a problem then I would go to therapy to work that out. (Liz, 30:4)

There is acknowledgement of the restorative function of supervision to ensure that clinical practice is optimised, however this is distinct from with the need for personal therapy and it is her responsibility to attend to her own needs.

In summing up the SR, Jenny reflects

> I think we have a warm and mutually respectful relationship with Liz. I certainly feel comfortable, and I think she does. We often reflect together.. what's been useful, what went well, what has not so well…I think she feels supported. She has told me on occasions that she feels I've got her back. (Jenny, 3:28)

4.6 Chapter Summary

To summarise the themes, the first is 'Being in the SR' and refers to the phenomenological experience of 'being'. Participants' situatedness in a culturally threatening context often activated negative self-schema around inferiority, unworthiness, and inability. When the SR felt safe and supportive, participants described 'an ease' or compatibility within the relationship but for some participants power dynamics (on the part of both supervisor and supervisee) created a tension that constrained supervision.

The second superordinate theme, 'Playing the part', represents participants' vulnerabilities in the context of the SR and explains how these play out. There is a sense that, for some, pre-existing psychological vulnerabilities were exacerbated within a stressful context of transitioning to a new role (as a qualified therapist or supervisor), and they battled to 'play the part'. The role was 'played out', as opposed to happening in an automatic, authentic manner.

The third superordinate theme, 'Dancing around interpersonally', reflects the dissonance between what was spoken, which did not necessarily reflect the reality of being in role, and what was left unsaid, often to the detriment of the SR. Participants were not always explicitly aware of the dynamic within the SR and the metaphor "*dancing around the elephant in the room"* aptly represents the irony of psychotherapists not attending to what is occurring interpersonally. Whilst participants shared their experiences of non-disclosure within supervision These themes are expanded upon, and related to relevant literature, within the discussion chapter that follows.

CHAPTER 5: DISCUSSION

5.1 Overview of Chapter

In this chapter, I discuss study findings in relation to the research question: *How do IAPT supervisors and supervisees make sense of their experiences of interpersonal processes in the supervisory relationship?* Three superordinate themes were identified: 'Being in the SR', 'Playing the part' and 'Dancing around interpersonally'. A range of pertinent literature will be drawn upon to discuss each theme.

5.1.1 Study aims

- To gain insights into what happens interpersonally within the supervisory relationship;
- To synthesise findings and consider implications for IAPT supervisory practice; and
- To contribute to the body of IAPT clinical supervision research by enhancing knowledge and understanding of IAPT CBT therapists experiences of clinical supervision, thus informing supervision practice and research.

5.1.2 Key findings

The key contribution of this IPA study is the insights into participants' embodied experiences of being in an IAPT supervisory relationship. This has facilitated an understanding of how participants made sense of their experiences. 456 Behaviours and communications that create 'pushes and pulls' (Safran et al. 2000 p.138) were highlighted and provide insight into the lived experiences of the participants and how they perceive their reality. As is the nature of IPA studies, analysis has taken the research into 'unanticipated territory' (Smith et al. 2009) and engagement with theories and literature not previously considered in terms of the SR. This contrasts with descriptive phenomenology that requires the researcher to shed all previous knowledge of a phenomenon in order to understand the lived experience of study subjects (Lopez & Wills 2004). IPA assumes the researcher to have contributory preconceptions and expert knowledge (ibid.), thus interpretative analysis presents the opportunity for the researcher to be more speculative (Larkin et al. 2006).

Consistent with Bhaskar's ontology, and the third domain of reality *the real*, this stage of analysis recognises the existence of generative mechanisms, described by Blom & Morén (2011) as concepts and phenomena that provide explanations. Relevant theories will support discussion and interpretation of the supervisory dyads' experiences and the subtleties of patterns identified. Theories are applied tentatively in order to contextualise the findings and illuminate the experiences of supervisory dyads. Table 5.1. presents superordinate and sub-themes and the theoretical lens drawn upon to support my interpretation of participants' accounts. These colour-coded themes identified through IPA analysis structure the discussion, with the purpose of enhancing understanding of the SR in IAPT. I elaborate on study findings that suggest that self-concept and

one's internal representation of the self plays a significant part in supervisory dyads' experience of being in the supervisory relationship.

5.1.3 Summary of Findings

Superordinate Theme	Subordinate themes	Theoretical lens
Being in the SR	The back stories Comfort versus constraint	Self-concept
Playing the part	Role vulnerability Proving oneself	Belonging Social representation theory IAPT cultures
Dancing around interpersonally	The spoken and the unspoken	Power Interpersonal processes

Table 5.1. Superordinate themes, subordinate themes and theoretical lenses

Three superordinate themes were identified. The first, '*Being in the SR',* relates to participants' embodied experiences, and their cognitive, behavioural and emotional responses to being in an IAPT SR. The second superordinate theme '*Playing the part'* represents participants' vulnerabilities in the context of the SR and explains how these manifested. The third superordinate theme, '*Dancing around interpersonally',* reflects the dissonance between what is spoken, which does not necessarily reflect the reality of being in role, and what was left unsaid, often to the detriment of the SR. Themes are expanded upon and related to extant literature.

5.2 Being in the Supervisory relationship

Superordinate Theme 1.	Subordinate themes
Being in the SR	The back stories Comfort versus constraint

Table 5.2 Superordinate theme 1. and subordinate themes

Supervisors and supervisees reflected on their journey so far, which contextualised their current experiences of being in the supervisory relationship. Past experiences of dysfunctional supervision were implicitly used as a guide on *how not to be a supervisor*. For some participants, a discord was apparent between self-identity (as supervisor or supervisee), and their implicit perception of how they should be. Insights into earlier life experiences provided a greater understanding of participants' current phenomenological experience.

Study findings suggest that for some (such as Liz, 2:10; Dan, 2:26; and Joe, 2:20), the SR was a positive and comfortable environment that provided the milieu for professional growth. However, for others (such as Mia, 6:11; and Michael, 15:13), the SR appeared to be threatening and constraining. Whilst participants considered their supervisory relationships to be positive, study findings suggest that an affiliative relationship alone is not sufficient to ensure positive supervisory experiences. In the context of a "good" SR, there was evidence of avoidant behaviours such as supervisee non-disclosure and supervisors not challenging inappropriate behaviours (such as withholding relevant information from their supervisor). Supervisors and supervisees (Jenny, Lily, Liz and Joe) described previous, dysfunctional SR's but were comfortable in their current relationship. A "good" SR was recognised to influence the experience of clinical supervision, but this alone did not guarantee a functional SR. It seems that a number of variables influence the SR, as discussed below.

5.2.1 Participants' Relationship with Themselves

The study found that therapists who had a healthy relationship with themselves, and who demonstrated awareness and acceptance of their flaws, experienced fewer issues in the supervisory relationship. Issues that arose were managed and, in the main, resolved. I draw on supervisor Emily, who recalled her experience of being criticised by her supervisor as a trainee therapist. Patterns of behaviour and expression of thoughts provide a window into her self-concept:

> I felt shaky, I really internally felt shaky, very shaky…You're not aware of the power, [but] there is a power, the supervisor has a power over the supervisee … and I felt that. I did challenge her on it. (Emily, 5:19)

Emily had a strong negative response to what she perceived to be inappropriate criticism and challenged her supervisor (whilst owning that she had made a clinical error). This contrasts with other participants who experienced issues in the SR that were left unaddressed and impacted the quality of the supervisory relationship and indeed their wellbeing. Cath, though aware that her supervisee had recently sought supervision elsewhere, did not address this. It is notable that, in contrast to Emily who recognised that she had been treated unfairly, Cath interpreted her supervisee's dubious behaviour to mean that her supervisee questioned the extent of her knowledge ("*She thinks I don't know enough about it"* (Cath, 15:26)).

As highlighted in section 4.3.1, themes evident within participant back stories appeared to play out in their current SR. It is noteworthy that neither Michael's current nor previous supervisees discussed supervision-/therapy-related issues. Michael (36:6) stated that he was comfortable challenging his supervisees, by asking "*is this the full story? What's happening*?" However, he did not explicitly address with Mia why she withheld her distress from him. Indeed, Mia described a sense of inferiority in her previous SR; her inability to share her

distress with Michael suggests that this sense of inferiority (Mia, 8:17) impacted her ability to share emotional experiences.

In the main, participants stated that they felt comfortable in their current SR; however, discussion (within the interviews) led to reflection, which in turn seemed to uncover further issues, as was the case with Cath (15:22) who reflected on her supervisees' behaviours. Supervisees and supervisors drew upon previous and current experiences of being in SR. Participants' accounts of feeling judged (Mia, 16:10), criticised (Emily, 5:19), and having their practice scrutinised (Jenny, 12:13), suggest that such emotions in the SR are not uncommon. Some participants who experienced difficulties in their current SR had previously experienced issues (as a supervisor or supervisee). These recurring themes may indicate participants; reluctance to address issues; Michael referred to a rupture in a previous SR when his supervisee had approached a manager to request a change of supervisor (Michael, 26:30), while Mia described a previous SR in which she felt uncomfortable and 'just sat' on issues (Mia, 8:24). In each case, issues were not addressed.

To enhance understanding of participant's experience of being in an IAPT SR, self-concept theory (presented in the post-analysis literature review) is drawn upon to support analytical discussion. In keeping with IPA, data is interpreted with caution and theoretical connections are close to analysis of the interviews, as advocated by Smith et al. (2009). The Multiple Self-Aspects Framework (McConnell 2011) proposes that self-concept is a collection of context-dependent self-aspects, filtering life events and producing invisible context that determines the level of affect produced and the behavioural response. Participants' narratives provided insight into their self-aspects, and for some it is apparent that the way in which they perceive themselves and information relating to the self was not consistent with how they believed they should be.

Supervisee Mia's narrative demonstrates how self-aspects can contribute to participants' self-concept. When discussing her experiences in the SR, she stated, "*I should be able to cope with this"* (Mia, 15:10); "*I don't like to cry in front of anyone"* (16:1); "*there's just that fear you're going to be judged"* (16:10), and "*I should be able to get on with this and work with these complex cases and I couldn't*" (16:30). On the same theme, Michael alluded to the belief that he should be a better-than-average supervisor (11:17). Other implicit beliefs were apparent; his statement that "*there's always the mild anxiety*" (11:8), "*but it's not a real fear*" (11:10) suggested that he held a belief that he shouldn't be anxious. He stated that there needed to be something special in his therapy recording for him to share it with his supervisees (11:18), which suggests that he had doubts about the standard of his work.

One's developmental experiences are influenced by a myriad of environmental, cultural, and biological factors (Corte & Szalacha 2010), leading to the formation of self-schemas, which Linehan (2018) posits mediate a behavioural response. Cath connected her experiences of being criticised excessively as a child with her urge to be knowledgeable in order to avoid criticism (Cath, 3:22), but did not relate this to her automatic cognition ("*She* [her supervisee] *thinks I don't know enough"* (Cath, 15:26), which reflects her *need-to-know* schema. This can be understood in relation to Pilarska (2017), who found that those without a clearly defined sense of self are more likely to seek validation externally. Cath and Michael appear to use knowledge to self-validate; however, this doesn't have the desired effect for either and their concern about not knowing enough remains. Cath's poor SCC is evident later in the interview when she states, "*I don't at all feel under pressure to know everything"* (5:7), which is clearly at odds with what she said earlier (Cath, 4:20).

Evidence of participants comparing themselves negatively to others is scattered throughout the interviews (e.g., Michael, 15:20; Mia, 8:17), which impacted their experience of being in the SR. This reflects the findings of studies presented within Chapter 2 (section 2.9), which found that those less confident in their own judgements and opinions engage more in social comparisons (e.g. Gibbons & McCoy 1991; Butzer & Kuiper 2006). Studies suggest that SCC can moderate how an individual perceives self-relevant feedback by acting as a buffer and therefore either maintaining self-esteem or confirming negative self-beliefs. Consistent with literature discussed in Chapter 2 (Guerettaz & Arkin 2015; Campbell 1990; Swann et al. 2007), participants with SCC resisted feedback that didn't fit with their belief whilst behaving in a self-consistent and stable way (as apparent in Emily's case). Similarly, supervisee Kate acknowledged that she "*skate[d] across information"* (Kate, 16:3) and sought supervision elsewhere, which could be interpreted as an attempt to avoid feedback with which she disagreed. In contrast, Cath interpreted events self-negatively in accordance with her self-schema and, because she didn't challenge Kate, her automatic thought wasn't disproved.

The benefits of Self Concept Clarity (SCC) are likely to reflect the ease and level of fulfilment of the SR (Parise et al. 2019, discussed in Chapter 2) and an enhanced ability to problem-solve (Bechtoldt et al. 2010), hence a greater ability to address issues in the SR. Given the evaluative nature of working within IAPT and the pressure on individual therapists to meet targets, exploration of the influence of self-concept on interpersonal processes in the SR is an area worthy of research.

Schema models such as Young, Klosko & Weishaar (2003) identify self-concept as a potentially modifiable psychosocial factor thus supporting an argument for consideration of self-concept within clinical supervision. Apparent

from this study is that, when patterns of behaviours relating to a compromised self-concept were attended to within the context of a positive and trusting SR, this was acknowledged as a pivotal juncture, as stated by Joe:

> It's… the thing I've been most uncomfortable about in supervision [that] is probably the thing I value the most about it now. (Joe, 20:15)

The literature suggests that self-concept has not previously been studied in relation to clinical supervision. Findings from this study echo general studies, which indicate that some participants inextricably related their worthiness to idiosyncratic personal qualities in an absolute way, on which their self-concept depended. Those with poor SCC are more likely to have difficulty receiving critical feedback and may rely on external validation to feel good about themselves (see Guerrttaz & Arkin 2015). Participants' self-consciousness seemed to contribute to behaviours such as avoidance, with supervisors less likely to address supervisees' avoidant behaviours and indeed be less attentive to the emotional experiences of the supervisee.

It seems that Cath assumed that her supervisee has discounted her advice and she did not challenge this. Michael did not notice that supervisee Mia was having emotional difficulties, and when this came to light, he does not address why she had not disclosed those difficulties to him. An explanation for this may lie in supervisor's self-schema detracting from their awareness of supervisee behaviours, such as avoidance or emotional upset (as was the case in this study). Furthermore, supervisors with poor SCC may interpret supervisee behaviours based on their own concept of self and so fail to address issues with their supervisee (as seen in the case of Cath). Michael reflects on a problematic SR with a previous supervisee:

> It wasn't an enjoyable process, to be honest. It was absolutely fine for a long time and then something shifted and there was misinterpretation as to what I was kind of putting forward and it became quite uncomfortable, and I would not look forward to it. (Michael, 26:29)

Whilst Michael clearly conveys the awfulness of the situation, he gives a vague account of the rupture. His experience can be related to Glover & Philbin's (2017) IPA study, which highlighted supervisor's sense of responsibility, for which the metaphor "Leaping in" symbolises anxious supervisors' behaviours, whilst "Leaping ahead" represents the use of relational approaches to address issues in the SR. It is possible that Michael, who acknowledged his own lack of confidence (35:30; 15:13; 7:2), was "leaping in" and behaving in an inauthentic way, hoping to mask his anxiety. In turn, his [previous] supervisee lost confidence in him.

5.3 Playing the Part

Superordinate Theme 2.	Subordinate themes
Playing the Part	Role vulnerability Proving oneself

Table 5.3 Superordinate theme 2. and subordinate themes

How the participants evaluated CS and their SR was, on occasion, at odds with their behaviour. As discussed in Chapter 4, in the context of positively evaluated SRs, emotional distress and vulnerability were hidden (e.g., Mia, 13:18) and non-disclosure was common and often unaddressed, despite being recognised by supervisors (e.g., Cath, 15:26). This was unexpected. Participants referred to non-disclosure nonchalantly and in doing so, normalised this within the culture of IAPT. I draw on theories relating to organisational culture to explore this further.

5.3.1 Cultures within IAPT

Culture is defined as a collection of shared practices and beliefs that define a group of people (May 2013). Theories relating to cultures (post-analysis literature review) provide insights into implicit cultures, the impact of which was apparent across the superordinate and subordinate themes. There was evidence of participants' critical self-evaluation and negative comparison of oneself to others, manifested as a tacit unease about knowing "enough" and being "good enough", as highlighted in the superordinate theme '*Playing the Part*'. Such anxieties impacted upon behaviours, with participants (Cath, 1:25; Joe, 9:7) acknowledging that they tried to '*prove*' their worth by projecting themselves as knowledgeable. Exploration of IAPT culture contextualises the phenomenon of professional self-doubt and illuminates how this played out interpersonally in the SR.

Those working within IAPT are subject to much appraisal. Compulsory IAPT Minimum Data sets (MDS) provide session-by-session measures of patients' mental states (DOH 2016), whilst monitoring both IAPT services and (by proxy), therapists' ability to move the patient towards recovery. IAPT services are monitored to ensure that the minimum required 50% target is achieved. Thus there is pressure on both the IAPT service and individual therapists. The Organisational Culture framework (Mannion & Davies 2018, presented within the post-analysis literature review) enables a nuanced perspective of cultures within IAPT and analysis of how this impacted the supervisory dyads. This *visible manifestation of (IAPT) culture* adds a previously absent market force into the provision of NHS psychological therapies and represents the first of three levels of the framework. Participants were immersed in a world in which Key Performance Indicators, 'Movement to recovery' and targets were the currency.

Whilst it may seem that therapists had autonomy, they were closely monitored through the use of metrics, and inherent in the IAPT model is that is

that patient psychometric scores are used as an indication of therapists' performance. It seems that the participants were immersed in a culture of being evaluated through measure and in turn they self-evaluated, often critically. Indeed, Mia (14:9) referred to being "*thrown into the deep end"* on completing her training and being concerned that she was "*going to get sacked*" when she experienced symptoms of vicarious trauma. Supervisee Liz recognised the need to "*be a bit savvier"* regarding which clients to discuss in CS (2:13). The need to tolerate the uncertainty around what issues supervisees would bring to supervision was identified by Jenny (5:24), while Lily reflected on her dual clinical leader/supervisor role in the context of IAPT being driven by performance (3:30) and placing excessive demands on therapists, who become "*stressed by these demands they have in the service … so they're not willing to give as much in the supervision room"* (Lily, 4:10).

Therapeutic and supervisory relationships are recognised as fundamental to CBT and CS, as reflected in competency frameworks such as the Manual of Revised Cognitive Therapy Scale (James et al. 2001) and Supervision Adherence & Guidance Evaluation (SAGE) (Milne & Reiser 2011). Thus, therapists are attuned to building a rapport. The professional identity of a CBT therapist centres on sound interpersonal skills and the ability to develop positive relationships. It seems that participants were so invested in maintaining positive SRs that they engaged interpersonally on a less profound level and presented a 'safe' version of the self. The desire to maintain the status quo of the supervisory relationship, took precedence over maximising supervision outcomes. Analysis of supervisor and supervisee transcripts points to a culture of non-disclosure and, indeed, supervisors' failure to address non-disclosure.

Cath's reluctance to address issues with her supervisee (Cath, 14:9) can be understood as an attempt to preserve the SR and avoid a relationship rupture

that could reflect negatively on her. She stated emphatically that difficulties encountered in a (previous) SR were "not *personality related"* (Cath, 10:23). Similarly, Michael (26:8) conveyed a sense of shame and described being "a little bit rattled" (27:28), when a previous supervisee requested a change of supervisor. Participants seemed mindful of the negative connotations of relationship breakdowns, the implications of which are reflected in the third superordinate theme and will be expanded upon in Section 5.5.4.

Non-disclosure was used to hide perceived shortcomings, as was the case for Mia, who tried to supress her emotional issues (Mia 22:10). This reflects findings from a study by Foskett & Van Vliet (2020), which suggests that non-disclosure can relate to performance anxiety. It seems that non-disclosure in the SR was the norm rather than the exception, evidenced by supervisees' nonchalance in sharing nondisclosure in interview. Furthermore, supervisors' failure to address such nondisclosures manifested as a resigned acceptance. This is in keeping with literature on non-disclosure in supervision (Murr, Nicklas & Harper 2020; Ladany et al. 1996; Mehr et al. 2010), which highlights the frequency of non-disclosure. Whilst Sweeny & Cremer (2014) conceptualised non-disclosure as a symptom of relational issues, within this study it seems that participants did not disclose in order to *preserve* the SR.

Shared beliefs and values reflect the second level of Mannion & Davies's (2018) OC framework and participants agreeing to take part in this study was testament to their commitment to informing CS research and practice. Whilst participants supported the role of CS, this seemed to be on their terms, as evidenced by supervisee non-disclosure and supervisors condoning this. It appears that despite being monitored within IAPT, supervisees subtly exerted control over what they disclosed within supervision. This dynamic reflects the third level of the OC framework, which recognises everyday practices that can be

conscious or unconscious. It appears that the practice of withholding information in supervision is so entrenched that it is normalised, as evidenced by the ease with which participants referred to non-disclosure in this study. It seems that clinical supervision was much on supervisees' terms.

This is concerning given the complexity of people treated within IAPT and the high risk of burnout (Westwood et al. 2017). Moreover, Wakefield et al. (2020) assert that movement to recovery is more challenging for those with complex presentations. It is notable that Mia worked in a particularly deprived area and spoke of seeing several patients with sexual trauma in quick succession. She reflected later that her concern at being judged (Mia, 14:9) prevented her seeking support. The effect of working in IAPT has not been fully explored (Mason & Reeves 2018). Recovery targets run the risk of creating a punitive culture whereby therapists are evaluated (and indeed self-evaluate, as was apparent in this study) based on data that doesn't reflect the complexity of their patients. This paradox is recognised by supervisor Lily:

> If you're being told as a therapist by a manager 'Let's get them [patients] in and get them out [treated and discharged as quickly as possible], and then you have supervision with them [supervisees], they're not really willing … they see it as me being tokenistic (possibly) with them [thinking] ... *"you're not bothered anyway so why should I?*" (Lily, 4:17)

It seems that Lily acknowledges that patients and therapists are being objectified within the IAPT business model. She highlights the tension between her role as supervisor this supporting supervisees and her role as senior therapist with management responsibility to ensure that key performance indicators are met.

5.3.2 Career progression within IAPT

I return to Mannion & Davies's (2018) OC framework to make sense of career progression within IAPT and how this appeared to play out within the SR. A specific route of career progression is evident, despite this not being an intended career pathway within the IAPT model. A sizable proportion of therapists do not have a 'core profession' (such as Social Work/Mental Health Nursing), and access Psychological Wellbeing Practitioners (PWP) training to provide 'low intensity' wellbeing interventions that form part of the IAPT model, following which they access High Intensity CBT training (Clark 2020). PWP entry requirements are broad, with 'life experience' sufficient to apply for a trainee PWP position, whilst experience of working with people with mental health problems is desirable (https://www.healthcareers.nhs.uk/ accessed 18 June 2021). PWPs can the apply for HIT training two years post-PWP training. Consequently, a high proportion of High Intensity Therapists have a PWP background, with many lacking a core profession. The original IAPT model intended that trainee HITs would come from a range of core professions and indeed the 2015 IAPT workforce consensus report (NHSE & HEE 2016 p.18) states:

> High intensity interventions are usually delivered by therapists who will have received several years of specific training and supervision in a particular therapeutic approach and will usually have been trained in a recognised health care professional role (e.g., counsellor, nurse, psychologist, psychiatrist, social workers etc.) and may be registered with an appropriate professional body (e.g., BABCP, BACP, UKCP).

The recent drive by the National IAPT team to recruit people with core professions may contribute to some participants having difficulty disclosing issues and feeling the need to project themselves as knowledgeable. There is some justification for this move, however: an observational naturalistic study by Clark et al. (2018) compared the progress of trainee therapists with and without core professions on a specific training course between 2008 and 2015 using the

revised Cognitive Therapy Scale (CTS-R Blackburn et al. 2001), General Anxiety Disorder-7 (GAD-7; Spitzer et al. 2006) and Patient Health Questionnaire (PHQ 9; Kroenke et al. 2001) to assess trainee therapy skills at the beginning, middle and end of IAPT CBT training. It was found that those without a core profession required greater support to pass the course and reach a recognised level of competence as HI therapists. However, those with core professions who embark on CBT training need to challenge previous learning, and move from conscious competence to conscious incompetence, which can delay learning (Wilcockson 2018; 2020).

With IAPT services under pressure to expand access by 2024 (NHS England 2019), and an increasing workforce of therapists without a core profession, there is a danger that trainee and recently qualified therapists may not receive the required support, compromising their learning and development, as was evident in this study:

> all of a sudden it was five days a week, five clients a day, very complex clients, I just burnt out to be honest. (Mia, 20:8).

Mia's account highlights the impact of insufficient support for recently qualified therapists. Support was available but she didn't feel able to access it. Her level of distress may have impacted her ability to conceptualise her psychological symptoms. Whilst non-disclosure is not unique to those from a PWP background, the findings of Clark et al. (2019) suggest that developmental and supportive supervision is vitally important for this group.

5.3.3 Social Representations and the Supervisory Relationship

Social representations theory (presented in Chapter 3) concerns how a cultural phenomenon enters everyday life and, for some, becomes 'common sense' (Bauer & Gaskell 2008). Here the framework is used to provide insight into how supervisors and supervisees have adapted to the introduction and integration of IAPT. The focus is firstly on how supervisors and supervisees navigate their role within a milieu of performance management, high caseloads and treating people with complex difficulties, and secondly their role within CS.

There are suggestions that IAPT has been built on a skewed evidence base (Williams 2015; Gilbert 2009; Keller et al. 2000), yet the scientific practice that defines IAPT has rapidly expanded, which in turn has led to an increase in the quantity of therapists trained in CBT, and thus the number of people treated within IAPT. This resonates with Bauer & Gaskell's (2008) description of the challenge of finding a '*middle ground between the Scylla of debunking vulgar distortions and the Charybdis of diffusion, of research'* (p.335) to depict the perils of the interpretation and integration of research findings into practice. Representations are generated by people's desire to know the world, thus making the unfamiliar familiar (Moscovici 2008), but, as they are based on a constructed reality, do not represent the whole of reality (Jovchelovitch (2001).

Analysis using SRT comprises consideration of characteristics of communication systems relating to IAPT therapists, including content, processes, consequences and subsequent segmentation of social groups. This provides insight into participants' behaviours, cognitions, formal and informal communication. How IAPT is represented within society and how it has influenced society's response to psychological difficulties is apparent in the growing numbers of people accessing IAPT services (Liness et al. 2019; Saunders et al. 2020). However, as highlighted by Hepgul (2016), a third of referrals have

previously had treatment within IAPT, suggesting that sustained recovery is not achieved, possibly due to the complexity of the psychological difficulties. IAPT CBT clinical supervision has been developed to support therapists treating patients with moderate mental health problems, yet complexity, trauma and personality issues are the norm, and it is questionable whether IAPT High Intensity training, or indeed supervision training, reflects this.

Patients seen within IAPT are more complex than was initially intended (Hepgul et al. 2016; Lamph et al. 2021; Wakefield et al. 2020), yet the provision of CS has not changed. CS of complex clients is likely to require more discussion and instruction and therefore a greater allocation of time. Further, supervisors require the skills to work with axis 2 patients. Given that a high percentage of IAPT therapist do not have a core profession, and new supervisors are drawn from these practitioners, it is questionable that all clinical supervisors are sufficiently equipped to support supervisees. Standard CBT assumes that patients can change their problematic thoughts or behaviours, yet Young et al. (2003) argue that distorted thoughts and self-defeating behaviours associated with personality disorders require schema therapy. On this theme, Linehan (1993; 2018) has developed Dialectical Behavioural Therapy (DBT), a treatment programme for personality disorder. Whilst it is based on CBT principles, DBT has a number of distinctive defining characteristics to treat personality disorder.

This may account for failures to meet the required 50% recovery target (NHS Digital 2019). This '*failure*' to assist patients to reach '*recovery*' may be construed negatively by the individual therapists. Indeed, participants' concern with performance was evident within interviews, and when Mia was supported to undertake additional training, she found this upsetting rather than supportive (Mia, 14:13). Missing the required 50% recovery target can implicate IAPT

services and deficits in therapist recovery rates are addressed as part of case management supervision. This is likely to influence therapists' self-concept.

5.3.4 Social representations and IAPT supervision

As discussed in Chapter 4, social representations are a system of values, ideas and practices that serve to make the unfamiliar familiar (Moscovici 1984). Participants' appreciation of the centrality of clinical supervision was evident, as reflected in the review of supervision literature. Clinical supervision is recognised as central to the IAPT High Intensity training curriculum (Hool 2010) with trainees receiving regular clinical supervision from suitable supervisors. Paradoxically, in the context of positively evaluated supervisory relationships, non-disclosure and withholding of relevant information was commonplace, suggesting that a *"good"* relationship may not be sufficient to ensure openness. This is consistent with studies of non-disclosure, reported to be as high as 84.3% (Mehr et al. 2010).

It appears that, on a professional level, participants were socialised to acknowledging the importance of clinical supervision and did value the supervisory relationship. At the same time, a culture of superficial engagement in clinical supervision was apparent. This reflects the work of Tateo & Iannaccone (2012), who shed light on the marrying of knowledge and culture. They propose that social life is the context within which individuals learn to critique the world, thus broadening knowledge through an ongoing cyclical process. Firstly, a culture of development occurs through the appearance of "genius" or scientific knowledge, and through turning experiences of the world into discoveries (p.59). Next, social practices become more detached from academic debates, and address fundamental issues. We see evidence of this dilution of evidence-based clinical supervision within the study, with supervisee non-disclosure a regular occurrence and clinical decisions that contradict supervisor's advice (e.g., Joe, 13:12; Kate, 15:30). Supervisors meanwhile chose the path of least resistance

(e.g., Lily, 7:20). A desire for therapeutic creativity may account for supervisee Kate bypassing her supervisor Cath's advice, leaving Cath to conclude "*I'm not giving her what she wants to hear"* (Cath, 15:30), feeding her implicit insecurities as a supervisor.

Supervisees' lack of clarity on the parameters of confidentiality within supervision contributed to supervisees playing it safe, as highlighted by Dan who reflected that confidentiality would be essential for him to disclose within supervision: "*Trustworthy I guess would be a big one, that it would remain within limits*" (Dan, 11:12). Participants' non-disclosure as a consequence of ambiguity relating to confidentiality was apparent (e.g., Mia, 20:24; Dan, 11:12). Furthermore, it was evident that supervisors were reluctant to challenge significant supervisee non-disclosure; Cath did not ask why Kate bypassed her to seek advice elsewhere (15:30) and Michael did not address Mia's failure to disclosure distressing psychological symptoms to him.

Social representations bring together the scientific world and the consensual world of clinical supervision, which illuminates the dichotomy between the scientific notion of clinical supervision, reliant on supervisees providing a transparent account of clinical practice, and the shared '*real life'* version, as highlighted in the literature review and as was apparent in this study. This is consistent with Jovchelovitch's (2001) view of social representations developing over time, meeting other representations and changing. It is evident that IAPT supervisors and supervisees found ways of navigating IAPT supervision, cognisant with their values, ideas and practice, as proposed by Gelo et al. (2016). It seems that much is left unsaid and interpersonal dynamics can remain unaddressed. Whilst study participants proclaimed the importance of clinical supervision and the supervisory relationship, they had found means of negotiating this to suit them.

Inskipp & Proctor's functions of supervision model (2001) refers to clinical supervisors' roles as formative (relating to the learning and development of the supervisee), normative (relating to managerial and ethical responsibilities), and restorative (relating to the emotional effects of working with people with emotional problems). In this study, participants' behaviours suggest that supervisors' normative role may compromise supervisees' ability to safely disclose, thus limiting supervisees' ability to reach out. Whilst supervisees verbalised concerns about confidentiality, supervisors were aware of supervisee non-disclosure. It seems that, in the quest to maintain status quo, participants tolerated discomfort. A consequence of this is that clinical supervision becomes less authentic, with supervisors turning a blind eye to non-disclosure, which in turn impedes supervisee development and wellbeing. This theme is elaborated upon through the lens of belonging theory below.

5.3.5 The importance of belonging

Traditionally in healthcare, professions come together, each with a unique identity. Mental health nurses and social workers have flourished within a multidisciplinary setting (DeMatteo & Reeves 2013), providing a context for each professional to promote their own identity within the team, thus enhancing cohesion. IAPT therapists, in contrast, often work remotely and independently, and the Covid 19 pandemic has transformed working practices, further reducing physical co-presence with others. IAPT is relatively new yet has been in a near-constant state of flux since its inauguration. The historical figurehead within mental health services of ward sister (or equivalent) has been replaced by (often several) clinical leads and whilst the IAPT therapist works autonomously, their performance is closely monitored. Participants expressed doubts about themselves and their place in the profession. Difficulty being authentic was

represented in the sub-theme *"playing the part"* and participants were preoccupied with how they believed they should be, in terms of appearance Michael (35:30), level of knowledge (Cath, 2:17; Michael, 15:13) and behaviour (Mia, 6:6). Theories relating to belonging, presented in Chapter 2, offer a window into the dynamic and complex nature of participation (May 2012) and provide justification for promoting shared representations amongst the IAPT community.

The work of Miller (2003) explains some participants' difficulties in being authentic and feeling a need to 'prove themselves' through being knowledgeable or being passive. Miller (2003) refers to Kierkegaard's notion of *'correct relation*' (see post-analysis literature review), which represents a mode of being perfectly integrated in oneself, having the ability to self-synthesise and consequently know oneself. *Correct relation* reflects the ability to present the self in a true and authentic way. Such perfect integration was not apparent for all participants, with some describing difficulties in the SR (such as opening up emotionally). Their difficulties in being authentic were evident within the interviews.

The relevance of belonging is illustrated in Grobecker's (2016) study of nursing students and sense of belonging, which suggests that a sense of belonging has a positive influence on student learning. The significance of belonging to the hermeneutical experience and conscious participation in the world is highlighted by Palmer (1969). Absence of sense of belonging, however, predicts emotional exhaustion (Skaalvic & Staalvic 2011). Application of *belonging* theories to the context of the SR in IAPT suggests that, for therapists to fully engage in CS, an inherent understanding of workplace cultures (such as debriefing following a difficult therapy session or sharing an experience of *not knowing* in clinical supervision) is required. Being connected socially is associated by the internalisation of the goals and motivations of others (Walton et al. 2012). Furthermore, May (2013) proposes that one's sense of self can be understood

through the concept of belonging. We see evidence of this in participants' narratives. Whilst Mia interpreted her symptoms of vicarious trauma as shameful (Mia, 15:7) and didn't discuss her distress in the SR, Kate normalised her reaction and sought support immediately (Kate, 20:30). The benefits of social learning are apparent in Kate's internalised knowledge of, and response to, vicarious trauma, which contrasted markedly to Mia's. Indeed, studies suggest that socio-cognitive interventions (such as team discussion and checking wellbeing) has a lasting positive impact on health (Marksteiner et al. 2019).

It is conceivable that IAPT therapists may attain a greater awareness of cultures within the organisation through an enhanced sense of belonging (see Chapter 6). Study participants' difficulties in being authentic and assertive within supervision can be related to *Belonging Uncertainty* as highlighted in Walton and Cohen's (2007 p.82) psychological intervention study, which found that in domains of achievement, such as academic and professional settings, people are more sensitive to a sense of not fitting in, and this can be more pronounced for socially stigmatised groups. Their study within an academic setting underscores the importance of normalising the experience of having doubts about belonging and considering the nature of social inequality. This is consistent with findings of this study that suggest the experience of being in the SR and the expectation of sharing one's practice or challenging the practice of others within a power relationship, was comfortable for some, yet highly challenging for others.

5.4 Dancing around Interpersonally

Superordinate Theme 3.	Subordinate theme
Dancing around interpersonally	The spoken & The unspoken

Table 5.4 Superordinate theme 3 and subordinate theme

The third superordinate theme 'Dancing around interpersonally' reflects the dissonance between what was spoken and what was left unsaid, often to the detriment of the SR and in some cases, therapist wellbeing. Some participants were not conscious of this dynamic within a SR, which they evaluated positively. The metaphor "*dancing around"* was used by Liz (22:12), to depict avoidance of issues that manifests in the SR and are not addressed. Whilst study participants shared their experiences of non-disclosure within supervision, known non-disclosures within the supervisory dyad were not addressed. The theme reflects the complicated nature of the SR: although participants appeared invested in the SR, much went undiscussed. To explore this final theme, findings are discussed within the broader theoretical frame of power below.

5.4.1 Power within the IAPT Supervisory Relationship

Power dynamics are a ubiquitous feature of human interaction (Sluga 2011), and supervisors and supervisees' experiences of power in the SR relationship are referred to in the 'Findings' chapter under the sub-theme 'The spoken and the unspoken' (section 4.4.1). Power differentials within the supervisory relationship cannot be denied (Corrie & Lane 2015; Koocher, Shafranke & Falender 2008) but the traditional depiction of power in which the supervisor holds power over the supervisee was not found in this study. Conversely, some supervisors seemed reluctant to acknowledge or use the power inherent in their role. More common was a subtle power that, in the main, was exercised by some supervisees and evident in the withholding of information. Recently qualified supervisees made

decisions independent of their clinical supervisors, which often went unchallenged. It seemed that clinical supervisors implicitly prioritised the SR over their normative role and consequently supervisees held an unspoken power.

Evident across the participants was a power associated with the unspoken as much as the spoken. There was a sense that, superficially supervisors and supervisees operated as normal within their supervision, and although discomfort and indeed distress were felt, this was not discussed. Supervisees had the power to '*skate across information'* (Lily, 16:1) and although noted by supervisors, 'the six-foot monkey' (Cath, 15:27) was not talked about. This metaphor represents a dynamic whereby the supervisor/supervisee was aware of an issue in the supervisory dyad but did not address this.

5.4.2 'Responsibilisation' and IAPT

As advocated by Foucault, what follows is a systemic analysis of power within IAPT in order to understand supervisor and supervisees' position within an organisation that is under the realm of IAPT and indeed the Government. I contend that 'responsibilisation' at a governmental level impacts IAPT and in turn, IAPT supervisors and supervisees.

The development of IAPT, ostensibly to reduce the financial burden of sickness benefits and increase tax revenue through helping people to return to work (LSE 2006), can be related to Foucault's (1996) notion of biopower. Described as a Government's ability to disperse power through society, biopower is characterised by 'strategic games' in which people try to control others (Lemke 2011). We see evidence that, over the last decade, IAPT has influenced the general public's needs, attitudes and behaviours towards mental illness. In contrast to the traditional view of power, biopower does not necessarily remove options and can be instrumental in empowering subjects through

'*responsibilisation*' (Lemke 2011), a process whereby people are rendered individually responsible for a task that was previously the responsibility of another (Juhila, Raitakari & Hansen 2017), typically the state.

Responsibilisation is apparent in the IAPT model which promotes individual responsibility for their own mental health, by firstly self-referring and thereafter, promoting active patient involvement in the therapy and recovery experience. The move to reduce the numbers of people on sickness benefits has inadvertently shifted responsibility for the mental health of the nation from the government to IAPT services and, in turn, IAPT therapists and supervisors. Consistent with some participants' experiences (Lily, 3:20; Mia, 20:8), and reflected in the subordinate theme *Comfort versus Constraint,* the '*success*' of IAPT has led to high volumes of referrals, thus high caseloads for IAPT therapists and pressure on therapists to get patients to recovery as quickly as possible.

However, just 50% of people in treatment reach recovery (Hepgul et al. 2016). The *'failure'* to reach recovery forms part of therapists' self-representation, which in turn may influence the climate of clinical supervision and how the individual is measured within the service (as a therapist). This study has uncovered IAPT therapists' propensity to internalise perceived failure, which Foucauldian analysis would suggest is symptomatic of biopower. IAPT recovery targets do not account for patients' level of severity or therapist stage of development and as highlighted previously, those treated within IAPT have more complex presentations than originally intended when IAPT was set up.

5.4.3 Unequal gaze

Just as power is used '*to drive'* people '*to conduct*' themselves (Foucault 1982 p.789), within IAPT, a top-heavy hierarchy enables the level of observation required to ensure that set targets are being achieved. This reflects Foucault's notion of 'Unequal Gaze' (1977) drawn from Jeremy Bentham's concept of a panopticon prison, which Foucault uses as a metaphor to depict disciplinary power. Traditionally the panopticon represented a means to enable observation of prisoners from *'a central point that would be both the source of light illuminating everything and a locus of convergence for everything that must be known'* (Foucault 1977 p.173). The shining light in the panoptic prison served as a constant reminder that vast numbers of prisoners, who remained separate from one another, were under surveillance. Within IAPT, panoptic observation of clinical practice comes in the form of Minimum Data Sets (MDS) which measure patient progress and therapist performance. The awareness of being observed through quantitative monitoring of clinical activity thus forms '*a policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviour*' (Foucault 1977 p.138). Consequently, therapists are inducted to conform to a distinctive working model that emphasises the '*dominant knowledge'* of IAPT and science. Such '*architecture*' or structuring of services is conducive to increasing workforce productivity (Foucault 1979 p.146). Disciplinary power emphasises power differentials, with the assumption that being observed leads to conformity and thus the creation of *'docile bodies'* that are easier to manage, and *'may be subjected, used transformed and improved'* (Foucault 1977 p.138).

The notion of Foucauldian 'gaze' can be related to supervisors and supervisees subject to surveillance within the IAPT service, which in turn is answerable to the commissioners who dictate service targets. A performance

management model promotes the creation of norms in respect of KPIs, which become targets for therapists, thus standardising practices (Lilja & Vinthagen 2014), which Foucault (1977) argues subtly dictates behaviour to the extent that we are unaware. The "normalizing gaze" is a mode of power that imposes self-regulation (Hancock 2018): to conform to accepted norms, the therapists turn the gaze in on themselves.

We see evidence of this in participants' propensity to compare themselves negatively to others and one participant described feeling 'almost inferior' (Mia, 8:17) in her supervision and feared being judged as not being up to doing her job (16:11). This dynamic was more complex for supervisors, who, on the one hand, were subjected to a normalising gaze in their therapist role, but as supervisors were under the surveillance of supervisees (Lily, 4:13). This gaze appeared to shape supervisor behaviours in order to preserve the SR, and perhaps the referent power that comes with being respected or perceived as interpersonally attractive (Holloway 1995). Supervisee digressions from IAPT protocols and their dismissal of advice given by supervisors (as supervisor Cath experienced, 14:29), went unchallenged. Supervisor Michael described '*the mild anxiety*' (11:9) and '*not a real fear*' (11:10) of supervisees seeing his standard practice. He would prefer that there was '*something special …. they took away*' (11:18). This can be related to Foucault's notion of power-knowledge and the pressure that participants felt to be sufficiently knowledgeable. Supervisor Cath recognised this in herself (1:25) and concerns about not knowing 'enough' were scattered throughout the participant interviews.

5.4.4 Medicalisation of misery

In contextualising power-knowledge in IAPT and how this can play out for IAPT therapists (and ultimately the SR), I draw on the concept of medicalisation. Defined by Conrad (1992) as the act of '*defining a problem in medical terms …. or using a medical intervention to 'treat' it*' (p.211), orthodox critique centres on the limited efficacy of support medical interventions and highlights the iatrogenic consequences of many medical interventions, such as medication and surgery (Illich 1975). Those who see illness as socially constructed (such as Barbee et al. 2018; Herman 1995) point at how social pathologies increasingly receive medical diagnoses (Nye 2003) and the increasing medicalisation of new knowledge (Conrad & Leiter 2004). Subsequently, people have less autonomy with regards to their own health and are constrained by those in the medical profession and the power inherent in that role (Fitzpatrick & River 2018).

Such a critique is apparent within Foucault's *The Birth of the Clinic* (1976) in which he outlines the growth of medical knowledge whereby human states become defined as medical problems and subsequently require medical intervention (Hahn 1975). This double emphasis on medicine and the medical profession, strengthens the power to develop and apply medical categories that then become internalised (Hancock 2018). Furthermore, medical discourse supports the rich and powerful, whilst oppressed groups such as women, those with mental illness and the poor, are unheard (Nye 2001). Medicalisation is fuelled by factors such as consumerism, and the growth of people's knowledge of medical care and what is available (Timmermans & Oh 2010).

Apparent in recent years is that conditions previously viewed as 'normal' such as shyness and insomnia are being medicalised (Barbee et al. 2018). Whilst highly beneficial for some, such as the private healthcare and pharmaceutical industry, this can lead to individuals redefining themselves as abnormal. The

proliferation of medicalisation within mental health care has been highlighted by Bentall & Pilgram (1999 p.261) who aptly refer to '*the medicalisation of misery*'. Consequently, a growing market for treating distress is evident, and Hancock (2018) argues that we are '*socialised into our subjectivity*' (p.444). Power-knowledge in IAPT has a normalising system, in which medical diagnostic classifications are used that support medicalisation. The IAPT therapist makes such judgements, and clinical supervision provides the context for ensuring that patient distress is correctly (medically) categorised and treated.

Such medicalisation can be related to Foucault's observation that medical discourse is instrumental in constructing the body (Nye 2003). His notion of the 'medical gaze' depicts power inherent in the role of the medic to identify what is believed to be present. This can be related to IAPT therapists, immersed in a world in which they apply 'clinical gaze' reflecting IAPT '*knowledge*' and MDS are used to decipher 'caseness' and 'wellness'. Standardised assessment and treatment are informed by diagnostic classifications; furthermore, IAPT High Intensity Therapist training is standardised to fit this model. MDS provide a framework for measuring the level of distress and pathology, but this is based on reported (and not observed) symptoms.

Thus, the therapist gaze is much filtered by what is considered 'knowledge' within IAPT. With much weight on reported symptoms, Conrad (2007) argues that human states are defined in medical terms and treated accordingly. Therapists' previously learnt knowledge and skills in assessing patients (in their core profession) may no longer be valid. Also evident is that presentations that previously may have been construed as normal (such as anxiety) are now 'treated', albeit with low-level interventions.

5.4.5 The Machine

IAPT as a model has been hugely successful in providing a framework that manages the medicalisation of emotional distress, as is apparent in the exponential growth of referrals and referral pathways, reflecting the ballooning of research into areas previously neglected, such as long-term and medically unexplained conditions. In order to meet IAPT targets, therapists are under pressure to treat and discharge patients quicker and to "*get them [patients] in and get them out*", which, as supervisor Lily identifies, can lead to supervisees perceiving supervision as tokenistic (Lily, 4:19). The deleterious impact of the fast pace of IAPT is evident in this study, with two of the five recently qualified therapists (Mia & Kate) experiencing vicarious trauma. That her distress was not identified by her supervisor and was identified by her manager only when she became visibly upset, may be a consequence of the fast pace within IAPT. Whilst study participants conveyed that they felt well supported, emotions of shame, sadness and anxiety were apparent within their accounts of being in the supervisory relationship.

It seems that, whilst therapist distress and the need for restorative clinical supervision is recognised, this does not always extend to the supervisor explicitly checking supervisee wellbeing. Mia was supported in undertaking additional training and her contracted hours were reduced (without choice) when her distress became known. Such a response may convey a tacit message that her emotional response was abnormal. Supervisor vulnerability may have contributed to this; Michael had a recent negative experience as a supervisor in a SR which he described as 'a bad match' (26:18) and the relationship was terminated without his having the opportunity to discuss the issues. Worthy of consideration is the impact of dual roles and whether supervisors have sufficient time to check out therapist wellbeing in clinical supervision.

Emotional labour in mental health practitioners is well documented (Bondarenko, du Preez, & Shepard (2017) and the 50 percent rate of burnout in High Intensity therapists (Westwood et al. 2017) is concerning. Whilst supervisors normalised therapists' emotional responses (Michael, 8:26), systems to address this were not always made explicit. The necessity for restorative supervision in which the supervisee has access to a safe place to make sense of the complexities of working as a therapist is highlighted by Worrell et al. (2018). However, it appears that therapists have conflicting expectations of their own emotions; As highlighted previously, some therapists' self-expectations indicated that they should be able to cope with the emotional demands of high caseloads and complex patients. This view may be reinforced by a lack of robust measures in place to address the emotional impact of the therapy role.

5.4.6 'The six-foot monkey that's not being talked about'

How does power play out in the supervisory relationship? Foucault refers to power relations in terms of 'force relations' or social influences, the strength of which determines the 'force' of the influence. This IPA study has illustrated that, as Foucault suggests, power is commonplace and not exclusive to those in a hierarchically superior position (Foucault 1998). A consistent finding is that within the supervisory relationship, on one level supervisors and supervisees reported positive alliances but in-depth discussion with participants uncovered a dynamic of supervisees not disclosing relevant information and supervisors (if they were aware), not addressing this non-disclosure.

It seems that in a highly controlled environment, supervisees use non-disclosure as a means of asserting their power to withhold or indeed discreetly discount advice provided within supervision as was acknowledged by several participants (Joe, 14:21; Kate, 16:1). This reflects the findings of an IPA study of

supervisee non-disclosure in trainee clinical psychologists by Singh-Pillay and Cartwright (2020). Their study suggests that power dynamics feature strongly in '*purposeful non-disclosure',* used as a means of gaining some control over the supervisory relationship. Whilst this can be without consequence, non-disclosure can also have a detrimental impact on wellbeing, as was apparent in this study.

In considering 'force' influences, it is conceivable that, within a competitive environment, the culture of proving oneself in the position of High Intensity therapist, through meeting recovery targets and projecting oneself positively, has contributed to therapists being sensitised to feedback from others. Avoiding potentially negative feedback appeared to offer some supervisor's (Michael and Cath) self-protection and may have determined why they did not challenge their supervisees. (Cath, 17:6; Michael, 26:31).

The degree of therapists' openness is likely to be influenced by their perception of how they fit their role, based on an often hierarchised social representation of the profession. In essence, if one believes one falls short of how one should be in terms of skills and knowledge, it becomes harder to be open and honest.

Although seldom theorised, a large percentage of PWPs who wish to access CBT training do so in the knowledge that they are deemed to lack a core profession and so are required to demonstrate sufficient experience and knowledge to embark on IAPT CBT training. Experience of and familiarity with working in IAPT in itself does not offer any advantage over those with a core profession who may have little experience of providing therapy or of working within a fast-paced, target-driven environment. This conveys a tacit message that those with core professions are deemed to have more knowledge and experience than PWPs. Indeed supervisor (Cath 25:8) remarked that she should be given credit for working in secondary care. The notion of *'uneven gaze'* is especially

relatable to clinical supervisors who, although higher up the hierarchy, are subject to 'gaze' from both above and below. The power implicit in the role of supervisor is somewhat overridden by supervisees' ability to withhold information. Participant's experiences of what they experience as harmful supervision, may lack recognition of their role in this. For instance, supervisees described "*a bad match*" with a previous supervisor (Kate, 30:13) but does not consider that, as a trainee, her work may not have been good enough. Interestingly, the same phrase was used by a supervisor, "*It was just a bad match from the start*" (Michael 26:19), in describing his experience with a previous supervisee who requested to be moved to another supervisor. "*Uneven gaze*" is apparent in the power of others, (supervisees manager,) to make judgements, without supervisors having a say. Whilst supervisees and patients are protected by codes of conduct, the same does not apply for clinical supervisors. In addition to formal evaluation of their clinical practice, a culture of supervisees making informal judgements of their supervisors was apparent within the study, with supervisees providing a rationale for accessing supervision from a more knowledgeable supervisor and discussing non-disclosure nonchalantly.

Within IAPT communities, it is conceivable that supervisors are mindful that to challenge supervisees may invite negative appraisal. For the supervisor heavily invested in being liked, it may be tempting to appease the supervisee, as was apparent within the study. In common with supervisor Lily, who reflected that she would be devastated if a supervisee elected to terminate the relationship, Michael described his upset when a previous supervisee requested a change of supervisor. For him, being on the receiving end of negative evaluation evoked shame and it is conceivable that his desire to be a 'good' supervisor, and to protect his reputation, led to him inadvertently focusing on establishing a rapport with Mia to the detriment of other areas, such as assessing her

competence, monitoring her wellbeing and supporting her adjustment to her role as a qualified therapist. This also appeared to be the case for Cath who, although aware of, and clearly upset by her supervisee not disclosing relevant information, did not address this (Cath, 17:6).

Supervisor reluctance to address issues resonates with Foucault's description of '*docile bodies*. Ironically, supervisees have the power to cast an '*uneven gaze'* and make judgements of their supervisor, who in order to avoid conflict, take on a submissive role.

5.5 The scope of confidentiality

Therapists are supervised by more senior therapists who typically work within the same service or have pre-existing relationships, which can influence willingness to disclose. Supervisees made clear that in order to disclose within supervision, they had to be sure that confidentiality in CS was maintained (Dan 11.12, Mia, 20.24). Indeed, a lack of clarity on the subject of confidentiality led to non-disclosure. A search of literature highlights the absence of a nuanced argument on confidentiality which may be reflective of the complexity of the issue. Whilst supervision contracts are a recommended component of psychotherapy supervision, little guidance is available. We are guided by professional codes such as the BABCP Standards of Professional Conduct and Ethics (2017) and ultimately required to act in the best interests of service users. Whilst several sections and sub-sections offer guidance (such as 13:13 below), often this can be construed in several ways:

> You must limit your work or stop practicing if your performance or judgement is affected by your health.

Such guidance puts the onus on the individual to recognise and in turn, disclose their difficulties, however the feared implications of such actions may act as a

deterrent. Within this study, a participant described her attempts to hide her distress which suggests that within her work environment, therapy-related distress was not freely recognised as an occupational hazard. Thus, manifestations of vicarious trauma were hidden and went unnoticed. Mia's concerns about confidentiality (Mia, 20:24) seemed to relate generally to *others* knowing, and potentially losing her job. Whilst the BABCP Standards of Professional Conduct and Ethics (2017) states that the confidentiality of service users must be maintained, no such provision is made for the supervisee. Her dilemma (in the context of a 'good' SR) emphasises the ambiguity of the scope of confidentiality in supervision. The role of supervision contracts and whether this carries any weight, is worthy of consideration. Participants stressed the importance of trust and knowing that information would "*stay within limits"*. To quote Lily, "*in order to disclose…you have to be in a trusting relationship"* (11:5). Trust, like many aspects of the supervisory relationship, is tacit and manifests as a felt sense. Supervisees such as Joe and Dan felt trusted (and indeed were trusted by their supervisors), which in turn promoted openness. For others, it seems that the felt 'sense 'of trust was absent and may be reflective of self-concept and not necessarily the quality of the SR.

During the contracting stage of supervision, a rather perfunctory approach to a bureaucratic expediency seems to be the order of the day. In the 'honeymoon' phase of the SR, it can be difficult to anticipate issues and therefore hypothetical discussion of the management of ruptures may not seem like a priority. Further, power differentials are likely to be more pronounced for those with a compromised self-concept who may not feel able to assert their opinion (or concerns). The multiple roles and conflicting functions of the clinical supervisor, complicate the dynamic somewhat. Whilst supervisors may prioritise

their restorative role, supervisee awareness of their supervisors' normative role may feed a reluctance to expose issues related to practice.

CS would seem the appropriate forum for identifying and addressing supervisee vulnerability. To enable this, the supervisor needs to be attuned to supervisee emotions, and the supervisee needs to feel safe in disclosing both their practice and the emotional impact of this. However, in this study, supervisee distress was not noticed or shared in supervision. Power differentials are likely to be more pronounced for those with a compromised self-concept who may not feel able to assert their opinion. The conflicting functions and roles of the clinical supervisor complicate the dynamic somewhat. Whilst supervisors may prioritise their restorative role, supervisee awareness of their supervisors' normative role may feed a reluctance to expose issues related to practice. Confidentiality will be returned to in Chapter 6.

5.6 The emotional costs of therapy and supervision

This study has identified that work-related emotional distress is not always recognised within clinical supervision even when the key ingredients of a good SR appear to be in place. Here, discussion of therapy-related distress ensues, following which supervision related distress is explored, as each influence the supervisory experience.

The impact of emotional stress is highlighted in the literature review (Chapter 2, section 2.12). In the context of their roles, supervisors and supervisees referred to recent difficulties, yet these had not been robustly addressed and were shaming (e.g. Michael, 26:6; Cath, 15:6). IAPT therapists referred to the emotional impact of their work yet were in roles which required them to have emotional control. Whilst supervisors are required to undertake emotional labour for their work with patients, their role extends to containing

the emotions of their supervisees. Within the study, there was evidence of both supervisor and supervisee work-related negative emotion.

For supervision to be effective, openness and engagement is required, and the findings of this study suggest that, paradoxically this does not always happen; Moreover, as highlighted in the literature review (Part 2, section 2.12), emotional exhaustion can be a cause and consequence of non-disclosure. Participant Kate's narrative depicts how formal and informal supervision assisted in the processing of vicarious trauma. Such was the culture within her organisation that psychological symptoms were normalised. Furthermore, there was an explicit understanding that support from supervisors (and colleagues) was necessary and available. The alternative strategy (adopted by Mia and Michael) was to manage their emotional experience through behavioural means of suppression. When utilised to regulate emotions, emotional expression is reduced but levels of emotion remain unchanged and physiological responses and associated symptoms, such as memory impairment, can be increased. Further, deficits in emotional regulation (for instance, excessive use of suppression) are linked to mood disorders (Ehring et al. 2010).

Although the forum of clinical supervision was available and the SR deemed as positive, a supervisees' distress was neither expressed nor noticed. Considering the broader context, this is not altogether surprising. Her supervisor, also a CBT therapist within a busy service, lacked in confidence as a supervisor following a recent rupture with a previous supervisee (which also has not explicitly been addressed). Being aware of Mia's difficulties with a previous supervisor, Michael was possibly less challenging and did not probe sufficiently to unearth her distress.

5.7 Emotional support

Given the demands of working within IAPT and the relationship between compassion fatigue and burnout, it seems imperative that the forum of clinical supervision can nurture supervisee development whilst offering solace to therapists despite the evaluative role of the clinical supervisor. Furthermore, a culture whereby therapist distress and emotional labour is expected, and psychological support available (as was evident in the study), would normalise support seeking.

An internet search identifies a number of NHS England-supported IAPT staff wellbeing initiatives, such as '*The Happy hour Project*' (Dowthwaite 2016) but there are no specific IAPT Key Performance Indicators (KPIs) to incentivise the promotion of staff wellbeing within IAPT services. This is surprising, considering the emotional labour required for working in such a context (Hunter et al. 2007). Findings from this study suggest that therapist emotional distress in recently qualified therapists, is not uncommon. As discussed in Chapter 2, deficits in emotional processing are linked to emotional disorders (Baker 2012), which underscores the need for clinical supervision to provide a forum conducive to discussion and *'working things through'* issues (Wills 2015 p.38). Equally important is that clinical supervisors are sufficiently emotionally attuned to their supervisees' and are able to take necessary action. Arguably, if therapist wellbeing is not part of the general conversation, there is a risk that distress may not be recognised as a normal response to the emotional labour of the role.

In this study, not all therapists felt able to share their emotional distress, and therapists expressed tacit and unhelpful beliefs relating to the experience of heightened emotions. This suggests the need to acknowledge the emotional toll of being a therapist and promote self-care more robustly as part of clinical supervision and at a group level.

With regards to the IAPT model, the ever-present and imposing "*elephant in the room"* (Liz, 22:12) is that the success of IAPT has seen a ballooning of referral numbers resulting in the over-stretching of limited resources. IAPT therapists are caught between a rock and a hard place, in that limited numbers of CBT sessions potentially restrict the extent of recovery and therefore the likelihood of meeting recovery targets. This is particularly challenging for recently qualified therapists, who were trained to deliver protocolised CBT consistent with the IAPT curriculum and the CBT evidence-base. Ideally, such issues should be brought to clinical supervision. However, as highlighted by Sloan (2007), the ability to share emotional experiences within clinical supervision is highly influenced by self-concept anchorage and comfort in projecting the 'true self'.

5.8 Interpersonal processes in the supervisory relationship

This chapter has addressed how participants' psychological factors impact interpersonal processes in the SR. Apparent within the study is the detrimental effect of nondisclosure, indeed in some cases supervisors were aware that issues had not brought these to the fore and did not challenge this. Equally damaging is the impact of supervisee and supervisor blindness to what is happening interpersonally. Cultural and contextual factors that strongly influence interpersonal processes have been discussed. These findings are in line with Safran & Segal's (1990) seminal work (discussed in Chapter 2) in which they postulate three interpersonal processes through which self-development is mediated: empathic transmission of anxiety, affect attunement, misattunement, and 'reading' affective change (p.64). Here, in relation to the study findings I explore how such interpersonal processes can be addressed in supervision.

Apparent from the study is that effective clinical supervision contributed to supervisees' development. This was influenced by supervisor attunement and ability to 'read' the supervisee. Whilst a good SR contributes to this, other factor

such as self-concept appear to mediate the ease with which the relationship develops. A consistent finding was that some therapists managed interpersonal issues by subtly withdrawing and not overtly addressing these. Drawing on Kiesler's (1983) theory on key relational components, a supervisee who has a controlling supervisor (or indeed vice versa) is likely to behave submissively. Findings from this study are consistent with studies of non-disclosure in supervision (discussed in literature review), and notably the tendency for issues to be swept under the carpet. The established CBT practice of viewing recordings of therapy sessions within supervision provides a means of reflecting on interpersonal processes within therapy.

Although CBT therapists undertaking IAPT supervisor training are required to show recordings of their supervisory practice within supervision-of-supervision, this is not standard practice. As discussed, resources within IAPT services are spread thinly, and the introduction of mandatory recordings of supervision sessions for analysis within supervision of supervision adds a further drain on resources. In the words of Woolf & Tholstrup (2010 p.606): '*at what point do we ask who supervises the supervisors of supervision and so on?*'

Apparent from this study is that a 'good' SR alone is insufficient to guarantee openness. Findings have important implications for supervisor training, given that supervision literature tends to emphasise the centrality of the supervisory relationship. Although it may feel safe and comfortable, supervision without reflection is likely to be unstimulating and becomes more about monitoring and support (Haarhoff & Thwaites 2016) than professional development. Supervisors have limited control over supervisees' implicit power to withhold information, highlighted as common practice (Mehr et al. 2010; Ladany et al. 1996). As discussed in the literature review, certain supervisory behaviours promote openness, such as acknowledging and discussing the power

differential, and the potential impact on disclosure. Such behaviours are dependent on the supervisor being reflexive (Cook et al. 2018; Mangioire et al. 2011) and having the ability to promote thoughtful, reflective discussion.

Reflective practice has long been recognised as a key component of therapist development, with Beck (1995) and Padesky (1996) encouraging therapists to apply CBT techniques to themselves. It is noteworthy that competency requirements for the IAPT clinical supervisor as highlighted by Roth & Pilling (2007b) relate to the ability to be reflective and to enhance supervisees' ability to reflect. Equally this calls for supervisees to be sufficiently reflective, as this is a competency requirement of IAPT CBT therapists (Roth & Pilling 2007a).

In short, both supervisor and supervisee have a professional responsibility to be reflective practitioners. The key to promoting reflexivity lies in a more formal integration of Self-Practice/Self-Reflection (SP/SR) in CBT training, thus socialising all therapists to self-reflect. In turn, those therapists who are established in the art of reflective practice are versed in promoting reflection within clinical supervision, as therapists and eventually as supervisors.

5.8.1. Self-Practice/Self-Reflection

This study uncovered a propensity for participants to articulate a commitment to clinical supervision and reflective practice however there was a dissonance between their expressed perspective (which reflected the importance of CS) and supervision behaviours in which non-disclosure and superficial engagement featured. Personal dynamics were outside of some participant's consciousness which suggests the need for IAPT therapists to engage in reflection on a more profound level. The six-stage process model (Bennett-Levy & Thwaites 2009) encourages deliberate and profound reflection, recognised as a key component of adult learning (Kolb 2014). Building self-reflective awareness can take different

forms and involves exploring various domains such as personal defences, strengths and weaknesses, and how one handles criticism, and is increasingly being used as part of CBT training programmes. Indeed, the framework is suited for self-supervision in conjunction with, or independent of, a clinical supervisor.

Consideration of what learning is required, how this is likely to take place and how the supervisee is adapting to their environment, consistent with contextual behavioural science, is relevant to CS (Morris & Bilich-Eric 2017). Contextual behaviouralism conceptualises psychological problems as interactions between the individual and situationally defined contexts, with a particular focus on function over form (Hayes 2004). Applied to the supervisory context, Morris & Bilich-Eric (2017) propose that such an approach encourages a shift of focus from 'rule-governed behaviours' such as applying a therapy model in a standardised way, to a more experiential focus, i.e., gaining insight into patients' previous experiences and values in order to better understand their world. Contextual CS provides a psychological space for the supervisee to explore meaning, thus promoting greater understanding. Such an approach not only enhances the variability of behaviours within CS but is also conducive to greater therapist flexibility.

Integration of experiential models in CS requires discussion of vulnerabilities, potential responses to critical feedback or clinical errors, at the inception of the supervisory relationship/CBT training thus setting a precedent for an expectation of reflexivity and openness within supervision. Safran & Muran's (2000) cognitive-interpersonal supervision model is based on Safran and Segal's interpersonal cycle (1990), which addresses supervision ruptures and is a logical next-step. This, however, is reliant on firstly acknowledging any issues and conveying willingness to address these. Such a model is also dependent on a SR in which each party feels sufficiently safe to contribute to a reflective discussion.

5.8.2 The Quiet Ego

This study underscores the importance of prioritising self-care to manage the emotional burden of being a CBT therapist in a high-pressured environment such as IAPT. The use of self-practice/self-reflection is promoted within clinical supervision. Whilst recognised as central to therapist development and wellbeing, it seems that some participants' reflection was superficial, and the focus was not on others, such as supervisor/supervisee/patient. Quiet ego interventions contrast with self-practice/self-reflection, in that they promote consideration of self *and* others. As discussed in the literature review, perspective taking, detached awareness, inclusive identity and being growth-minded (consistent with the quiet ego) all promote self-compassion and consideration of unhelpful tendencies. Integration of quiet ego principles may offer an alternative means for supervisors and supervisees to consider the wellbeing of themselves and others.

5.9 Chapter Summary

Relevant theoretical frameworks have been utilised to support the discussion of themes identified through analysis of interviews. Whilst extant supervision literature highlights non-disclosure within CS, the extent of this, particularly within the context of an otherwise positive SR, was unexpected. Furthermore, that supervisors did not address supervisee behaviours such as non-disclosure in the context of a 'good' SR was unexpected. Analysis of findings suggests that participant self-concept and sense of belonging appeared to impact the experience of being in the SR. It seems that those with a healthy understanding of, and acceptance of, themselves, engaged in supervision on a more profound level. Whilst CS has been the subject of much research in recent years with a growing emphasis on the SR, no studies of self-concept in the context of CBT supervision were found. Indeed, there appears to be little consideration of

personality and how this may influence one's experience of clinical supervision. The implications of these findings are considered in the following chapter.

CHAPTER 6. IMPLICATIONS FOR PRACTICE AND DISSEMINATION

6.1 Implications for practice

The use of IPA as a research method has facilitated an in-depth study of high intensity therapists' experiences of the IAPT supervisory relationship. The findings contribute to a dearth of empirical evidence on the IAPT supervisory relationship. Within this chapter, consideration is given to how the findings can be applied to supervision practice, training, and policy.

6.1.1 Promoting reflection in clinical supervision.

Whilst clinical supervision provides a milieu for the articulation of thoughts and emotions relating to clinical practice, it seems imperative that discussion within CS provides space for reflecting on *what is happening* for the supervisor and supervisee. Despite SP/SR being heavily promoted within High Intensity and IAPT supervision training courses, in this study there was evidence that for some supervisors and supervisees, the level of reflection was superficial. On the part of the supervisor, there is a need to consider the phenomenological experience of the recently qualified therapist within a power relationship. Supervisors must be sensitive to factors that may hamper openness within the SR (such as anxiety) and manage this robustly. Supervision literature emphasises the possible implications of power differentials in a SR, however in this study it seemed that some supervisors assumed that supervisees disclosed relevant information; this was often not the case.

Clinical supervisors are positioned to set a tone within supervision that promotes supervisee and indeed supervisor reflection. Whilst SP/SR can be a solo activity for the more experienced reflexive practitioner, models of reflection such as Bennett-Levy et al. (2009) recognise the role of the more experienced therapist in facilitating others to reflect. Apparent from this study was that some

supervisors level of reflection was superficial, and they appeared to lack insight into their own supervision-related interactions. In some cases, supervisees seemed more aware of supervisor vulnerabilities than the supervisor themselves.

As discussed in the literature review, reflective practice is recognised as a critical aspect of adult learning, which Schon (1983) argues unlocks professional mastery. Both High Intensity CBT training and the high intensity supervision training course, recognise reflection as a core competency (Roth & Pilling 2008a & 2008b). Completion of each course requires the individual to demonstrate competence and in turn, the relevant competencies are signed off by their supervisor. Deficits in one's ability to reflect need to be identified and addressed at an earlier stage of development. Roth & Pilling (2008a) acknowledge that it can be difficult to gauge supervisee competence, hence a variety of methods are required in order to triangulate information. For instance, the supervisor and supervisee may watch a recording of the supervisee's practice, following which the supervisee is encouraged to reflect on the recording. The clinical supervisor provides feedback and encourages the supervisee to reflect on how this may be applied in practice. Assessing one's competence in the ability to reflect, can be a time intensive exercise and requires sufficient time to be allocated.

The provision of clinical supervision is built into IAPT CBT therapists' roles. In this study, newly qualified therapists spoke of their supervision quota being reduced from one hour per week during training to two hours per month. This is a vulnerable time for recently qualified therapists (or supervisors new to the role) who are adjusting to working at full capacity without the support of a second (university) supervisor. It seems important that supervisees have the psychological space within supervision to reflect on how they are adjusting to the role. Incorporating the practice of SP/SR as a required component of CBT and clinical supervision training courses sends a clear message that reflective practice

is central to CBT therapists' development. However, sufficient time to reflect is required, particularly for those in the early stages of their development as CBT therapists. In this study it was apparent that the time allocated for supervision was not always sufficient to engage in meaningful reflection, and supervisees referred to the challenges of trying to discuss clients within the allotted time.

Self-supervision can be promoted as an adjunct to clinical supervision (Bennett-Levy & Thwaites 2009) and a means of further developing reflexivity skills. Consideration of the extent to which, trainee therapists and supervisees are required to demonstrate competence in core competencies such as reflection, would promote a consistent approach. Described as "[a] moving target" (Robiner et al. 1993 p.5), competency-based assessment requires reliability, consistency and validity (Falender & Shafranke 2004). Whilst clinical supervisors are well positioned to measure therapist competence, this requires agreement on benchmarks required to demonstrate sufficient competence. Factors such as the strength of the SR, beliefs about reflection and time pressures may influence supervisors' judgement of competence.

Trainee CBT therapists formally submit recordings of therapy sessions for assessment within the training institute, in addition to having competencies signed off by their supervisors. Thus, student assessments go through the formal marking processes of the training institution. IAPT supervision training courses vary and commonly, supervision practice is assessed by a practice supervisor through viewing a live or recorded supervision session. The submission of a summative recording as part of IAPT supervision training is not mandatory across all training institutions, thus the judgment of competence is based on the supervisor's perspective. Given the centrality of reflection in the roles of IAPT CBT therapist, supervisor and supervisee, it is important that those accessing IAPT HIT training have the ability to reflect. This could be factored into trainee therapist

application and interview processes. Furthermore, SP/SR training updates for qualified therapists would provide a space for supervisors to consider their practice and how this can be enhanced.

6.1.2 The role and responsibilities of the clinical supervisor

In this study, both supervisors and supervisees referred to interpersonal dynamics being left unaddressed. Clinical supervisors' role in monitoring and addressing interpersonal processes within clinical supervision is of utmost importance and requires supervisors to reflect on their practice. Describing reflection as the life-blood of supervision, Carroll (2014) advocates supervisor reflection, in order to *make meaning* (p.135). Consideration of self-concept and how this may impact supervisory behaviours, such as avoidance, is an important consideration for the supervisor and for the therapist reflecting on a therapy session. Just as the reflective therapist reviews therapy sessions, recordings of supervision sessions have the potential to provide additional insights for the clinical supervisor. This study suggests that we cannot assume that supervisees open up within clinical supervision; the role of the reflective supervisor must extend to initiating discussion of personal factors including personal defences. Consideration of how these may manifest within clinical supervision or therapy provides an added dimension of supervisee self-awareness.

Whilst clinical supervision is assumed to provide a supportive forum for supervisees (Bambling 2014; Shafranske & Falender 2008; Proctor 1986), the frequency of non-disclosure found in this study is consistent with supervision studies and reflects the complex nature of the SR. This needs to be factored in and addressed pragmatically from the outset of the SR. Consideration of supervisee' sense of belonging and instigation of discussion within supervision to promote supervisees' consideration of self-identify as a therapist provides an

opportunity to reflect on one's own vulnerabilities. Dual roles can impinge disclosure, and it is understandable that individuals try to preserve working relationships by avoiding conflict (as discussed in section 6.1.5), but this has implications. Personality factors cannot be disregarded, and some people are naturally more open than others, as was apparent in this study. Participants flourished in the context of a SR when they felt trusted (and not scrutinised, as had previously been the case). Positive impact on his professional development was acknowledged by a supervisee as a consequence of feeling safe.

Privacy and confidentiality are fundamental for those seeking therapy; however, this study highlights the issue of confidentiality in supervision as an '*elephant in the room'* with supervisees reporting that they were unsure of the boundaries. One's level of comfort greatly influences the tone of any relationship and in the absence of clarity on the boundaries of confidentiality, supervisees understandably, may be reluctant to fully disclose. This potentially limits development and learning opportunities. The IAPT High Intensity core curriculum (HEE 2019) includes teaching on BABCP standards of conduct performance and ethics; however, such a profound subject cannot be addressed in a single teaching session. The nuances of confidentiality relating to the SR could be addressed more appropriately in clinical supervision itself. In his discussion of ethics and professional practice in CS, Carroll (2014) refers to 'ethical maturity' as a journey and not a destination, recognising the constant flow of ethical dilemmas. Trainee therapists and supervisors in training would benefit from encouragement and support to utilise SP/SR as a context for such a journey.

6.1.3 Understanding the world of the IAPT therapist

Participants provided insights into the emotional labour of the role and recounted their experiences of vicarious trauma. Their accounts underscore the importance of an organisational culture within which the emotional impact of being a therapist is recognised, and distress is met with compassion. It is recommended that clear measures are in place to support IAPT staff and encourage an ethos whereby therapists understand work-related distress as an implication of their role which requires support and does not need to be hidden.

It seems prudent that training institutions and IAPT services acknowledge that pre-existing vulnerabilities may need to be addressed thus appropriate support must be available. Whilst clinical supervision is distinct from therapy, the psychological wellbeing of therapists is highly relevant and clinical supervision provides a context for discussion of therapy-triggered distress. The emotional consequences of being a therapist in a fast-paced service must be recognised, and access to appropriate support available. In order to support patients accessing psychological therapy, the IAPT workforce needs to be psychologically robust, and supervisors are best placed to be alert to signs of psychological distress in supervisees.

Sufficient time must be allocated for supervision. Whilst the centrality of reflective practice is recognised within literature, it is debatable whether enough time is dedicated to CS within IAPT services to enable purposeful reflection and participants referred to the difficulty of trying to discuss clinical issues in CS. Given the much-documented literature highlighting therapists' reluctance to disclose, which supports findings within this study, it seems imperative that the wellbeing of therapists is promoted. There are some fine examples of IAPT wellbeing initiatives set up for IAPT staff, one being *The Happy Hour Project* (Dowthwaite 2016) set up to increase awareness of the science of happiness and to improve

staff wellbeing. Team-focused events promote a greater sense of belonging, which is conducive to therapist wellbeing. This is especially important given the changing work cultures and the expansion of remote working in recent years. By implication, opportunities to debrief following a difficult therapy session or to access ad hoc supervision, are reduced and engagement with peers minimised. Remote working reduces the opportunities to 'read' colleagues' mood and notice signs of distress, all of which are implicit parts of teamwork and supporting colleagues.

6.1.4. Promoting a sense of belonging

As discussed in section 5.3.5, some participants lacked an intrinsic sense of belonging, and this was reflected in the theme '*Playing the Part'*. The notion of Kierkegaard's *'correct relation*' is of relevance, which refers to the state of being perfectly able to present the self in a true and authentic way, as was the case for some participants. Some had a strong sense of belonging and adapted to their roles with ease. In contrast, those whose sense of belonging was compromised lacked confidence and were less likely to acknowledge vulnerabilities. Socio-psychological interventions that acknowledge the challenges of a subjective sense of belonging may be helpful for some therapists, such as those who have taken a non-traditional route, and perhaps have no prior experience of working in IAPT. As advocated by Tibbetts et al. (2018 Chapter 2), unseen difference must be considered. Indeed, a consistent finding was that some participants expressed doubts about fitting in. It seems imperative that we consider what unspoken message is being conveyed through the current systems for recruiting, appointing and training High Intensity CBT trainees, and whether this may contribute to therapists having a sense of not being good enough, or of not belonging. In a spirit of diversity, there is a need to contemplate current systems and whether

these reinforce the privilege or disadvantage to which that individuals have been subjected in their formative years.

6.1.4 Enhancing awareness of 'High intensity' supervision.

CBT therapists within IAPT have varying professional backgrounds which is likely to influence their experiences of clinical supervision. On commencement of High Intensity training, an introduction to CBT supervision forms part of the IAPT curriculum (Roth & Pilling 2008a). Whilst a theoretical knowledge of clinical supervision is important, the intricacies of clinical supervision, including its function and how this can be utilised by therapists, needs to be discussed. Trainees should be encouraged to reflect on their prior experiences of CS and implicit beliefs or concerns that they may have as a consequence. Within literature, clinical supervision is presented as a supportive and nurturing component of professional training, and it seems that not all participants were prepared for the challenges of supervision. The statement "*I like it, but I don't like it sometimes"* (Liz: 6.27) sums up the two sides of supervision.

The complex nature of CS and the SR cannot be underestimated. Supervisors and supervisees need to be prepared for the challenges that are implicit in the role, such as delivering (or receiving) critical feedback and addressing supervisees' issues. These are essential components of the role, the avoidance of which can deplete supervisees' professional development, as was apparent in this study. Indeed, there was evidence of supervisor avoidance of even discussing supervisee non-disclosure. Supervisors need to honour their role in exploring supervisees' emotional experience of being a therapist and be mindful of their own emotions and whether support is required to manage such dilemmas (such as supervision of supervision).

There was evidence of a lack of clarity on the role and functions of CS, and, importantly, the boundaries of confidentiality. This prevented participants from utilising clinical supervision to address psychological distress. Supervisees' reluctance to reach out was impacted by a power dynamic, which, although inevitable in the SR, can be managed through discussion and empowering the supervisee, which Bernard & Goodyear (2014) argue is a duty that a supervisor needs to take seriously.

Whilst the function and roles of clinical supervision are discussed early in the IAPT training programme, participant experiences highlight the importance of timing. Trainees new to High Intensity training are contending with much new information and unfamiliar practices, including clinical supervision. It may be difficult to articulate questions relating to an unfamiliar model of supervision until a rapport is established. Supervisees need to feel able to ask critical questions to gain a greater understanding of the role of supervision. In this study, some supervisees were not aware that supervision is a forum within which therapy-related psychological distress can be disclosed.

Whilst Roth & Pilling's (2007) supervision competencies provide some structure, there is a need for clarity on the issue of wellbeing being relevant to CS. This needs to be a standard agenda item that can be addressed safely within CS. This in turn conveys the important message that therapist psychological wellbeing is a priority.

6.1.5 Addressing confidentiality in clinical supervision.

This study highlights confidentiality in supervision as the *"the elephant in the room*". One's level of comfort greatly influences the tone of the SR but is seldom explicitly discussed. In the absence of clarity on the boundaries of confidentiality, supervisees may be reluctant to fully disclose, which limits their development and learning opportunities. The covid pandemic has radically changed working practices, with remote working now being the norm thus face-to-face contact with peers is reduced. Consequently, informal communication with colleagues, often a source of *ad hoc* support, is minimised. This is likely to impact relationship-building and in turn, the ability to reach out to others. The remote delivery of CS does, however, provide the potential to reduce power dynamics, by widening the choice of supervisors to those outside of the supervisees' organisation. In doing so, conflicting relationships such as those in senior roles providing supervision (which can be detrimental to one's ability to open up), can be avoided. Thus, the dyadic relationship can be entirely dedicated to CS and not contaminated by other roles, making confidentiality a more tangible concept.

The implications of lack of clarity regarding confidentiality was apparent in this study and participants seemed to *play it safe* and not disclose. This illustrates the need for confidentiality within supervision to be discussed pragmatically. For instance, what does confidentiality mean for a supervisee in distress? This needs to be addressed as part of the contracting stage of CS. Supervisors are positioned to share scenarios with supervisees depicting example of situations in they may feel obliged to share information with others. Furthermore, IAPT clinical supervision training provides a forum for discussing the scope of confidentiality within the SR. Supervisees and supervisees need to be aware of the nuances of confidentiality and situations in which sharing of information can be justified.

6.1.6 Dual Relationships

Within this study, supervisees tended to be supervised by others within the organisation in more senior roles, or by people with whom they had pre-existing relationships. Whilst power dynamics within CS are a reality, factors such as position within the organisation, discomfort in disagreeing with colleagues or feeling intimidated by someone's level of knowledge, can exaggerate this. Some supervisors did not question the inappropriate behaviour of supervisees. This is just as concerning as supervisee non-disclosure and suggests a reversed power dynamic.

The absence of pre-existing or power relationships removes the temptation for players to invest in 'pleasing' the other or trying to fit in, as was apparent in this study. Supervisees often held back relevant details and there was evidence that supervisors did not challenge this despite being aware. Whilst it is imperative that the wellbeing of IAPT therapists, particularly recently qualified therapists, is prioritised, clinical supervisors' role extends to ensuring that supervisees have the required knowledge and skills and are sufficiently psychologically robust to be therapists. Supervisors' conflicting roles were found to influence supervisee disclosure within this study. It seems prudent that supervisory dyads explicitly discuss how this can be managed as part of the contracting process.

There is justification for considering alternative models of providing clinical supervision within IAPT services. Out-sourcing from other IAPT services provides a means of avoiding dual relationships, thus reducing power dynamics. Supervisors and supervisee may feel less invested in saying the "right" thing and more able to be honest than they would with someone with whom they work. Thus the experience of challenging inappropriate behaviour (such as non-disclosure) is less difficult. Consequently, supervisors may feel more comfortable

in challenging supervisees' practice and behaviours in the knowledge that it is their job to do so. Furthermore, supervisees may feel more able to disclose to an external supervisor and feel less concerned about sharing confidential information in the absence of dual roles.

6.1.7 Advanced clinical supervision training

Currently, IAPT High Intensity supervision training is five days in duration. Course assessment comprises the achievement of competencies, for which the student is required to have 'supervisor of supervision' in the workplace. This involves the supervisor evidencing competence, through viewing recordings of clinical supervision within supervision of supervision. Therapists are normally keen to expand their skillset, and many tend to embark on clinical supervision training soon after completing CBT training. The findings of this study support other studies that refer to the complexity of clinical supervision and indeed the supervisory relationship. Access to more specialist supervision training that focuses on interpersonal issues such as management of ruptures, non-disclosure and power differentials, is long overdue.

It seems imperative that we consider what unspoken message is being conveyed through the current systems for recruiting, appointing and training High Intensity trainees, and whether this may contribute to some therapists having a sense of not being good enough, or of not belonging. In the spirit of diversity, there is a need to contemplate current systems and whether these reinforce the privilege or disadvantage that individuals have been subjected to in their formative years.

6.1.8 Recommendations for practice

Recommendation 1: Formalised SP/SR within clinical supervision for trainee therapists and trainee clinical supervisors to enhance the depth of reflection.

Recommendation 2: Additional time for clinical supervisors in training and trainee HI therapists to meaningfully engage in SP/SR.

Recommendation 3: Supervisors must promote more profound reflection within clinical supervision through role-modelling. Consideration of supervisee self-concept, how vulnerabilities may manifest influence the SR and the TR, is essential.

Recommendation 4: Formal recognition of the transition to qualified CBT therapist status and acknowledgment that some may require additional support. A period of preceptorship should be considered.

Recommendation 5: Out-sourcing clinical supervision from other IAPT services provides a means of avoiding dual relationships, thus reducing the power imbalance. This is conducive to supervisees being more open within the SR.

Recommendation 6: Wellbeing initiatives within IAPT services could promotes sense of belonging and normalise the experience of therapy related distress. Therapists need to be aware that support is available (such as ad hoc supervision or access to therapy).

Recommendation 7: Access to more specialist supervision training that focuses on interpersonal issues such as management of ruptures, non-disclosure and power differentials for more experienced supervisors.

Recommendation 8: Explicit discussion of confidentiality, what this means for the supervisee and supervisor and the nuances relating to this, must be discussed as part of the contracting process. This needs involvement from the

service lead and discussion of circumstances when breaking confidentiality may be appropriate.

6.2 Strength, limitations, and future research

6.2.1 Contribution to Knowledge

This study of the SR in IAPT has enabled an in-depth exploration of the supervisory relationship in IAPT and provides insights into how cultural, social, and psychological factors play out in the SR. Findings suggest that one's self-concept can impact how one experiences aspects of the SR, such as receiving critical feedback or being required to provide a rationale for use of treatment models and protocols. The findings support the integration of SP/SR to enhance supervisor and supervisee awareness of one's vulnerabilities and how these have the potential to contribute to interpersonal dynamics.

6.2.2 Foucauldian analysis of power in the SR

Consideration of power from a Foucauldian perspective has provided insights into the tacit but profound presence of power in the supervisory dyad. We see how this can be destructive if not acknowledged. Many of the issues that have manifested in the SR such as non-disclosure can be related to power dynamics, for instance participants inadvertently resisting or exercising their power. This Foucauldian framework has enabled analysis of social and political influences on IAPT and consideration of how these invariably impact psychologically upon the supervisory dyads. Subtle resistance of power through non-disclosure and inauthenticity has become ingrained in the practice of IAPT supervisory dyads, to the extent that this appears to be the norm. Consequently, clinical supervision, in its current state, is limited in its functionality.

6.2.3 The process of analysis

This study has illustrated how participants make sense of their innately unique experiences of being in a supervisory relationship. Focusing on a small slice of the whole has facilitated in-depth analysis of the SR from a supervisor and supervisee perspective. To my knowledge, no previous interpretative phenomenological studies of the IAPT SR have been conducted. I acknowledge that my own experiences as a supervisor and supervisee, and my involvement in IAPT CBT and clinical supervision training, has contributed to my interpretation of how participants have made sense of their experiences of a SR and the meaning they attach to this (this is consistent with the double hermeneutic of IPA research). This experience has drawn me to notice participant utterances that may seem insignificant to others but resonate with me based on my various roles. I have strived to hold theories in parentheses and whilst interpreting data, have remained close to the narratives of participants from which theories have developed.

6.2.4 Sampling and generalisability of findings

In considering the limitations of the study, the fact that some participants were known to the me in my professional capacity is likely to have contributed to how information was filtered. Participants may have been reluctant to share some experiences of supervision or indeed, negative beliefs that they held about CS or their supervisory partner. As each half of the dyad had to agree to participate, one member may have felt obliged to do so. The sample derived from various IAPT services, most of which I had some involvement in a professional capacity, prior to or at the time of the study. Participants with whom I had no prior relationship and whom I am unlikely to meet again may have felt less self-conscious and more able to give an authentic account of their experiences. My experience of interviewing participants with whom I had no

previous relationship, however, was that I worked harder to develop a rapport and to interpret their non-verbal behaviours. I felt less at ease, and whilst I gained much useful data, I believe that I was less spontaneous as an interviewer. Conversely, Green & Thorogood (p.12) posit that all language requires a degree of interpretation and my knowledge of IAPT, and the SR enabled me to be alert to implicit cultures.

It seems less likely that those in dysfunctional supervisory dyads would each have been agreeable to share their experiences with a researcher known to them professionally; thus, a polarised perspective of the SR may have been provided by the sample. That said, although many study participants stated that they enjoyed a strong SR, the interview process brought interpersonal issues to light. Furthermore, much reference was made to previous supervisory issues, which has provided further insights into supervisory relationships and illuminated study themes.

The issue of theoretical rather than empirical generalisability is of relevance: the sample consists of five supervisory dyads, and whilst it cannot be assumed that the findings can be applied to all supervisory dyads, IPA recognises that less is often more, enabling tentative claims to be made (Hefferon & Gil-Rodrigue 2011). The '*narrowly defined'* notion of generalisability has been criticised by Stephens (1982 p.75), whilst Skate (1994 p.236) observes that often no attempt is made to generalise beyond the '*intrinsic case study*'. Theoretical generalisation makes links between the study findings, one's own professional experiences and current literature (ibid.). The identified themes were common to most of the supervisors and supervisees interviewed, which is suggestive of wider application (ibid.), and readers might consider the relevance of the data to their professional and experiential knowledge (Smith et al. 2009). Indeed, Smith (2018) cautions that statistical methods of generalisability cannot be applied to

qualitative research; researchers need to respect underpinning epistemologies, ontologies, and methods, which I believe to be the case in this study.

Of the ten participants who took part, just one was from a Black Asian Minority Ethnic (BAME) group. This largely reflects 2011 census information (ONS 2011) whereby 86% of the population are of white ethnic groups. Of these, 80.5% identify as white British (so almost 20% do not). BAME groups are under-represented in the north-east of England general population and within the adult IAPT workforce where 83% identify as white (NHS England 2015). The lack of participants from various BAME groups limits insights to that provided mainly by a majority white group, meaning that significant supervisory experiences unique to other groups may be omitted. However, it is noteworthy that all participants who volunteered to be involved in the study were interviewed. To recruit a sample that includes more minority groups is likely to be time-consuming and would require a larger sample, which runs the risk of compromising the depth of analysis. In this study, my priority was specific to the experiences of IAPT CBT therapists and in the words of Smith and Eatough (2012 p.446), 'the research sample selects itself in the sense that potential participants are or should be free agents who choose to participate or not'. On reflection, the costs of deliberately including cultural groups would outweigh the benefits; indeed, Allmark (2009) argues that proliferation of research is the best means of ensuring that neglected areas are covered. This is consistent with Smith & Eatough's (2012) view that later studies can investigate other groups to enable generalisations to be made.

6.2.5 Future research

Further research of therapists' experiences of interpersonal processes in the SR in more ethnically diverse populations using IPA would add to much-needed research on the SR, particularly the nuances that enhance positivity, safety and openness and factors (such as gender and class), which may have an influence. A sample from a more ethnically diverse area, would provide insight into the phenomenological experiences of the SR for minority groups without compromising depth of analysis through the introduction of more variables such as a white/BAME or BAME/BAME dyads. The strength of IPA as a research method is its commitment to detailed analysis and such a study would enable an in-depth exploration of ethnically diverse therapists' experiences of the IAPT CBT supervisory relationship.

The Quiet Ego interventions have the potential to provide an alternative means of promoting the self-care of HI therapists and is worthy of research.

6.3 Dissemination

In considering the dissemination of study findings, the use of a theoretically informed framework is recommended by Wilson et al. (2012). Whilst the importance of traditional means, such as publication in peer-reviewed publications is acknowledged in a framework presented by Whitty (2019), the use of non-traditional means such as stakeholder engagement to create a 'waiting audience' is also recognised and has been utilised. Such a strategy also acknowledges that some CBT therapists may not routinely access CBT publications, and that discussion forums, such as supervisors' days, can be more conducive to reflective discussion of CBT supervision.

Indeed, Whitty (2019) advocates the use of a dissemination strategy that considers how to amplify the message. My mission is to promote discussion of CBT supervision amongst IAPT professionals and develop a greater understanding

of how clinical supervision can be delivered within the context of IAPT. From the outset, supervisors, supervisees and IAPT clinical leads and managers were recognised as the primary audience and, through a series of supervisors training events, were informed of the research. My position as course leader for Postgraduate CBT (IAPT) and course leader for a Postgraduate clinical supervision module has given me access to this audience and I have kept supervisors and supervisees informed of the study findings.

My dissemination strategy has involved engaging with IAPT services in the Northeast of England to inform them of the research being undertaken, and then to disseminate study findings. The interpretative nature of IPA is of relevance, and I am mindful of the need to present my findings tentatively. This dissemination strategy has extended over a timeline of several years, beginning with a poster presentation of my pilot study, to presenting my research at University of Derby and Teesside University research forums. I applied to present my research at the annual BABCP conference, but the pandemic meant that the conference was cancelled. Earlier in the process I wrote up the pilot study, which was peer reviewed for the journal *CBT Today*. Extensive amendments were required, and I made the decision to focus on my doctoral work and write for publication following the write-up of my thesis, at which point I could present it more coherently. Indeed, the process of writing this thesis has served as a means of reflecting further on the supervisory relationship and I believe that I can present a more coherent narrative now than I would have done earlier in the process.

CHAPTER 7: CONCLUSION

This study set out to establish how IAPT supervisors and supervisees make sense of interpersonal processes in the supervisory relationship in an IAPT service. This topic was identified as deserving of analysis, given the relative newness of IAPT and the glut of supervision literature suggesting the commonality of non-disclosure in clinical supervision. Five supervisory dyads were recruited from IAPT services in the North East of England.

One-to-one semi-structured interviews were conducted with each of the five supervisors, and their supervisees. Whilst they were aware that I would be interviewing their dyadic partner (and had consented to this), confidentiality was maintained. Participants were encouraged to explore their experiences of being in an IAPT supervisory relationship and reflect on challenges and support mechanisms within their role. Interviews were audio recorded and transcribed verbatim. These were analysed using IPA, from which three superordinate themes and five subthemes emerged.

The study provides new insights into the phenomenological experience of being in the supervisory relationship and the hidden nature of the self. In the context of "good" SR, supervisors' and supervisees' narratives provided an understanding of how participants navigated aspects of the SR. There was evidence that whilst both groups were subject to subtle but close monitoring within the service, paradoxically, some supervisees used their power to withhold information in CS, hoping to avoid overt disagreement by carefully filtering the information they shared. Supervisors and supervisees each provided accounts of not disclosing relevant information.

Typically, supervisees did not inform their supervisors that the advice provided was discounted. Further, when supervisees experienced strong

therapy-related emotions, this was often not shared. Supervisor non-disclosure related to supervisees' behaviours not being challenged and the related emotional responses not being addressed. Non-disclosure appeared to be used as a means of maintaining the SR by avoiding conflict.

It was apparent that their relationship with the self-impacted their experience of the SR. Those with clarity of self-concept, identified by their acceptance of self despite recognition of faults, were more open within the SR, and were more likely to address interpersonal issues that arose. Whilst participants were invested in establishing a good SR, some individuals seemed more invested in being liked, and paid less attention to other essential components of the SR, such as reflecting on their practice and considering interpersonal processes. Those with poor self-concept clarity, evident in individuals' propensity to doubt themselves and negatively compare themselves to others, experienced more issues in the SR and described incidents of non-disclosure. Supervisors with poor self-concept invested in the SR but were less likely to address supervisee non-disclosure, which had implications. Participants described how, through being in a positive SR, their confidence as a therapist was enhanced, and they had become more self-aware and accepting of themselves.

This study has explored what happens interpersonally in the supervisory relationship. There was evidence that, in order to maintain the status quo, supervisors and supervisees level of interaction can be superficial, which has implications for therapist development and wellbeing. It seems that some IAPT supervisors and supervisees have subtly adapted their behaviours to maintain the relationship, but the findings show that this creates other tensions.

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Appendix III University of Derby Ethical Approval

UNIVERSITY of DERBY

Approval Letter

Date: [redacted] 2015
Name: Bernie Gibson

[redacted]
Dear Bernie Gibson

Topic: Improving Access to Psychological Therapies (IAPT); Cognitive Behavioural Therapy supervisors and supervisees experiences of interpersonal processes within clinical supervision. An Interpretative Phenomenological Analysis pilot study

Thank you for submitting your application to the College of Health and Social Care Research Ethics Committee.

Your study has been approved by the Committee and you are now able to proceed.

Once the study commences if any changes to the study described in the application or to the supporting documentation are necessary, you are required to make a resubmission to the College of Health and Social Care Research Ethics Committee.

We will also require an annual review of the progress of the study and notification of completion of the study for our records.

Yours sincerely,

[redacted]

Martyn Harling
Vice Chair, College of Health and Social Care REC.

Appendix III.i Letter of Access to NHS

County Durham and Darlington NHS
NHS Foundation Trust

Centre for Clinical Research and Innovation,
5th Floor,Darlington Memorial Hospital,
Darlington
County Durham
DL3 6H

Tel: 01325 743737
Fax: 01325 743768

Private & Confidential

17 August 2015

[redacted] – Senior Lecturer
Teesside University
School of Health & Social Care
Centuria Building
Borough Road
Middlesbrough
TS1 3BA

Dear [redacted]

Letter of access for research – Service Evaluation – Improving Access to Physcological Therapies (IAPT)

This letter confirms your right of access to conduct research through County Durham & Darlington NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on 17 **August 2015** and ends on **31 January 2017** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at County Durham & Darlington NHS Foundation Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to **County Durham & Darlington NHS Foundation Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through County Durham & Darlington NHS Foundation Trust, you will remain accountable to your employer **Teesside University** but you are required to follow the reasonable instructions of **Lisa Boyd – Clinical Lead / Tarn Nozedar - Research**

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

[redacted]

Tarn Nozedar
Clinical Research & Innovation Manager

cc: Recruitment
County Durham & Darlington NHS Foundation Trust
Darlington Memorial Hospital
Memorial Hall
Hollyhurst Road
Darlington
DL3 6HX recruitmenthelpdesk@cddft.nhs.uk

Lynn Percy – HR Manager
Teesside University
University House
Middlesbrough
TS1 3BA percy@tees.ac.uk

Appendix III.ii Registration form for service evaluation

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Service Evaluation Registration Form

REGISTRATION FORM FOR SERVICE EVALUATIONS

PROJECT TITLE:	An Interpretative Phenomenological (IPA) analysis of High Intensity Cognitive Behavioural Therapy supervisory dyads experiences of interpersonal processes in the supervisory relationship

PROJECT LEAD DETAILS:					
Surname:	[redacted]	**First Name:**	[redacted]		
Job Title:	CBT Therapist Bowes /Senior Lecturer				
Base:	Lanchester road hospital & Teesside University	**Contact Telephone Number:**	[redacted]		
Service:	AMH ☒	C&YPS ☐	LD ☐		
	MHSOP ☐	Pharmacy ☐	Substance Misuse ☐		
	Forensics ☐	Offender Health ☐			

PROJECT TEAM:
[redacted] Interviewer.
Wendy Wood Principle research, Supervisor University of Derby w.wood@derby.ac.uk
So far I have interviewed 8 supervisory dyads from various locations within the North East.
The supervisor who has agreed to be interviewed about her experiences of providing IAPT supervision works within TEWV.

PROJECT DETAILS					
Locality:	Teesside ☒	Durham & Darlington ☐	York and Selby ☐		
	Forensic Services ☐	North Yorkshire ☐			
Location of Project: CBT Therapists place of work					
Proposed **Start** Date of Project:		Proposed **Completion** Date of Project:			
24/11/16		24/11/16			

Aims, rationale and objectives:

In my position as senior lecturer I am also a programme leader for PgD CBT training programme and I also manage Clinical supervision for CBT practice course. The study is part of my Doctorate studies

The aim is as follows:

- Elicit an understanding of IAPT supervisees and their supervisors subjective experiences of interpersonal processes in the supervisory relationship

Objectives:

- Explore the lived experience of how challenges and ruptures in the supervisory and therapeutic relationship are attended to within the supervisory relationship.
- Consider the nature of the supervisory relationship
- Examine the influences of openness and disclosure within the supervisory relationship

- The findings can be used to inform clinical supervision training and development. The study elaborates on a recent pilot study in which one supervisory dyad was interviewed on their experiences interpersonal processes in the SR the results of which will be used in main study.

Methodology:

- 8 supervisory dyads (Supervisor and supervisee) have already been interviewed from other services.
- One remaining dyad will be interviewed separately using a semi structured format.
- The interview will be audio recorded and transcribed verbatim with consent from the individual.
- The interview will be approximately 50 minutes in length.
- IPA is concerned with the detailed examination of the lived experience and will be utilised for data analysis.
- Main themes (across all interviews) will be identified. Results will be used to inform Clinical supervision training

Page 1 of 2

Key Areas/ Questions to be investigated	Source of Evidence (e.g. Essential Standards for Quality and Safety, National Surveys, PROMS)
Perspective of being an IAPT supervisor	A competence framework for the supervision of Psychological Therapies (Roth & Pilling 2008 UCL)
Experiences of being in a supervisory relationship	
Degree of openness in supervision	
Interpersonal issues that supervisee has experienced in the therapy relationship	
Signed: [redacted] Project Lead	**Dated:** (26/10/16)

Thank you for completing this form.

Following receipt of the completed registration form the Clinical Audit and Effectiveness Team will confirm receipt and enter the project onto the Clinical Audit database. You will be contacted, thereafter, with the database number assigned to the project.

Please return your completed form to:

Address: Clinical Audit and Effectiveness Team, Tamcroft,
Lanchester Road Hospital, Lanchester Road, Durham, DH1 5RD

Tel: 0191 333 3557 **Email:** tewv.clinicalauditandeffectiveness@nhs.net

Appendix III.iii Research passport

Research Passport Application Form – Version 3 01/09/2012

Please refer to the guidance notes before completing the form.

Section 1 - Details of Researcher *To be completed by Researcher*

1.	Surname: [redacted]	Prof☐ Dr☐ Mr☐ Mrs√☐
	Forename(s): [redacted]	Miss☐ Ms☐ Other☐
	Home Address: [redacted]	
	Work Tel: 01642218121 Mobile: [redacted] Email: [redacted]	
2.	Date of birth: 04/07/1966	Gender: Male☐ Female √☐
	Ethnicity: Irish	National Insurance number: [redacted]
3.	Professional registration details, if applicable (Doctors undertaking any form of medical practice should confirm they have a licence to practise). N/A☐	
	NMC Pin: [redacted] BABCP membership: [redacted]	
4.	Place of study: University of Derby	
	Work Address/ Teesside University	
	Post or status held: Senior Lecturer	

Section 2 - Details of Research *To be completed by Researcher*

5.	What type of Research Passport do you need? Project-specific √☐ Multi-project☐			
	If you will be conducting one project only please complete the details below. If you anticipate that you will be undertaking more than one project at any one time, please give details in the Appendix.			
	Project Title: Improving Access to Psychological Therapies (IAPT); Cognitive Behavioural Therapy supervisors and supervisees experiences of interpersonal processes within clinical supervision. An Interpretative Phenomenological Analysis pilot study			
	Project Start Date: July 2015 End Date: 2017			
	Proposed start and end-date of 3-year Research Passport: Start Date: July 2015 End Date: January 2017			
	NHS organisation(s):	Dept(s):	Proposed research activities:	Manager in NHS organisation:
	CDDFT	IAPT service	Interview a clinical supervisor and their supervisee	[redacted]

Section 3 – Declaration by Researcher *To be completed by Researcher*

6.	Have you ever been refused an honorary research contract?	Yes☐ No √☐
	Have you ever had an honorary research contract revoked?	Yes☐ No √☐
	If yes to either question, please give details:	

I consent to the information provided as part of this Research Passport and attached documents being used, recorded and stored by authorised staff of the NHS organisations where I will be conducting research.

When Sections 1-3 have been completed, the researcher should forward the form to the appropriate person to complete Section 4.

Section 4 - Suitability of Researcher
To be completed by researcher's substantive employer, e.g. line manager, or academic supervisor

7.a	Will this person's research activity mean that they may be undertaking regulated activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012)? (please use the Research Passport algorithm to make this judgement)	Yes ☐ No √☐
7. b	I am satisfied that the above named individual is suitably trained and experienced to undertake the duties associated with the research activities outlined in this Research Passport form.	
	Signed:	Date: 9/7/15
	Name: Gordon Mitchell	Job Title: Principle Lecturer
	Department and Organisation: School of Health & Social Care	
	Address: Centuria Building Teesside University, Borough Road Middlesbrough TS13BA	
	Tel No:01661 218121	Email: G.mitchell@tees.ac.uk
	Managerial responsibility for the applicant: Line Manager	

When Section 4 has been completed, the researcher should forward the form to the appropriate person to complete Section 5.

Section 5 - Pre-engagement checks *To be completed by the HR department of the researcher's substantive employer or registry at place of study*

8.	Does the above named individual's research involve Regulated Activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012)?	☐ Yes ☑ No
	If yes to the above, has the above named individual been checked against ISA barred lists for adults and/or children, as appropriate and have you received confirmation via the criminal record disclosure that the person is not barred from working with adults and/or children? (*NB individuals who are barred from working with adults or children must not undertake a regulated activity in the NHS with the vulnerable group from which they are barred, and you must not submit a Research Passport form in such cases).*	Checked against: ISA Adults List? Yes ☑ No ☐ N/A ☐ ISA Children's List? Yes ☐ No ☑ N/A ☑
	Can you confirm that a clear criminal record disclosure has been obtained for the above-named individual, with no subsequent reports from the individual of changes to this record? *NB for Regulated Activity this must be an enhanced level criminal record check. For non-regulated activity, ensure the criminal record check is at the mandated level.*	Yes ☑ No ☐ N/A ☐
	If yes, please provide details of the clear disclosure:	
	Date of disclosure: 30/7/2015	Type of disclosure: ENHANCED
	Disclosure No.: [redacted]	Organisation that requested disclosure: [redacted]
9.	Have [redacted] been carried out with regard to the above-named individual and is confirmation of the necessary checks, including any required satisfactory documentary evidence, available in the employing organisation's/place of study's records?	
	▪ Employment/student screening:	
	o ID with photograph	Yes ☑ No ☐
	o two references	Yes ☑ No ☐
	o verification of permission to work/study in the UK	Yes ☑ No ☐
	o exploration of any gaps in employment	Yes ☑ No ☐
	▪ Evidence of current professional registration	Yes ☑ No ☐ N/A ☐
	▪ Evidence of qualifications	Yes ☑ No ☐
	▪ Occupational health screening / clearance	Yes ☑ No ☐
	Is the named individual on a fixed term contract or is the contract end imminent? Yes ☐ No ☑ Please indicate current contract end-date Date:	
	Signed: [redacted]	Date: 5/8/2015
	Name: [redacted]	Job Title: HR Manager
	Organisa[redacted]	Department: Human Resources

Appendix III.iv Service Evaluation Registration Form

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Service Evaluation Registration Form

REGISTRATION FORM FOR SERVICE EVALUATIONS

PROJECT TITLE:	An Interpretative Phenomenological (IPA) analysis of High Intensity Cognitive Behavioural Therapy supervisory dyads experiences of interpersonal processes in the supervisory relationship

PROJECT LEAD DETAILS:					
Surname:	[redacted]	**First Name:**	[redacted]		
Job Title:	CBT Therapist Bowes /Senior Lecturer				
Base:	Lanchester road hospital & Teesside University	**Contact Telephone Number:**	[redacted]		
Service:	AMH ☒	C&YPS ☐	LD ☐		
	MHSOP ☐	Pharmacy ☐	Substance Misuse ☐		
	Forensics ☐	Offender Health ☐			

PROJECT TEAM:
Bernie Gibson, Interviewer.
Wendy Wood Principle research, Supervisor University of Derby w.wood@derby.ac.uk
So far I have interviewed 8 supervisory dyads from various locations within the North East.
The supervisor who has agreed to be interviewed about her experiences of providing IAPT supervision works within TEWV.

PROJECT DETAILS					
Locality:	Teesside ☒	Durham & Darlington ☐	York and Selby ☐		
	Forensic Services ☐	North Yorkshire ☐			
Location of Project: CBT Therapists place of work					
Proposed **Start** Date of Project:		Proposed **Completion** Date of Project:			
24/11/16		24/11/16			

Aims, rationale and objectives:

In my position as senior lecturer I am also a programme leader for PgD CBT training programme and I also manage Clinical supervision for CBT practice course. The study is part of my Doctorate studies

The aim is as follows:

- Elicit an understanding of IAPT supervisees and their supervisors subjective experiences of interpersonal processes in the supervisory relationship

Objectives:

- Explore the lived experience of how challenges and ruptures in the supervisory and therapeutic relationship are attended to within the supervisory relationship.
- Consider the nature of the supervisory relationship
- Examine the influences of openness and disclosure within the supervisory relationship
- The findings can be used to inform clinical supervision training and development. The study elaborates on a recent pilot study in which one supervisory dyad was interviewed on their experiences interpersonal processes in the SR the results of which will be used in main study.

Methodology:

- 8 supervisory dyads (Supervisor and supervisee) have already been interviewed from other services.
- One remaining dyad will be interviewed separately using a semi structured format.
- The interview will be audio recorded and transcribed verbatim with consent from the individual.
- The interview will be approximately 50 minutes in length.
- IPA is concerned with the detailed examination of the lived experience and will be utilised for data analysis.
- Main themes (across all interviews) will be identified. Results will be used to inform Clinical supervision training

Page 1 of 2

Key Areas/ Questions to be investigated	Source of Evidence (e.g. Essential Standards for Quality and Safety, National Surveys, PROMS)
Perspective of being an IAPT supervisor	A competence framework for the supervision of Psychological Therapies (Roth & Pilling 2008 UCL)
Experiences of being in a supervisory relationship	
Degree of openness in supervision	
Interpersonal issues that supervisee has experienced in the therapy relationship	
Signed: [redacted] Project Lead	**Dated:** (26/10/16)

Thank you for completing this form.

Following receipt of the completed registration form the Clinical Audit and Effectiveness Team will confirm receipt and enter the project onto the Clinical Audit database. You will be contacted, thereafter, with the database number assigned to the project.

Please return your completed form to:

Address: Clinical Audit and Effectiveness Team, Tarncroft,
Lanchester Road Hospital, Lanchester Road, Durham, DH1 5RD

Tel: 0191 333 3557 **Email:** tewv.clinicalauditandeffectiveness@nhs.net

Appendix IV Letters to service managers and participants

School of Health & Social Care
Teesside University
Borough Road
Middlesbrough
TS1 3BA
[Date]

Dear

As a Doctorate student at the University of Derby I am writing to inform you of a research study that is shortly to commence which relates to IAPT Clinical Supervision. I wish to interview supervisory dyads and seek supervisors and supervisees who are agreeable to taking part in the study. The study title is

"Improving Access to Psychological Therapies; Cognitive Behavioural Therapy supervisors and supervisees experiences of interpersonal processes within clinical supervision. An Interpretative Phenomenological Analysis pilot study".

The study aims to find out more about supervisees and supervisors experiences of the supervisory relationship and about how open supervisees can be in relation to their clinical work.

In your role I am aware that you will have contact with clinical supervisors in your area and I would be grateful if you could forward the attached email to supervisors who may be interested in participating in the study.

The inclusion criteria for clinical supervisors is as follows:

- Currently or has recently supervised a High Intensity CBT Therapist who completed training between six months and two years prior
- Is a BABCP accredited CBT Therapist

Feel free to email me if you have any questions about the study on @unimail.derby.ac.uk

[redacted]
Doctorate Student University of Derby

Research supervisor: Wendy Wood
w.wood@derby.ac.uk

Covering Letter for Participants

School of Health & Social Care
Teesside University
Borough Road
Middlesbrough
TS1 3BA
[Date]

Dear

As a Doctorate student at the University of Derby I am writing to inform you of a research study which is shortly to commence which relates to IAPT Clinical Supervision. I wish to interview supervisory dyads and seek supervisors and supervisees who are agreeable to taking part in the study.

Inclusion criteria for Supervisor:

- You are currently or have recently supervised a High Intensity CBT Therapist who completed training between six months and two years prior
- You are a BABCP accredited CBT Therapist
- You and your supervisee consent to participating in the study

Inclusion criteria for supervisee:

- You completed Postgraduate Diploma in CBT within the timeframe of more than six months ago but within the last two years
- You currently work within an IAPT service as a High Intensity Therapist or has recently moved to another service (within 3 months)
- Both you and your supervisor consent to participating in the study

Please find enclosed information relating to the study. On reading the information if you are interested in participating in the study I would be grateful if you could forward this email to one of your supervisees who may also like to participate.

Please email me on: @unimail.derby.ac.uk if you and your supervisor wish to participate. I would be happy to arrange a time at your convenience to discuss the study in more detail.

Yours Sincerely

[redacted]

Doctorate Student University of Derby

Research supervisor: Wendy Wood
w.wood@derby.ac.uk

Full title of Project:
An Interpretative Phenomenological Analysis of High intensity Cognitive Behavioural therapy supervisory dyads experiences of the supervisory relationship

[redacted], Senior Lecturer

		Please Initial Box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3.	I agree to take part in the above study.	☐
4.	I agree to take part in the study and to being audio recorded	☐
5.	I agree to the use of anonymised quotes in publications	☐

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Researcher Date Signature

Appendix V Interview schedules: supervisors and supervisees

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Guidance for Semi-structured Interview Schedule (supervisors)

Introduction:

Confidentiality/consent/ right to withdraw
Viewing of transcripts and the right to change if inaccurate

Aims of interview (from researcher):

Themes to be explored and initial prompt questions:

What are your experiences of providing IAPT supervision? (warm-up)

What are your current experiences of supervising IAPT workers?
Describe what you enjoy about supervising
What kind of difficulties do you experience?

What are your experiences of the supervisory relationship?

How comfortable do you feel within supervision?
Do you feel that you have a good relationship with your supervisee?
Do you think he/she opens up to you within supervision?
Have you ever needed to address issues relating to the supervisory relationship?
Can you tell me a bit about this?
Does your supervisee have any interpersonal issues that make supervision difficult?
Do you feel able to discuss these with your supervisee?

Disclosure within supervision

Do you believe that your supervisee provides a fair and accurate representation of therapy sessions and clients within supervision?
Has your supervisee ever disclosed that they s/he made clinical errors?
Have you any reason to believe that your supervisee isn't always open in relation to their clinical work?
Do you ever suspect that your supervisee is 'holding back' some information?
How would you deal with non-disclosure within supervision?

The Therapeutic relationship

What is the main focus within supervision?
If we were to look at how much time was spent in different areas within supervision can you give me a rough idea of how much time is spent on different areas?
How important do you think it is to discuss the therapeutic relationship when supervising?
Do you feel you have sufficient time to address this within supervision?

When considering interpersonal behaviours of supervisees or clients are there any theories that you draw upon? (e.g. attachment, personality disorders)

How do you view yourself as an IAPT supervisor?

What are your thoughts about providing IAPT supervision?
What are your thoughts about your current practice?
Do you ever feel distressed within supervision?
Are there any areas that you feel you need to develop?
Do you ever feel unable to supervise (for whatever reason)?

What support is in place for you as a supervisor?

If you have a bad supervision experience, how do you deal with it?

Other

Is there anything else you would like to say that hasn't been covered?
Is there anything else I should be asking?

Debriefing

Semi - structured Interview Schedule. Participant no.

What are your experiences of providing IAPT supervision**?**	
Experiences of the supervisory relationship	
The therapeutic relationship	
Disclosure	
How do you view yourself as an IAPT supervisor?	
What support is in place for supervisors?	
Other	

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Guidance for semi structured interview schedule (Supervisee)

Introduction:

Confidentiality/consent/ right to withdraw
Viewing of transcripts and the right to change if inaccurate

Aims of interview (from researcher):

Themes to be explored and initial prompt questions

Previous experience/intro to supervision (warm-up)

Can you tell me a little bit about your previous experiences of being supervised?
How did you come to be a high intensity therapist?
How different is HI supervision

What are your experiences of receiving IAPT supervision?

- *What are your current experiences of being supervised within an IAPT service?*
- *What happens in supervision?*
- *What initial hiccups did you experience when you first started being supervised as a newly qualified therapist?*
- *Have these hiccups been resolved?*

Perspectives of supervisory relationship

- *For you how important is the SR in supervision?*
- *For you what would a good relationship be and what does this enable?*
- *How would your supervision differ if your relationship was better/worse/neutral?*

The supervisory relationship

- *How comfortable do you feel within supervision?*
- *How would you describe your relationship with your supervisor?*
- *Do you feel able to open up within supervision?*
- *We all have different backgrounds, experiences, sensitivities, needs etc. and in CBT we recognise that these are at play within sessions the same can be said for supervision (offer example); Can you reflect on factors that may affect the interpersonal dynamics that you are aware of within your current supervision? (e.g. performance targets, resource issues, differing goals)*
- *Do you or your supervisor have any interpersonal issues that impact supervision (such as power differentials, wanting to be liked, lacking enthusiasm?*
- *Have you ever needed to address issues that relate to the supervisory relationship?*
  Can you tell me a bit about this?
- *Do you feel able to discuss these with him/her*

- *Is your relationship with your supervisor discussed within supervision?*

Disclosure within supervision

- *Have you and your supervisor ever discussed the ability to be open/disclose information within supervision?*
- *Have you ever disclosed that you had made a clinical error?*
- *Have you ever held back information that was relevant to supervisory discussion?*
  Can you tell me a bit more about this?
- *What would make you less likely to disclose within supervision?*
- *What factors within supervision are conducive to you 'opening up' in relation to clinical errors?*

Your relationship with clients

Does your supervisor encourage you to reflect on your relationship with clients?

Are you encouraged to reflect on how you and your client relate to one another and the impact of this?

Do you reflect on your/your client's personality traits within supervision, for instance attachment styles?

How do you view yourself as an IAPT supervisee?

How collaborative is supervision?

How much do you value supervision in relation to your development as a therapist?

Have you ever felt a sense of shame or guilt because of what you have said or not said in supervision?

Can you tell me more about this?

What is your view of supervision?

Is it something you engage in for accreditation reasons?

Can you tell me more about this?

What aspect of supervision makes you feel more/less uncomfortable?

What support do you get within supervision?

If you had an unpleasant experience relating to your clinical practice would you feel able to discuss it within supervision?

Do you feel judged within supervision?

If you have a bad supervision experience, how do you deal with i

Other

Is there anything else you would like to say that hasn't been covered?

Is there anything else I should be asking?

Debriefing

Semi-structured Interview Schedule. Participant no.

Warm-up Previous supervision experiences How did you come to IAPT?	
Experiences of receiving IAPT supervision? (what happens, how often, what gets discussed etc)	
Perspective of the importance of supervisory relationship *How important is the SR in supervision?* *What would a good relationship be and what does this enable?* *How would your supervision differ if your relationship was better/worse/neutral?*	
Experiences of the supervisory relationship Describe How comfortable? Ability to open up Any factors that affect dynamics e.g. background, role? IP factors (SPVR or SPVE that affect IP Processes (e.g. needing to be liked, power differentials, lack of enthusiasm) Any issues that could have been discussed? Do you feel able to discuss issues? Is supervisory relationship discussed?	
Disclosure *Discussion re the ability to open/disclose info within supervision?* *Disclosure re clinical error?* *Ever held back relevant info?* *Can you tell me a bit more about this?* *What would make you less likely to disclose within supervision?* *What factors within supervision are conducive to you 'opening up' in relation to clinical errors?*	

Your relationship with clients *Encouraged to reflect on your relationship with clients* *Encouraged to reflect on how you and your client relate to one another and the impact of this* *Do you reflect on your/your clients'* *personality traits within supervision, for instance attachment styles?*	
Bordin SWA Mutual agreement on goals & task Bond	
Your experiences and perspectives of supervision *How collaborative?* *How much do you value in relation to your development as a therapist?* *Felt a sense of shame or guilt because of what you have said or not said in supervision?* *Can you tell me more about this?* *What is your view of supervision?* *Is it something you engage in for accreditation reasons?* *What aspect of supervision makes you feel more/less uncomfortable?*	
Support within supervision *Any unpleasant experience relating to your clinical practice would you feel able to discuss it within supervision?* *Do you feel judged within supervision?* *If you have a bad supervision experience, how do you deal with it?*	
Other Any questions I should be asking	

Appendix VI Participant Information Sheet and Consent Form

Participant Information Sheet

1. Study Title

"Improving Access to Psychological Therapies; Cognitive Behavioural Therapy supervisors and supervisees experiences of interpersonal processes within clinical supervision. An Interpretative Phenomenological Analysis".

2. Invitation

I would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read through the following information and talk it over with others if you wish. Included is information relating to the purpose of the study and what will happen to you if you take part. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. An important part of any study is informed consent and it is essential that you have sufficient information to make the decision regarding involvement

3. What is the purpose of the study?

Clinical supervision is recognised as an essential part of Cognitive Behavioural Therapy training and practice development. The purpose of this study is to explore the IAPT supervisor and supervisees experiences and perspectives of interpersonal processes in supervision

You are being invited to participate because:

- You are currently or have recently supervised a High Intensity CBT Therapist who completed training between six months and two years

  OR

- You have completed a Postgraduate Diploma in CBT within the timeframe of more than six months ago but within the last two years and currently receive supervision in your post as a High Intensity CBT Therapist.

The study aims to find out more about supervisees and supervisors experiences of the supervisory relationship and about how open supervisees can be in relation to their clinical work

4. Do I have to take part?

Taking part in the study is entirely voluntary and it is up to you to decide. If you do decide to participate, you will be asked to sign a consent form prior to commencement of the interview to show you have agreed to take part. You are free to withdraw at any time up to the point of data analysis without giving a reason.

5. What will happen to me if I take part?

You will be asked to be interviewed by me either face to face or via skype, depending on your location. This will entail you being asked to share your experiences of being an IAPT supervisee. My aim is to acquire in- depth knowledge, therefore you would be expected to reflect deeply on your experiences and share your opinions. In order to explore how you make sense of your experiences, a qualitative research approach called Interpretative Phenomenological Analysis (IPA) will be used. This is described below. The interviews will take approximately 50 minutes to one hour.

The interview will be audio-taped. Confidentiality will be maintained and the information you share will be anonymised (unless it becomes evident that malpractice has occurred in the event of which information will be passed to the relevant person). You can choose not to answer questions if you do not wish to and any point, and you can terminate the interview at any point if you feel uncomfortable. The audio recording will be coded to ensure that confidentiality is maintained. Data will be stored securely and only the researcher and my supervisors will have access to this. The audio recording will be transcribed; this means that the interview will be presented in typed form. You will be asked to read over it carefully and confirm the accuracy of the transcript.

6. What is IPA?

Qualitative research adopts research methods such as interviews, focus groups and observation to learn more about the area being studied. IPA is a type of qualitative research which engages with the meaning that experiences, events and actions hold for the person involved. This method of research involves the detailed analysis of an experience. More information on IPA can be found on: http://ipacommunity.tumblr.com/

7. Expenses and payment

You will not receive payment for taking part in the study.

8. What will I have to do practically?

You will be interviewed by myself regarding your experiences of being in IAPT supervision. The venue will be a suitable environment of your choice provided health and safety requirements are met (where we can be guaranteed privacy and quiet). If a face-to-face interview is not possible due to geographical location you will be interviewed by skype. You should be able to draw on your experiences and share these. Following completion of transcription of the audio recording, you will be asked to read through the transcript of your interview. If there is any part of this that you do not agree with or feel uncomfortable about, you can ask for it to be removed. I ask that you make your request within four weeks of receiving the transcript as following this, analysis begins, and it becomes more difficult to extract your data

9. What are the possible disadvantages of taking part?

You may feel uncomfortable sharing your experiences with me. Every effort will be made to make you feel comfortable and the style of questioning promotes reflection and discussion as opposed to you being asked to answer 'set' questions. Participating in the study will take up some of your time. I will be available to discuss any issues with you before or after interviews. Following the interview if you feel that you would benefit from speaking to someone who is independent of the study, I can provide contact details for an independent therapist and/or telephone helplines.

10. What are the possible benefits of taking part? I cannot promise that the research will help you but the information obtained through the research could be used to improve clinical supervision training and development. The study will provide the opportunity for you to reflect on your supervisory experiences and this may assist you to identify how the process of supervision can be enhanced

11. What if I wish to withdraw from the study? You are free to leave the study without jeopardy up to the point of data analysis which begins four weeks after a copy of the interview transcript is sent to you. You will be assigned an identity number and data will be colour coded so that in the event that you decide to withdraw following commencement of data analysis the relevant data may be extracted. If you wish to withdraw you can do so by emailing me on b.gibson1@unimail.derby.ac.uk

You do not need to provide a reason for withdrawing. Confirmation that you have been withdrawn will then be sent to you.

12. What if there is a problem?

If you have a concern about any aspect of the study you should speak to me, I will do my best to answer your questions. If you email me we can arrange a mutually convenient time to discuss any issues or concerns. (The email address is b.gibson1@unimail.derby.ac.uk. However if you do not wish to discuss your concerns with me or if you wish to make a complaint, you can contact:

Wendy Wood
The University of Derby
Kedleston Rd,
Derby DE22 1GB
01332 592344
w.wood@derby.ac.uk

13. Will my taking part in the study be kept confidential?

Your confidentiality will be safeguarded during and after the study.

You will be interviewed individually at an appropriate venue of your choice or via skype. You have the right to the assurance of reasonable data security even though interviews may be conducted using the Internet and skype does encrypt messages. The interview will be audio taped using a digital recorder. The recordings will be coded and therefore not identifiable. These will be stored in a secure environment at all times and only the researcher and the researcher's supervisors will have access. The recordings will be destroyed after the research has been written up and marked by the University of Derby. All researchers have a duty of confidentiality, and we will do our best to meet this duty however in the event that the best interests of service users are compromised for instance in cases of malpractice it may be necessary to pass information on to relevant people. This is in keeping with the '**The standards of conduct, performance and ethics in CBT'** (BABCP 2009)

The content of the tapes will be transcribed to paper form so that the content can be read. Once again, this will be coded and not identifiable. To ensure that the content is a fair representation of what you have said in the interview, the researcher will ask a second researcher to check for accuracy. Only the researchers will have access to the tapes and transcripts.

You will be asked to read over the transcripts to make sure that you agree with the contents. You will be given four weeks to contact the researcher in the event that you disagree with, or are uncomfortable about some information being included. This information can be omitted.

The researcher will carefully read over the transcript and extract any themes that become evident. This will be used to form part of the data for the research.

All data will be stored, analysed and reported in compliance with the Data protection legislation. Data will be destroyed once the research study has been written up and has been formally marked.

14. What will happen to the findings of the research study?

As stated above you will be asked to comment of the accuracy of the transcribed recording of the study interview. The findings of the research may be published as part of a doctoral thesis.

15. Who has reviewed the study?

The University of Derby's Research Ethics Committee has reviewed the research proposal

Contact for further information

Researcher: [redacted]@unimail.derby.ac.uk

Research Supervisors:
Wendy Wood: w.wood@derby.ac.uk
Dzintra Stalmeister: D.stalmeisters@derby.ac.uk

Thank you for taking part in the study
Please retain a copy of the information sheet and the signed consent form

If you would like to take part in the study, please read and sign the consent form on the next page.

Consent form

Full title of Project:
An Interpretative Phenomenological Analysis of High intensity Cognitive Behavioural therapy supervisory dyads experiences of the supervisory relationship

[redacted], **Senior Lecturer**

	Please Initial Box
2. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3. I agree to take part in the above study.	☐
4. I agree to take part in the study and to being audio recorded	
5. I agree to the use of anonymised quotes in publications	☐

Name of Participant	Date	Signature

Name of Researcher	Date	Signature

Appendix VII Initial noting framework

Participant 1 (Supervisee)	Participant 2 (Supervisor)
Start of the journey Increased autonomy and what this means – Need to have control Empowered /more freedom/being in control What all of the above mean (being good enough? Trustworthy?) Trust and what it means/metacognitions Able to make own discoveries (?Kolb) Optimum development contingent to SR Compatibility Prev SR incompatible/personality clashes Attachment styles Freedom to explore with support Self-exploration/formulation Vulnerabilities as supervisee, therapist, person Self-protection Core conditions – unconditional positive regard Holding back Am I good enough?/proving himself/conveying competence Representation of patient Role conflict Being a man in supervision and therapy Emotions Cultural expectations competitiveness Personal growth – reflections/ EI The impact of supervision Attachment (P7) – need for support/ nurturing 'Safe' to disclose Containment within SR – 'Pulls us up' 'Reins us in' p8 Controlled autonomy Disclosure versus holding back Identifying with clients (re disclosing) Personal growth Importance of TR/facilitating professional development thro TR	Socialising spve to procedures within supervision 'checking in' The world of the IAPT therapist/supervisor Establishing relational boundaries SR connecting within supervision (or not) Challenges of supervising Context of IAPT ? Protecting supervisees Divided loyalties Conflicting roles Holding back Pg 6 line 14 Piggy in the middle Proving herself/sense of duty The 'Being' of supervision Dealing with negative emotion Needing to be effective/useful/doing role properly – what it means to not? Working things out together Role satisfaction Holding back/restricting supervision p7 line 20 Giving back what she gets in supervision Supervisee avoidance Openness versus holding back Supervisees' journey Supervisee being open – ingredient of good SR? Sense of pride in supervisees Wants to convey that she shares/goes beyond call of duty Ability v vulnerability of spve The person – I- thou Emotion in supervision and therapy/Distress Being versus doing Formulating the supervisory relationship Conflicting roles of the spvr Playing at relationships Power differentials

Understanding the world of others Re-evaluating own world – ie meaning p13 The journey Journey of emotions	Addressing relational issues in supervision ‘Like ripping a plaster’ Humour, feeling comfortable, compatibility Trust Responsibility for supervisee Dealing with supervisee errors TR/addressing IP issues Demands of role/ compartmentalising Adapting spvn to reflect demands of IAPT service Loyalty to service

Appendix X Reflective journal extracts (removed)