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EXPLORING THE RELATIONSHIP BETWEEN CLINICAL SUPERVISION AND CLIENT OUTCOMES

Section A: Examining Evidence for the Impact of Clinical Supervision on Client Outcomes in Psychological Therapies: A Systematic Review

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Section B: Being Contained to Becoming the Container: A Reflexive Thematic Analysis of the Relationship Between Clinical Supervision and the Therapeutic Alliance from the Perspective of Trainee Clinical Psychologists

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Summary of MRP

Section A

This review sought to investigate the evidence for the impact of clinical supervision on client outcomes in psychological therapies. Professional guidelines and clinical practice reflected a broad assumption that supervision served the interests of the client with a relative lack of research examining this claim. Previous reviews in the area were also deemed to be dated or contained important limitations. Searches in online databases PsychInfo, CINAHL, and ASSIA yielded 12 studies that met eligibility criteria, which were assessed using appraisal criteria. The current review found little evidence that supervision contributes substantially to client welfare, and limited progress appears to have been made since the last review of this kind. Though studies in the area are low in number and evidently contain issues with design and clarity of reporting, the review also reinforced the real challenge in trying to comprehend the links between supervision and therapeutic outcomes. Researchers are encouraged to explore relationships between more proximal variables than those studies included in this review attempted, with the intention of gradually clearing the path between supervision and client wellbeing. Clinicians are encouraged to continue their engagement with the process of supervision, but with a critical eye on assumptions and possibilities in the absence of convincing data for guidance.

Section B

This study used reflexive thematic analysis to qualitatively explore the relationship between supervision and the therapeutic alliance from the perspective of trainee clinical psychologists. Based on nine participants' accounts, it appears that supervision offers a

model of relating that can be translated to the therapeutic relationship, and a crucible within which change happens, to the benefit or detriment of the alliance. Supervisors and trainees who engaged together with emotional and relational material were perceived as contributing more positively to the trainee-client relationship, whereas supervision which entailed a more detached and inflexible approach to what was brought by trainees was perceived as limiting or mitigating trainee and client security and development.

Tthe findings of this study suggest support for attachment and supervisory relationship models of supervision, which see the supervisor as a 'base' from which the supervisee can access security, support, and guidance. The psychodynamic model of supervision suggests a transfer of this relationship to the therapeutic alliance and vice versa, a concept which is seemingly supported by the data in this study.

Limitations, and research and clinical implications are discussed. Recommendations for future research include mixed methods longitudinal investigations of trainee experience over time, and concurrent efforts to better understand client and supervisor experinces. In terms of clinical practice, testimony provided by participants in this study illuminates the promise and pitfalls of supervision- its potential to contain so trainees may offer containment to their clients, and its potential to neglect in a way that is felt to be at best limiting and at worst distressing for trainees and, potentially, for clients. Qualified and trainee staff, as well as professional and training institutions, are encouraged to actively engage with the understanding and practice of supervision to avoid harm and to increase safety and effectiveness for the benefit of all parties involved.

Table of Contents

List of Tables

Section A

Section B

List of Figures

Section A

Section B

List of Appendices

Section A: Literature Review

Examining Evidence for the Impact of Clinical Supervision on Client Outcomes in Psychological Therapies: A Systematic Review

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Abstract

Clinical supervision is valued in the field of psychological therapies as reflected in practice guidelines and surveys of trainee and practitioner therapists. However, numerous reviews suggest that the impact of supervision on client outcomes is unclear, with the emphasis in the literature being on supervisee benefits. Understanding is further limited by poor study quality and the lack of a recent review focused on client outcome. This systematic review, conducted in accordance with PRISMA guidelines, examined the reported impact of clinical supervision on post-treatment outcomes suggestive of client benefit following engagement in psychological therapy. Searches in online databases PsychInfo, CINAHL, and ASSIA yielded 12 studies that met eligibility criteria, which were assessed using appraisal criteria. Though studies reported findings suggestive of client benefits, the current review found little cause for confidence in these claims, and limited progress appears to have been made since the last review of this kind, almost 10 years ago. Studies in the area evidently contain issues with design and clarity of reporting, and the review also reinforces the broader challenge in trying to comprehend the links between supervision and therapeutic outcomes. Clinicians are encouraged to continue their engagement with the process of supervision, but with a critical eye on assumptions and possibilities in the absence of convincing data for guidance. In terms of further research, researchers are encouraged to explore relationships between more proximal variables than those studies included in this review attempted, with the intention of gradually clearing the path between supervision and client wellbeing.

Keywords: supervision, therapeutic alliance, clinical psychology, trainee, supervisee, client outcome

Introduction

Clinical Supervision

Defining Clinical Supervision

Clinical supervision (henceforth used synonymously with "supervision") has been defined in clinical psychology as "the formal provision, by approved supervisors, of a relationship-based education and training that is case-focused and which manages, supports, develops and evaluates the work of junior colleagues" (Milne, 2007, p. 439). This empirically-based definition captures the breadth of supervision and how it is utilised across disciplines of psychological therapy (psychology, psychotherapy, counselling, etc.), involving 'normative', 'restorative', and 'formative' tasks. Normative tasks refer to case management and quality control of supervisees' work; restorative tasks refer to support provided by the supervisor to facilitate emotional processing and coping in the supervisee; formative tasks refer to maintenance and development of competence and effectiveness in delivering care (Milne & Watkins Jr, 2014). Bernard and Goodyear (2004) distil supervision down to two broad aims: (i) improvement of supervisees' professional functioning (effectiveness) and (ii) protection of clients (safety).

Relevance of Supervision

Clinical supervision is regarded as "a critical element of clinical practice" by The British Psychological Society (BPS; 2014, p.3), and although it is not legally mandated, the Society position is that it is a requirement for safe and effective practice (BPS, 2017). The British Association for Counselling and Psychotherapy (BACP; 2018) describe it as "essential to how practitioners sustain good practice" (p.22). This sentiment is shared by psychological

therapists and trainees across the UK, who in a survey rated supervision as being the most important influence on their practice (Lucock et al., 2006).

Clinical Supervision Literature

Although professional guidelines and practitioner views imply a valued place for supervision amongst professions, recommendations for how much time should be spent engaged in the activity are somewhat vague (BACP, 2018; BPS, 2017; Health and Care Professions Council (HCPC), 2015). This perhaps reflects the fact that theoretical understanding of supervision and evidence for its effectiveness are regarded as being in their infancy (Beinart & Clohessy, 2017; Watkins Jr., 2019).

Supervision Theory

There has been a shift in the literature from drawing on psychotherapy-specific models to "generic" or "supervision-specific" models of supervision (Beinart and Clohessy 2017). The integrated developmental model (IDM; Stoltenberg et al., 2014), describes the supervisees' passage through developmental 'levels' in supervision, from "anxious, highly motivated, and dependent" to a place of integration and individualised practice, with a strong self-awareness of strengths and needs. To facilitate this, supervisors must adapt the degree of structure and autonomy they provide. Social role models (e.g. Inskipp & Proctor, 1993) describe the different roles of the supervisor in terms of the normative, restorative and formative tasks. The systems approach to supervision (SAS; Holloway, 1995) adopts a systemic understanding of the process, foregrounding mutually influencing contexts in which supervision occurs (e.g. client, therapist and supervisor characteristics and relationships, the tasks of supervision, the institution within which the supervision occurs, etc.). Particular attention is given to the supervisory relationship in this model, which is a

variable that has come to receive independent focus as a key ingredient that determines effective supervision (Beinart & Clohessy, Models of supervision, 2017).

Bordin's model of the supervisory working alliance (SWA; Bordin, 1983), proposes that the supervisory relationship is composed of the goals and tasks agreed upon by both parties, facilitated by their bond. Beinart's (2002) grounded theory of the supervisory relationship (SR) illustrated the key role of a boundaried, supportive relationship in nurturing an emotionally containing space for the process of supervision to occur. Attachment theory literature complements this work by identifying the supervisor's role as a "safe base", akin to a primary caregiver, in facilitating an environment of support and learning (Pistole & Watkins, 1995).

Evidence for the validity of these theories and models has been sparse, particularly in the case of IDM, social role models, and SAS (Beinart & Clohessy, Models of supervision, 2017). Research has linked positive SWAs with reduced role conflict (Ladany & Friedlander, 1995), supervision satisfaction (Ladany et al., 1999), and increased willingness to disclose pertinent information (Mehr et al., 2015). A survey of clinical psychology trainees found that the 'safe base' component of supervision accounted for the greatest variance in their evaluation of their supervisory relationship (Palomo et al., 2010).

Supervision Evidence

Given the aims of supervision stated by Milne (2007) and Bernard and Goodyear (2004), does supervision do what it is intended to do? Most research attention, coming from a variety of psychological therapy disciplines (Milne & Watkins Jr, 2014), has focused on the impact on supervisees. This work has investigated the role of supervision in supervisee satisfaction (e.g. with supervision itself, turnover intention, etc.) and supervisee

competency (e.g. skill acquisition) (Watkins Jr., 2019). Several reviews have been conducted to synthesise and critique this research (Alfonsson et al., 2018; Kühne et al., 2019; Wheeler & Richards, 2007). Wheeler and Richards (2007) carried out a systematic review of the literature in counselling and psychotherapy, suggesting that supervision can foster skill acquisition and self-efficacy in supervisees. However, studies were of variable quality, with only two of eighteen eligible studies rated as 'very good'. Alfonsson and colleagues' review of cognitive behavioural therapy supervision also found study quality to be a concern, but offered further tentative support for the hypothesis that supervision benefits therapeutic competencies (Alfonsson et al., 2018). In the most recent review, the most consistent finding was "the high acceptance, satisfaction, and the perceived helpfulness of supervision by supervisees" (Kühne et al., 2019, p. 6). Other variables, such as the therapeutic alliance and competency development, were cautiously deemed to be positively impacted by supervision, but more rigorous investigation was recommended.

Of course, not all supervision is equal. The prevalence of harmful supervision across disciplines has been well documented (Ellis, 2017; Ellis, et al., 2015). This is an indication that, just as in clinical practice, one cannot assume that all supervision being researched is interchangeable. The type and quality of supervision as well as contextual factors must be taken into account, and therefore drawing conclusions from research is made all the more difficult.

Client Benefit

Crucially, supervisee gains do not necessarily correlate positively with client benefit. Though discussions of supervision reference client welfare as the ultimate "acid test" of good supervision (Ellis and Ladany, 1997), parity of esteem with supervisee benefit has not

been reflected in the literature (Freitas, 2002; Hansen et al., 1976; Watkins Jr., 2019). Holloway and Carroll (1996) compared researchers' emphasis on supervisee needs over client needs to "viewing parenthood solely for the enrichment of parents" (p. 54).

Watkins' inclusive review of 30 years' worth of research identified 18 studies examining supervision's role in client outcomes (Watkins Jr, 2011). Several studies self-identifying as 'client outcome research' were inappropriately labelled as such (e.g. lacked any measure of client outcome). Just one study, comparing the efficacy of problem-solving treatment with and without supervision, was regarded as being of good quality (Bambling et al., 2006), but its results were inconclusive. More recent reviews incorporating client outcome studies (Alfonsson et al., 2018; Kühne et al., 2019) had similarly low numbers of quality studies and were similarly inconclusive in their findings. Therefore, while shortcomings in supervisee outcome research are clear, the state of client outcome research is decidedly worse. Watkins Jr. (2011) concluded that "the drawing of any conclusions about supervision's effects on patient outcome seems premature" (p.252).

Adding to the complexity of this matter is the virtually unchallenged idea of "client outcome" as a singular, objective "acid test". Milne (2014) identifies key problems with this assumption: "client outcomes" are defined and measured differently (e.g. symptom questionnaires, treatment completion service audits); "supervision" and "therapy" vary depending on model, frequency, and length; "supervisors" and "supervisees" vary in training, adherence to, and experience of supervision and therapy; "clients" vary and present with different needs. These variances will have significant ramifications for the reliability, validity, and generalisability of findings if not accounted for.

It is also important to attend to the quality of research reviews. There is no shortage of them, but limitations are present. Some fail to document search terms clearly (Watkins Jr., 2011; Wheeler & Richards, 2007;), are of very limited scope (Watkins Jr., 2011), fail to detail how studies are evaluated, or fail to report important flaws (Alfonsson et al., 2018; Watkins Jr., 2011; Wheeler & Richards, 2007), or provide minimal discussion of client outcomes (Kühne et al., 2019). In a recent "survey of reviews", Watkins Jr. (2019) cautions about these shortcomings, and additionally points to "the limited evidence that affirms any type of supervision impact at all" (p.13). He reserves special sympathy for the client, who "has been, and continues to be, summarily neglected in supervision research" (p.14).

Rationale and Aims

Evidently there is a need for well-conducted reviews in supervision research, particularly one focusing on the impact that supervision has on client outcomes. The last review to focus exclusively on this was published nine years ago, and it did not follow established systematic review guidelines (Watkins, 2011; 2019). Therefore, the current paper aims to carry out a systematic review, seeking to address the following question: What evidence is there of the impact of clinical supervision on client outcomes in psychological therapies?

Method

The review was conducted in line with Grant and Booth's (2009) definition of a systematic review, i.e. "seeking to systematically search for, appraise and synthesis[e] research evidence, often adhering to guidelines on the conduct of a review" (p. 95). The design and implementation of the systematic review was conducted closely in accordance

with the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA; Moher et al., 2009).

Information Sources and Search Strategy

Scoping electronic searches were carried out in January 2020, with a final search of PsychInfo, CINAHL, and ASSIA databases conducted on 28/1/2020 using the search terms and limits outlined in Table 1. These databases were selected to access literature across disciplines that contain psychological therapy research. In addition, reference sections from existing reviews and other relevant articles were hand searched to identify qualifying articles not identified by the database searches. Only English language sources were included due to limited resources available in the context of a DClinPsy thesis. No date limits were applied, and research utilising qualitative, quantitative, and mixed-methods designs were included, in order to increase the scope of the study.

Inclusion and Exclusion Criteria

Titles, abstracts, and full texts of sources were screened to determine their relevance. Studies meeting the inclusion and exclusion criteria below were included in the review.

Guidance was taken from the literature to define and set parameters for ‘clinical supervision’, ‘psychological therapy’ and ‘client outcome’. Milne’s (2007) definition of clinical supervision was adopted for its boundaried inclusivity (e.g. includes supportive functioning, teaching function, power structure, etc.). Studies concerning individual (one-to-one) supervision between supervisor and supervisee, as well as group supervision (multiple supervisees) were included. As discussed previously by Wheeler and Richards (2007) in their review of the supervision literature, family therapy supervision often occurs in ‘live’ form,

wherein the supervisor is watching the therapy from behind a one-way screen or is even in the room and participating in the session. This form of supervision is excluded from the review given that it involves active, sometimes direct involvement of the supervisor in the therapy session. Peer supervision studies were also not included in the review given the lack of delivery by a more experienced member of staff, and the lack of management and evaluative components that would typically be found in clinical supervision.

Only studies concerned with the supervision of supervisees (qualified or in training) delivering psychological therapies (counselling, psychotherapy, etc.) for primarily psychological issues (e.g. in the case of treatment in a physical health setting, the intervention being focused on associated psychological issues) were included in the review. The delivery of the psychological therapy could come from a trainee or a qualified clinician, whose background could be from any mental health discipline (e.g. psychology, psychotherapy, social work, nursing). Supervision for other interventions (e.g. care coordination, general mental health nursing, pharmaceutical interventions, occupational therapy, etc.), were not included.

In order to address problems in the existing literature, it was imperative that this review applied clear parameters to the definition of 'client outcome'. Guidance was taken from Milne (2014), who distinguishes between process or mechanisms (which might be assumed to equate with client benefit) and more strictly defined client outcomes. Post-treatment outcomes suggestive of client benefit (e.g. quality of life, quality of relationships, symptom change, etc.) following engagement in supervised psychological therapy were the focus of this review. Studies using measures exclusively concerned with the *process* rather than the *outcome* of therapy, (e.g. therapeutic alliance, client engagement in therapy, client

satisfaction with therapy, etc.) were not included. Studies involving client-rated, therapist (supervisee)-rated, supervisor-rated or observer-rated quantitative and qualitative outcome evaluations were included. Clients were regarded as participants on the receiving end of the intervention (supervised psychological therapy). These decisions were taken in line with Reiser and Milne (2014), who discuss construct definitions and parameters in detail. This 'fidelity' approach, outlined by Borelli and colleagues seeks to "increase scientific confidence that changes in the dependent variable are attributable to the independent variable" (Borrelli et al., 2005, p. 852). As much as clear parameters are intended to bring clarity and validity to this review, they also present limitations. For example, Milne (2014) notes the potential for positivist bias in his adapted framework, which may exclude qualitative research that understands 'client outcome' in more subjective, constructivist terms.

A source was included if:

- It included a measure or description of the role of clinical supervision for psychological therapies on post-treatment client outcomes

A source was excluded if:

- It did not meet the inclusion criteria above
- It was not primary research (e.g. a systematic review)
- It was unpublished research (e.g. a dissertation)
- It related to clinical supervision for professional activities other than psychological therapy (e.g. occupational therapy)
- It related to 'live' supervision

- It related to peer supervision

Table 1

Database Search Terms and Limits

Database	Search Terms	Search Limits Applied
PsychInfo	supervis* AND (therap* OR psycholog* OR psychotherap* OR counsel*) AND (effect OR impact OR influence OR contribution) AND (client* OR patient* OR service user*) AND (outcome* OR benefit* OR satisfaction)	Advanced search English language only Map term to subject heading (off)
CINAHL	As above	Advanced search Apply equivalent subjects (off) English language only
ASSIA	ab(supervis*) AND ab)(therap* OR psycholog* OR psychotherap* OR counsel*)) AND (effect OR impact OR influence OR contribution) AND (client* OR patient* OR service user*) AND (outcome* OR benefit* OR satisfaction)	Advanced search Scholarly articles only English language only

Quality Appraisal

The review adopted the QualSyst tool to evaluate the quality of studies included in the review, based on its utility for critiquing a wide range of quantitative and qualitative designs across a number of domains (Kmet et al., 2004). The tool was adapted by the addition of an item from the National Institute for Health and Care Excellence (NICE) Quality Appraisal Checklist for Quantitative Intervention Studies, as it was felt that examination of each study's reporting on interventions received by participants (checklist item 2.2), regardless of design, was an important inclusion (NICE, 2012). Studies were rated on each item and scored a 'Yes', 'Partial', 'No', or 'N/A' as per the QualSyst tool, but a summary quality score was not calculated given the risk of bias in subjectively weighting individual items, as noted by the authors of the tool (Kmet et al., 2004).

Results

Identified and Included Studies

The PRISMA flow diagram (Moher, et al., 2009) below (Figure 1) displays the results from the database searches, including the number of sources eliminated during the screening process in accordance with inclusion and exclusion criteria. It also includes eligible articles identified from the manual hand search. Table 2 shows study characteristics for each of the final articles included.

Figure 1

PRISMA Flow Diagram

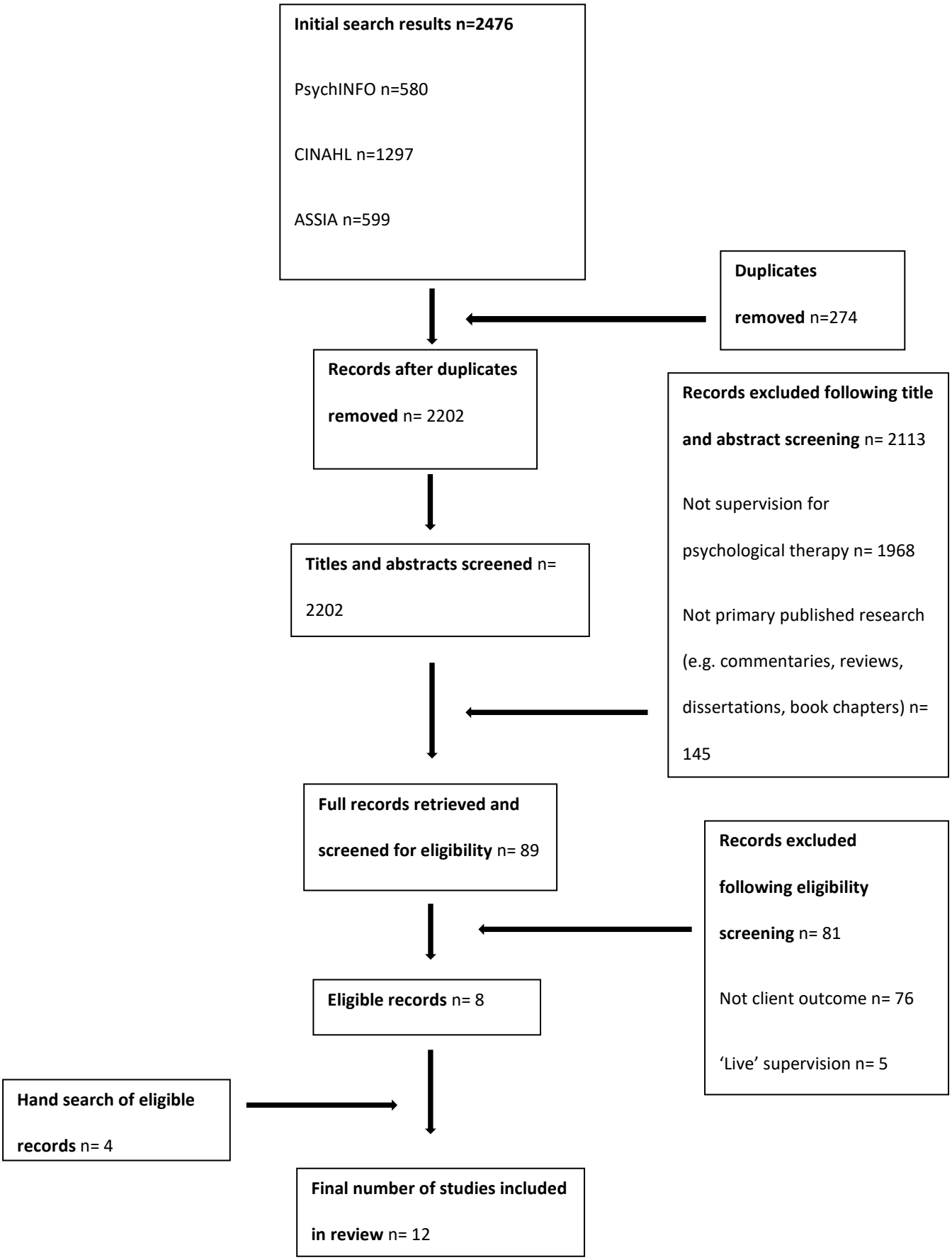

Table 2

Study Characteristics

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
Bambling et al. (2006) Department of Psychiatry (Australia)	The influence of alliance skill-focused v. alliance process focused supervision v. no supervision on client-rated symptom reduction in the brief treatment of major depression	40 supervisors (multidisciplinary) 127 supervisees (multidisciplinary therapists trained in PST)	• Quantitative • Randomised controlled trial Clients with depression diagnosis received eight sessions of PST from either supervised (experimental groups) or unsupervised therapists (comparison groups)	**Client outcome** Depression: Client-rated BDI	• BDI score sig. lower for clients receiving supervised therapy v unsupervised therapy • Non-completion was 30.6% for unsupervised therapy v 6.2% for supervised therapy (sig. difference) • No sig. difference in BDI scores between skill v process- focused supervision groups	• No blinding • Insufficiently powered • Potential therapist allegiance effects

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
		127 adult clients (primary diagnosis of depression)	Supervised therapists received eight sessions of either alliance skill-focused or alliance process-focused supervision	Client dropout/non-completion		
Bradshaw et al. (2007) **Various NHS Trusts (UK)**	Does PSI education plus participation in workplace-based clinical supervision result in improvements in symptoms and social	Supervisors (*n* unspecified; mental health nurses; completed 2-day supervision training) Service users with schizophrenia diagnosis received psychosocial	• Quantitative • Non-randomised historically controlled study	**Client outcome** Psychiatric symptoms:	• Sig. improvement in KGV (M) affective positive symptoms in both groups; no sig. difference between groups • Sig. improvements in SFS scores for both groups; no sig. difference between groups • No sig. improvement in KGV (M) negative symptoms in both groups • Sig. improvement in KVG (M) positive and overall	• Limited detail provided on client sample • Small sample size • Limited detail on supervision provided • Use of historical control means potential confounding variables undetected

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
	functioning for individuals with psychosis?	23 supervisees (mental health nurses with minimum one-year experience) 93 clients (diagnosis of schizophrenia, age unknown)	intervention (duration and frequency unknown) Nurses either received PSI education plus workplace supervision (experimental group) or PSI education without supervision (retrospective comparison group) in addition to programme group supervision (both groups)	Client-rated KGV (M) Social and personal functioning: Client-rated SFS	symptoms in experimental group v comparison group	

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
Callahan et al. (2009) Psychotherapy training clinic (USA)	The influence of supervisors on variability of client-rated intervention outcomes	9 supervisors (academic staff, various ranks) 40 supervisees (clinical psychology doctoral trainees at pre-internship level)	• Quantitative • Correlational study Clients received therapy with a CBT emphasis (minimum three; average 17.89 sessions) Supervisees received one-hour individual and two-hour group supervision weekly for duration of intervention	**Client outcome** Depression: Client-rated BDI-II Psychological and physical symptoms: Client-rated SCL-90-R	• Supervisors had moderate but not sig. effect on client-rated BDI-II	• Study question/hypothesis is not clearly stated • Study design not clearly stated • Limited detail provided on client sample • Limited detail on supervision provided • No estimate of variance in results • Misleading discussion of results

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
		76 clients (various presenting difficulties, age unknown)				

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
Dodenhoff (1981) Counsellor training centre (USA)	The influence of counsellor trainees' attraction to their supervisors and supervisor's style of influence on client and supervisor-rated outcome	12 supervisors (minimum MA level with 'extensive experience in supervision') 59 supervisees (second year MA counselling students) Clients (number unknown, age	• Quantitative • Correlational study Nature, frequency and duration of therapy received by clients unclear Nature, frequency and duration of supervision received by supervisees unclear	**Client outcome** Outcome rating: Client-rated RSO Supervisor-rated RSO **Other measures**	• CRS attraction and OSIA style of influence had no sig. effect on client-rated RSO • Sig. main effect for supervisor style of influence on supervisor-rated RSO • Direct style of supervisor influence (OSIA) scores positively correlated with supervisor-rated RSO	• Study design not clearly stated • Limited detail provided on client sample and clinicians • Robustness of outcome measures not discussed • Limited detail on supervision provided

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
		unknown, presenting issues unknown)		Supervisor style of influence: Observer-rated OSIA (adapted) Supervisor attractiveness: Trainee-rated CRS (short form)		

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
Ng (2005) General hospital psychiatric unit (China)	The influence of cognitive behavioural supervision on therapist competence and client outcome	1 supervisor (cognitive therapist with 3 years' supervision experience) 5 supervisees (psychiatry trainees) 8 adult clients (various diagnoses)	• Quantitative • Uncontrolled before-and-after study Clients received cognitive therapy (range 10-32 sessions; average 21.1) Supervisees "typically" received one-hour cognitive therapy supervision on a weekly basis	**Client outcome** Depression: Client-rated BDI Anxiety: Client-related BAI Hopelessness: Client-rated BHS	• Sig. improvement in BDI scores • Sig. improvement in BHS scores • No sig. change in BAI scores • Sig. correlation between CTRS and both BDI and BHS at various points throughout the course of therapy	• Limited detail on sample provided • Robustness of outcome measures partially detailed • Details of analytic methods not clearly reported • Design of study means conclusions difficult to draw

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
				Other measures Supervisor-rated CTRS		
Reese et al. (2009) Various clinical settings (USA)	The influence of session-by-session client feedback in supervision on client outcome The relationship between (i) supervisory alliance and (ii)	9 supervisors (programme staff) 28 supervisees (second year MA marriage and family or MA clinical-counselling trainees)	• Quantitative • Randomised controlled trial and quasi-experimental study* Clients received therapy (nature and frequency unspecified) for an average of 5.4 sessions in experimental group, and 4.19 in comparison group	**Client outcome** Life functioning: Client-rated ORS **Other measures**	Influence of session-by-session feedback on client outcome (randomised design) • Sig. difference between groups on ORS scores (small to medium effect size) Correlational relationship between other variables and	• Study design not clearly stated • Limited detail provided on sample • No blinding • Limited detail on supervision provided • Potential therapist allegiance effects

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
	supervision satisfaction and client outcome	100 adult and adolescent clients (various presenting issues)	Supervisees received weekly individual and group supervision (length not specified) over two 16-week semesters, including either weekly client feedback (experimental group) or no feedback (comparison group)	Supervisory alliance: Supervisee-rated SWAI-T Supervision satisfaction: Supervisee-rated SOS Supervisee self-efficacy:	client outcome (non-randomised design) • Low correlation between SWAI-T and ORS scores • Low correlation between SOS and ORS scores • Moderate positive correlation between COSE in the feedback (experimental) group and ORS scores (unclear if sig.) • Low correlation between COSE in the no feedback (comparison) group and ORS scores	

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
			*Participants randomised for one research question but not for others	Supervisee-rated COSE		
Rieck et al. (2015) Training clinic (USA)	The relationship between supervision factors and client outcome	13 supervisors 32 supervisees (doctoral students- "trainee clinicians" with 1-5 years of training)	• Quantitative • Correlational study Nature, frequency, and duration of therapy received by clients unclear Supervisees received one-hour individual and two-hour group	**Client outcome** Client outcome: Client-rated OQ (every session)	• Supervisor agreeableness was strongly and sig. inversely associated with positive OQ scores • Weak correlations between all other variables and OQ	• Study design not clearly stated • Limited details of sample provided • Limited detail on supervision provided • Limited detail on supervisors provided • Limited detail provided on length of therapy • Large number of correlations meaning increased

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
		256 adult clients (presenting issues unknown)	supervision weekly for an unspecified duration	**Other measures** Emotional intelligence: Supervisee-rated MSCEIT (pre-treatment) Supervisor-rated MSCEIT (pre-treatment)		possibility of Type I error • Possible administrative errors in reporting: variable B1 listed as correlating -.39 with itself (Table 2)

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
				Supervisory alliance: Supervisee-rated WAI-SV (pre-treatment) Supervisee-rated LMX (pre-treatment)		

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
				Supervisor-rated LMX (pre-treatment) Personality characteristics: Supervisee-rated NEO-FFI (pre-treatment)		

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
				Supervisor-rated NEO-FFI (pre-treatment)		
Robbins et al. (2018) Community FFT services (USA)	The influence of adding observation to FFT supervision externalising problem behaviours in clients	11 supervisors (clinic staff trained in FFT supervision) 47 supervisees (therapists trained in FFT)	• Quantitative • Quasi-experimental study Clients received FFT (unspecified frequency and duration) Supervisees received either one-hour BOOST supervision weekly (experimental group) or one-hour	**Client outcome** Externalising problems: Client-rated CBCL/YSR	• Sig. improvements in measured problem behaviours for clients above clinical threshold for externalising problems in experimental v comparison group • No difference between supervision groups in FES scores • No difference on outcome scores between supervision groups for clients with sub-clinical threshold behaviours	• Study design not clearly stated • Randomisation method unclear • No blinding • Between group difference in supervisors at baseline

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
		164 child or adolescent clients (with sub-clinical or clinical externalising behaviour problems) and families	group and one-hour individual supervision as usual weekly (comparison group)	Parent-rated CBCL/YSR Family functioning: Client-rated FES Parent-rated FES		
Rousmaniere et al. (2016)	Supervisor variance in psychotherapy outcome	23 supervisors (1-5 years supervisory experience)	• Quantitative • Correlational study	**Client outcome**	• Supervisors explained less than 0.04% of the variance in client outcome (not sig.)	• Study design not clearly stated • Limited detail on supervision provided • Therapy length not controlled for

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
Non-profit mental health centre (Canada)		175 supervisees (MA students and MA graduates in social work, psychology, or marriage and family therapy) 6562 adult clients (various presenting issues)	Clients received counselling (individual (83%) or couples (17%)), range 1-92 sessions (average 4.81) Supervisees received one-hour individual and two-hour group supervision weekly (various modalities)	Psychological and social functioning: Client-rated OQ-45.2		
Schoenwald et al. (2009)	Relationship between supervisor adherence to	122 supervisors	• Quantitative • Correlational study	**Client outcome**	• Adherence to structure and process of supervision sig. predicted improved CBC scores and VFI scores	• Study question/hypothes is not clearly stated

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
Various clinical sites (USA)	a clinical supervision protocol and changes in the behaviour and functioning of youth with serious antisocial behaviour	429 supervisees (trained in MST) 1979 "youth" clients and families (presenting with antisocial behaviour problems)	Clients received MST of varying frequency and duration (average 22.2 weeks) Supervisees received group MST supervision weekly for 1-2 hours	Youth behaviour problems: Caregiver-rated CBC Psychosocial functioning: Caregiver-rated VFI	• Adherence to focus on clinician development sig. predicted improved CBC scores and VFI scores	• Study design not clearly stated • Reliability and validity of CBC not detailed
Steinhelber et al. (1984)	The relationship between patient change and (i) the amount of supervision; (ii) the	Supervisors (psychiatry, psychology, or social	• Quantitative • Correlational study Clients received therapies of various models (average 31	**Client outcome** Overall functioning:	• Amount of supervision not sig. predictive of GAS score • Theoretical congruence sig. predictive of GAS score	• Study design not clearly stated • Validity of GAS not reported • Limited detail on supervision provided • Client outcomes measured at

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
Adult psychiatric outpatient service of a university medical centre (USA)	congruence of theoretical orientation between and the supervisor and trainee	work; number unspecified) 51 supervisees (pre- and post-doctoral level trainees, from various disciplines) 237 adult clients (various diagnoses)	sessions, average duration 8.4 months; some therapy ongoing) Supervisees received supervision varying in type, frequency and duration	Trainee-rated GAS **Other measures** Frequency of supervision for each client: Trainee-rated unspecified questionnaire		different stages of therapy within sample

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
				Theoretical congruence: Trainee-rated unspecified questionnaire		
Wrape et al. (2015) University psychology training clinic (USA)	Influence of supervisor faculty status and years of experience on client outcome	23 supervisors (faculty or adjunct faculty) 75 supervisees (preinternship doctoral trainees, various disciplines)	• Quantitative • Correlational study Clients received therapies of various models (average 10.9 session; range 1-76)	**Client outcome** General distress: Client-rated OQ 45.2	• No sig. effect of faculty status on client outcome scores • Sig. effect for time elapsed since supervisor qualification on client outcome scores (fewer years positively associated with greater improvement)	• Study design not clearly stated • Limited detail provided on supervision • No estimate of variance in results

Article/Setting	Relevant Aim(s)/ Research Question(s)	Participants	Design and Methodology	Relevant Outcome Measures	Relevant Reported Findings	Key Quality Issues
		310 adult clients (various presenting issues)	Supervisees received minimum one-hour individual and two-hour group supervision weekly	Psychiatric symptoms: Client-rated PDSQ		

Key. PST: Problem-solving Treatment; BDI: Beck Depression Inventory; sig.: Statistically significant(ly); PSI: Psychosocial Interventions; KGC (M): Krawiecka, Goldberg and Vaughan Symptom Scale; SFS: Social Functioning Scale; CBT: Cognitive Behavioural Therapy; BDI-II: Beck Depression Inventory II; SCL-90-R: Symptom Checklist; MA: Masters; RSO: Rating Scale for Outcome; OSIA: The Observational System for Interaction Analysis; CRF: Counselor Rating Form BAI: Beck Anxiety Inventory; BHS: Beck Hopelessness Scale; CTRS: Cognitive Therapy Rating Scale; ORS: Outcome Rating Scale; SWAI-T: Supervisory Working Alliance Inventory- Trainee Version; SOS: Supervision Outcomes Survey; COSE: Counseling Self-Estimate Inventory; MSCEIT: Mayer-Salovey-Caruso Emotional Intelligence Test; WAI-SV: Working Alliance Inventory–Short Version; LMX: Leader-Member Exchange Scale; NEO-FFI: NEO Five-Factor Inventory; OQ: Outcome Questionnaire 45.2; FFT: Functional Family Therapy; BOOST: Building Outcomes With Observation-Based Supervision of Therapy; CBCL/YSR: Child Behaviour Checklist/Youth Self-Report; FES: Family Environment Scale; MST: Multisystemic Therapy; VFI: Vanderbilt Functioning Inventory; GAS: Global Assessment Scale; PDSQ: Psychiatric Diagnostic Screening Questionnaire

Overview of Study Characteristics

The research strategy outlined above produced a total of 12 papers that satisfied the inclusion criteria of the review. This included eight studies from USA, and one each from Australia, UK, China, and Canada. In terms of design and methodology, all 12 studies were quantitative. Five studies involved experimental or quasi-experimental designs, while the remaining seven were correlational studies. The studies were conducted in a variety of settings: training clinics (seven studies), community clinics (three), or multiple settings (two). Client participants were adults (seven studies), children or adolescents (two), a combination of adolescents and adults (one), or came from an unspecified age range (two). Studies involved supervisees from psychology, nursing, psychiatry, social work, counselling, and specific psychotherapies (e.g. family therapy), with varying degrees of qualification: qualified clinicians (four studies), doctoral level trainees (four), MA level trainees (three), or a combination of trainee and qualified clinicians (one). They were supervised for cognitive or cognitive behavioural therapies (three studies), family or systemic therapies (two), individual or couples counselling (one), therapies of different modalities (two), psychosocial interventions (one), and unspecified therapies (three). In terms of client difficulties, participants in most studies presented with a range of distress and diagnoses (six studies), primary diagnosis of depression (one), 'schizophrenia' diagnosis (one), behavioural problems (two), or unspecified difficulties (two). Authors operationalised client outcome in various ways, with ten studies utilising client-rated outcome measures. Three of these used additional outcome measures rated objectively (client dropout rate; one study), rated by supervisors (one), and rated by client caregivers (one). One of the remaining studies used only a caregiver-rated outcome measure, and the other used only supervisee-rated outcome measures.

Quality Appraisal Summary

According to the amended QualSyst tool (Kmet et al., 2004), studies were judged to be of variable quality. The majority of papers outlined their research question and/or aim clearly, described analytic methods used in detail, reported results in depth and conclusions were based closely on the evidenced analysis. Authors generally outlined study design with only partial clarity, with two exceptions where study design was rated as being sufficiently described. Most papers failed to report on the nature or content of supervision and/or therapy received by clients. There were shortcomings in half of the studies when it came to discussing outcome measures and their robustness, with information such as reliability and validity data missing. There were also significant failure to report on controls for confounding variables and adequacy of sample size. Strengths and weaknesses are explored in detail in the context of reported findings below, but appraisal of each individual study, in accordance with the checklist criteria, is presented in Table 3.

Table 3

Quality Appraisal Summary

QualSyst Criteria*	**Bambling et al. (2006)**	**Bradshaw et al. (2007)**	**Callahan et al. (2009)**	**Dodenhoff (1981)**	**Ng (2005)**	**Reese et al. (2009)**
1.Question / objective sufficiently described?	Yes	Yes	Partial	Yes	Partial	Yes
2.Study design evident and appropriate?	Yes	Yes	Partial	Partial	Partial	Partial
3.Method of subject/comparison group selection *or* source of information/input variables described and appropriate?	Yes	Partial	Partial	Partial	No	Partial

4.Subject (and comparison group, if applicable) characteristics sufficiently described?	Yes	Partial	Partial	Partial	Partial	Partial
5.If interventional and random allocation was possible, was it described?	Yes	n/a	n/a	n/a	n/a	Partial
6.If interventional and blinding of investigators was possible, was it reported?	No	n/a	n/a	n/a	n/a	No
7.If interventional and blinding of subjects was possible, was it reported?	No	n/a	n/a	n/a	n/a	No

8.Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? Means of assessment reported?	Yes Yes	Partial Yes	Partial Yes	Partial Yes	Partial Yes	Yes Yes
9.Sample size appropriate?	No	Partial	Partial	Partial	No	Partial
10.Analytic methods described/justified and appropriate?	Yes	Yes	Yes	Yes	Partial	Yes
11.Some estimate of variance is reported for the main results?	Yes	Yes	No	Yes	No	Yes

12.Controlled for confounding?	No	No	No	No	No	No
13.Results reported in sufficient detail?	Yes	Yes	Partial	Yes	Yes	Yes
14.Conclusions supported by the results?	Yes	Yes	No	Yes	Yes	Yes
NICE (2012) Quality Appraisal Q 2.2: Were interventions (and comparisons) well described and appropriate?*	Yes	Partial	Partial	Partial	Yes	Yes

QualSyst Criteria*	**Rieck et al. (2015)**	**Robbins et al. (2018)**	**Rousmaniere et al. (2016)**	**Schoenwald et al. (2009)**	**Steinhelber et al. (1984)**	**Wrape et al. (2015)**
1.Question / objective sufficiently described?	Yes	Yes	Yes	Partial	Yes	Yes
2.Study design evident and appropriate?	Partial	Partial	Partial	Partial	Partial	Partial
3.Method of subject/comparison group selection *or* source of information/input variables described and appropriate?	Partial	Yes	Yes	Yes	Partial	Partial
4.Subject (and comparison group, if applicable) characteristics sufficiently described?	Partial	Yes	Yes	Yes	Yes	Yes

5.If interventional and random allocation was possible, was it described?	n/a	Partial	n/a	n/a	n/a	n/a
6.If interventional and blinding of investigators was possible, was it reported?	n/a	No	n/a	n/a	n/a	n/a
7.If interventional and blinding of subjects was possible, was it reported?	n/a	No	n/a	n/a	n/a	n/a
8.Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? Means of assessment reported?	Yes Yes	Yes Yes	Yes Yes	Partial Yes	Partial Yes	Yes Yes
9.Sample size appropriate?	Partial	Partial	Yes	Yes	Partial	Partial

10.Analytic methods described/justified and appropriate?	Yes	Yes	Yes	Yes	Yes	Yes
11.Some estimate of variance is reported for the main results?	Yes	Yes	Yes	Yes	Yes	No
12.Controlled for confounding?	No	Partial	No	No	Yes	Yes
13.Results reported in sufficient detail?	Yes	Yes	Yes	Yes	Yes	Yes
14.Conclusions supported by the results?	Yes	Yes	Yes	Yes	Yes	Yes
NICE (2012) Quality Appraisal Q 2.2: Were interventions (and comparisons) well described and appropriate?	Partial	Yes	Partial	Yes	Partial	Partial

Reported Findings

In terms of the question posed by the review, the studies can be broken down into three themes: (i) the reported impact on client outcome of clinical supervision compared to no supervision, (ii) the reported contribution of supervision to the variance in client outcome, and (iii) the 'impact' (reported or purported) of different components of supervision on client outcome. In most cases actual impact was difficult to assess because studies were correlational.

Supervision v No Supervision

Two studies explored the influence on client outcome of therapists receiving supervision or not. Bambling et al. (2006) carried out an RCT in which participants with a primary diagnosis of depression received problem-solving therapy (PST). Therapists in the study received supervision with an emphasis on the therapeutic alliance (either skills-focused or process-focused), or none at all. The authors reported that both forms of supervision predicted a statistically significant reduction in self-reported depression symptoms and treatment non-completion compared to the no supervision condition. Although the research was conducted to a reasonably high quality according to quality appraisal criteria, the results must be interpreted with caution, as the possible influence of a pre-treatment supervision session and therapist allegiance effects were not controlled for.

In their study with mental health nurses delivering a psychosocial intervention (PSI) to clients with a schizophrenia diagnosis, Bradshaw et al. (2007) reported a statistically significant improvement in overall and positive client symptoms for the workplace PSI supervision group compared with a historical control group who did not receive this supervision. There was no difference between groups in terms of negative symptoms and

social functioning outcomes. Though this work would seem to support Bambling et al.'s (2006) assertion that supervision provides benefits compared with none, the lack of validity data provided for the outcome measures used is cause for concern. Additionally, the lack of randomisation and the use of a historical control group introduces doubts about the internal validity of the design.

Reported Contribution of Supervision to Variance in Client Outcome

Two studies sought to estimate how much of the variance in client outcome is attributable to supervision. These findings are difficult to interpret, as by default a causal link cannot be drawn. Rousmaniere et al. (2016) reported that supervision, delivered for individual and couples therapy for a variety of difficulties, contributed 0.04% variance to client outcome (a very small effect size). The authors comment that the naturalistic design of the study means that potential confounding variables at the level of supervisor, supervisee, and client may be moderating the effect of supervision but could not be controlled for. Importantly, the findings do not suggest that supervision did or did not enhance client welfare, but that client outcome was very similar across all supervisors, hence the low variance. In the second study of this kind, Callahan et al. (2009) reported that a 16% variance (medium effect size) was contributed to client outcome by supervision for therapy with a cognitive behavioural emphasis, but this was not statistically significant. As with numerous other studies in the review, results were made more difficult to interpret due to a lack of information on the nature and content of supervision provided.

Reported Impact of Supervision Components on Client Outcome

Eight studies addressed the relationship between particular supervision components and client outcome in various ways, examining the role of factors such as the amount of

supervision received by supervisees, the model of or approach to supervision, and the characteristics of supervisor, supervisee, or the supervisory relationship.

Amount of Supervision. Steinhelber et al. (1984) asked pre- and post-doctoral supervisees to report how much time they had spent discussing each of their clients in supervision, reporting that this variable was not predictive of client outcome. However, the validity of the outcome measure used was not reported, and "client outcome" was measured in some cases at the end of therapy, and in other cases while therapy was ongoing, rendering internal validity of the study questionable. There was also little information provided regarding the type of supervision, therapy, and presenting issues involved in the study, making any conclusions difficult to generalise.

Model of Supervision. Three studies addressed this question. As discussed above, Bambling et al. (2006) compared two types of supervision for PST. The authors reported no difference between experimental groups (alliance skill- versus process-focused) in terms of client-rated symptoms. One caveat to consider is that while the supervision styles were reportedly different, all supervisors were nonetheless supporting supervisees in delivering the same type of therapy. There is therefore the possibility that the experience of supervisees across groups may have shared significant similarities, despite the purported emphasis on alliance process or skills.

Both Reese et al. (2009) and Robbins et al. (2018) took the approach of attempting to investigate the impact on clients of adding a particular component to supervision as usual (SAU). In the case of Reese et al. (2009), supervisees engaged in SAU were compared with supervisees who, in addition to SAU, received and discussed weekly client feedback in supervision. The addition of client feedback was reported to bring about a statistically

significant, small to moderate effect sized change in client outcome compared to SAU. Though randomisation was seemingly carried out, details of how it was done were omitted. It is not clear whether or not clients and supervisees were blinded to their group allocations in the study, meaning therapy allegiance effects could have influenced the outcome.

Robbins et al. (2018) compared observation-based supervision (BOOST) to SAU. Clients receiving therapy from functional family therapists in the BOOST condition saw statistically significant improvement in client and parent-rated externalising behaviour problems compared to SAU, though this was not the case for family functioning outcomes. Randomisation was again referenced in this study, but details of how participants were randomised were absent from the paper. Importantly, the authors note that supervisors in the BOOST condition were more experienced than those in the SAU condition, potentially a confounding factor in the results. Based on these three studies alone, it is difficult to conclude with confidence that the model of supervision employed plays a significant role in client outcome.

Characteristics of Supervisor, Supervisee, and Supervision Relationship. Supervisor and supervisee factors were reported to have varying effects on client outcome in five studies concerned with these relationships. In a study that examined the role of supervisor 'attractiveness' and style of influence, neither independent variable was found to be associated with client-rated outcome (Dodenhoff et al., 1981). Supervisors also rated client outcomes, and these ratings were positively associated with a direct style of influence (also according to supervisor ratings), i.e. a possible confound. The paper was vulnerable to a number of quality issues in terms of reporting, including a lack of detail provided on

participant characteristics, presenting issues, and the approaches of therapy and supervision employed.

Rieck and colleagues described supervisor agreeableness as the most influential factor in terms of client outcome when compared with the supervisory alliance and numerous other supervisor and supervisee personality characteristics. Greater supervisor agreeableness was identified as having an inverse effect on the outcome of therapy (a large, statistically significant effect), whereas all other variables did not reach statistical significance (Rieck et al., 2015). The authors speculated that low agreeableness may be associated with personality characteristics such as critical thinking and directness, which may be usefully transferred to the supervisee to the benefit of the client. This would seem to offer support for the supervisor perspective in Dodenhoff et al.'s (1981) work. However, limited data on supervisors, clients, and therapy offered in Rieck et al. (2015) again make results difficult to compare and extrapolate. In addition, the large number of correlations performed mean the finding may have been a Type I error. There was also an error noted in a table of correlations (Table 2) of the article, which may implicate the reported findings.

In the case of a large sample of youth clients receiving multisystemic family therapy, supervisor adherence to the structure and process of supervision and focus on supervisee development were predictive of positive caregiver-rated child problem behaviour and psychosocial functioning scores (Schoenwald et al., 2009).

One study (Reese et al., 2009) reported a significant moderate correlation between supervisee self-efficacy and client outcome, but only for those supervisees in the experimental group (who received and discussed weekly feedback from clients in supervision). The nature of this relationship is unclear (it may be that client feedback increased self-efficacy, or vice versa), and statistical significance was not reported.

Steinhelber et al. (1984) also reported that the theoretical congruence between supervisors and supervisees was positively associated with client outcome. However, in addition to the aforementioned design flaws in this study, both ratings of congruence and client outcomes were provided by supervisees, who may have been susceptible to a number of biases.

Wrape et al. (2015) examined the relationship between supervisors' faculty status and level of experience, and client-rated distress and symptoms. A significant effect was found for years of experience, with fewer years of experience positively associated with better client results. The authors had predicted this and suggested that the correlation could be due to the increased focus on supervision standards and guidelines in recent times. Faculty status was not identified as having a significant effect. Based on these studies, there are indications of supervisor characteristics possibly having an influential role in client outcome, but the important quality issues mean caution must be observed in interpreting findings.

Miscellaneous

One study did not fall under the above categories (Ng, 2005), which explored the relationship between cognitive therapy supervision and client-rated symptom scores. The reported findings suggest that cognitive therapy supervision led to improved client outcome via enhancement of supervisee therapeutic competencies, however conclusions are difficult to draw given the very small sample size and the nature of the uncontrolled before and after study design. The author notes that the reported correlation between therapist competence and clinical outcome should be cautiously interpreted, since potential confounding variables were not accounted for.

Summary of Reported Findings

The papers included in this review represented a wide range of client groups, presenting difficulties, therapeutic settings, therapeutic and supervisory approaches, and supervisee and supervisor characteristics. There were few examples of well-conducted and well-reported studies, Bambling et al. (2006) being perhaps the best example of an exception to this rule. The variety of study questions and populations meant potential for a broad examination of the relationship between supervision and client outcomes, but significant design and reporting flaws proved problematic. The limited number of studies in the area exacerbates this issue. Tentatively speaking, some supervision appears to be better for client welfare than no supervision, but the extent of its contribution to client outcome and what approaches might work better than others, is unclear. Similarly, supervisor characteristics such as adherence to supervision protocol and supervisee development, and being relatively newly qualified, may to be associated with client benefits. The overarching message, however, is that the quality, transparency, and volume of studies need to increase substantially if we are to meaningfully understand the extent and nature of the impact of supervision on client outcome in psychological therapies.

Discussion

The Review in the Context of Existing Literature

This review sought to address the question of what evidence exists for the impact of clinical supervision on client outcomes in psychological therapies. The answer is, in short, unclear. Twelve studies were reviewed, including research conducted predominantly in the U.S. in training clinics or other clinical settings with largely adult client populations, who

presented with a wide range of difficulties and received a wide variety of supervised therapies. Researchers focused on the relationship between supervision and client outcome from a number of angles, with reported findings suggestive of the idea that supervision does make a difference to client welfare, but the question of how, and how much, remains something of a mystery. This uncertainty is a function not only of the limited number of studies seeking to address this relationship, but also a function of the limitations in design and reporting across published papers. All studies were quantitative; most were correlational observational studies, meaning drawing causal links between variables is difficult. Those studies that employed a group comparison design suggested that some supervision is better than no supervision from the client perspective, and the kind of supervision offered may make a difference to outcomes. The lack of blinding and potential for therapist allegiance effects in these studies are cause for caution to be observed. Explorations of the role of the supervisor as an agent in the process also offer tentative signs that the personality and practice of the person offering supervision is of importance, possibly above and beyond the supervisee.

Interpreting the studies in this review alongside existing literature is necessary to place reported findings in the wider context, and to clarify possible implications for clinical practice and research. The broad uncertainty and tentativeness characteristic of past reviews (Alfonsson et al., 2018; Kühne et al., 2019) is very much present here. Given the variety of studies and limitations in design and reporting, this review reveals little in terms of challenging or concurring with theoretical and empirical understandings. Beinart's theory of the supervisory relationship (Beinart, 2002), supported by thinking from the attachment literature (Pistole & Watkins, 1995) which emphasises the importance of supervision as a 'safe base' to support and guide supervisees, arguably garners some credibility from this

review in the suggestion that supervisors adhering to the structure and process of supervision, and focusing on supervisee development, may significantly impact client outcome (Schoenwald et al., 2009). This could also be seen to concur with the integrated developmental model of supervision, where supervisors are seen to pay close attention to the developmental stage and associated autonomy of supervisees (Stoltenberg et al., 2014). The suggestion that recent supervisor qualification (Wrape et al., 2015), and the addition of supervisor observation data in the supervision process (Reese et al., 2009) may offer benefit to client welfare further strengthens the idea that the supervisor is an agent of import in the supervisory triad. The described positive influence of client feedback in supervision (Robbins et al., 2018), in addition to the reported contribution of theoretical congruence between supervisor and supervisee (Steinhelber et al., 1984) and supervisee self-efficacy, equally provides some broad support for the systems approach to supervision (Holloway, 1995) and its appreciation for a multitude of influencing factors (supervisor, supervisee, supervisory task and relationship, client factors, etc.) in the realm of supervision.

Limitations of the Review

The current review specified that included papers must relate to client outcomes rather than processes, in keeping with Milne's (2014) emphasis on clear operationalisation. This allowed for a more uniform approach with ease of comparison. For example, all studies used quantitative outcome measures, many including client-rated questionnaires, and a significant number shared similar designs and research questions. However, this emphasis on end-of-therapy experience likely excluded qualitative research that might not tend to define "outcomes" in such stringent terms. The review also excluded studies relating to peer supervision on the basis that by its very nature it does not involve a specified supervisor and

thus this “variable” in the process cannot be measured. The fact remains, however, that peer supervision is practiced and is likely to play some role in client outcomes, and therefore arguably research pertaining to this practice warranted inclusion. The same could be said for supervision provided to clinicians not delivering solely psychological therapy, e.g. mental health nurses and social workers, which would undoubtedly have increased the paper count.

The QualSyst tool for appraising papers, though supplemented in this case by an item from the NICE quality appraisal tool (NICE, 2012), is positivist in nature and defined by what the authors deem more or less important in research quality (Kmet et al., 2004). One example of this is the tool’s emphasis on reporting details of study design as a measure of quality, which, though undoubtedly important in terms of data interpretation, does not necessarily equate with actual quality of study design or execution. It was also not possible, within the scope of this paper, to incorporate rigorous validation through the input of a dedicated second reviewer. However, the author’s supervisor provided oversight and critique throughout the process, from design through to execution and analysis.

Implications for Clinical Practice

The evidence is strong that supervisees tend to benefit from supervision, at the very least in terms of their satisfaction with its perceived helpfulness (Kühne et al., 2019; Lucock et al., 2006). Based on this function alone, it could be argued that supervision should be protected and promoted as part of routine clinical practice (BACP 2018; BPS, 2014). The evidence for client benefit is far less clear, though compared to doing nothing at all, provision of supervision appears to benefit those in receipt of therapy, too (Bambling et al., 2006; Bradshaw et al., 2007). It would seem that the safer option is to continue engaging

with supervision, as advocated by the BPS (2017), but beyond this point, based on the studies explored in this review, how best to do that presents a conundrum for supervisors and supervisees alike. Rather than confidently advocating for one approach to supervision, the message of the review is perhaps that supervisors and supervisees should attend closely to numerous personal and interpersonal factors that may be at play: their own personal characteristics and experience, strengths and weaknesses, their supervisory relationship and theoretical congruence, the role of client feedback and supervisor observation in supervision, and how these factors may be impacting client welfare. In the absence of knowledge about what works well, when, and how, particularly holding in mind reports that experience does not necessarily equate with effectiveness (Wrape et al., 2016), clinicians and trainees alike should tread carefully.

Implications for Research

The implications for research are clear: more investigations are needed into the impact of clinical supervision on client outcomes in psychological therapies, and these investigations need to be of greater quality, both in terms of design and reporting, for any meaningful progress to be made in this field. Lack of basic clarity with regard to broad study design, randomisation, blinding, and statistical power were all evident in the reviewed studies. Beyond this, there is the significant challenge of trying to track the flow of influence from supervisor to client. As Rousmaniere et al. (2016) put it, “To affect client outcome, supervisors’ interventions have to, in effect, travel through three layers of mediating variables: client variables, therapist variables, and supervisor variables” (p. 7). Milne’s (2014) warranted call for the execution of well-constructed trials, controlling for confounding variables, has not yet manifested in a wealth of RCTs. Despite several reviews,

we are only beginning to understand the benefits of supervision for supervisees (Kühne et al., 2019; Watkins, 2019), and important mechanisms therein, such as the supervisory relationship (Beinart & Clohessy, Models of supervision, 2017).

To try to make concrete links between supervision and client outcome then, whilst a worthy pursuit, may prove to be a relatively difficult exercise if more proximal variables are not explored first as has been the case with supervisee research. To not take this approach could maintain uncertainty about the role of confounding variables between the supervision room and the therapy room. An example of such an approach might be to research more closely the relationship between supervision and factors that the literature suggests significantly *influence* treatment outcome, such as the therapeutic alliance (Horvath et al., 2011; Karver, et al., 2006; Martin et al., 2000). Although Milne (2014) advocates for tightly controlled quantitative study designs as a means to better understand links between supervision and client outcomes, a complementary route, which could add depth to the understanding of this seemingly complex relationship, would be through qualitative research. This could go some way towards shortening the lengthy journey through variables and experiences to which Rousmaniere et al. (2016) refer, helping to build promising hypotheses to test in the process.

Conclusion

This review sought to investigate the evidence for the impact of clinical supervision on client outcomes in psychological therapies, against a historical backdrop of assumption that supervision served the interests of the client yet a relative lack of research examining this claim. There was also a concern that previous reviews in the area were dated or contained important limitations. The current review found little cause for increased

confidence in the suggestion that supervision contributes substantially to client welfare, and limited progress appears to have been made since the last review of this kind, almost 10 years ago (Watkins, 2011). Though studies in the area evidently contain issues with design and clarity of reporting, the review has also reinforced the real challenge in trying to comprehend the threads between supervision and therapeutic outcomes. Clinicians are encouraged to continue their engagement with the process of supervision, but with a critical eye on assumptions and possibilities in the absence of convincing data for guidance. In terms of further research, researchers are encouraged to explore relationships between more proximal variables than those studies included in this review attempted, with the intention of gradually clearing the path between supervision and client wellbeing.

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Section B: Empirical Paper

Being Contained to Becoming the Container: A Reflexive Thematic Analysis of the Relationship Between Clinical Supervision and the Therapeutic Alliance from the Perspective of Trainee Clinical Psychologists

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Abstract

Clinical supervision is regarded as a crucial part of psychological therapy practice. However, the evidence base for its effectiveness on key outcomes is limited. This is particularly the case for client outcomes, despite safe and effective practice being purported aims of supervision. Understanding is impeded by the complexity of many variables being involved in the journey between supervision and the therapy room. The current study aimed to address this by exploring the connection between supervision and the therapeutic alliance, a variable which research suggests has a significant impact on client outcome. Reflexive thematic analysis was used to explore this relationship from the perspective of nine trainee clinical psychologists. A primary theme of 'Being Contained to Becoming the Container', was developed from the data, with secondary themes of 'Supervision as a Model of Relating' and 'Supervision as a Crucible for Change'. Participants were understood to experience supervision as a relational model to draw from and apply to the therapeutic alliance. Supervision also acted as a place to bring personal and clinical material and have it responded to, with the output of this process having implications for the alliance. Supervision environments tending towards engaging with feelings and relationships were associated with meeting trainee needs and better alliance conditions. Environments tending to detach from feeling and relating were associated with impeding trainee needs and alliance difficulties. Reported findings suggest an intimate relationship between trainee and client security and development, with the supervisor playing a central role. Research and clinical implications are discussed.

Keywords: supervision, therapeutic alliance, clinical psychology, trainee, supervisee, client outcome

Introduction

The Role of Clinical Supervision in Practice

Clinical supervision is regarded as a crucial part of psychological therapy practice (British Association for Counselling and Psychotherapy; BACP, 2018; British Psychological Society; BPS, 2014, 2017; Lucock, Hall & Noble, 2006) and is encouraged by professional standards (Health and Care Professions Council; HCPC, 2015). However, the research base for its effectiveness on key outcomes is in its infancy (Beinart & Clohessy, 2017; Watkins Jr., 2019) and existing studies are judged to be of limited quality (Alfonsson et al., 2018; Watkins Jr., 2011; Wheeler & Richards, 2007). There are some indications that supervision positively impacts skills development, work satisfaction, work-related stress, and turnover intention in supervisees (Knudsen et al., 2008; Sterner, 2009; Wheeler & Richards, 2007). Theories are increasingly emphasising generic components of supervision, such as the supervisory relationship, rather than therapy model-specific elements, as being key ingredients in its effectiveness (Beinart & Clohessy, 2017). A recent meta-analysis by Park et al. (2019) provides broad support for the hypothesised role of this relationship in various supervision outcomes.

However, recent reviews have cautioned against assumptions about the depth and breadth of the impact of supervision on clinical practice (Kühne et al.,2019; Watkins Jr., 2019). The most robust finding in the literature appears to be that it is highly valued by therapists and trainees (Kühne et al.,2019; Lucock, et al., 2006). Ellis (2017) and colleagues (Ellis et al., 2014) have also documented the deleterious effects that 'inadequate and harmful' supervision can have on supervisees, indicating a need for deep understanding of the process. Strikingly, the impact of supervision on clients is even less clear.

Linking Supervision and Client Outcomes: A Bridge Too Far?

Conventional definitions of supervision identify client benefit as a central aim (Bernard & Goodyear, 2004; Milne & Watkins Jr., 2014). Indeed, client outcome has been referred to as the "acid test" of supervision (Ellis & Ladany, 1997). Despite the emphasis on effective supervision, however, there has been continued neglect of client welfare in the literature, the primary outcomes of concern being support and skill acquisition of supervisees, with an often implied assumption that this will translate into client benefit (Holloway & Carroll, 1996; Watkins Jr., 2019). Reviews have found study quality examining client outcomes to be poor and judged there to be no substantial evidence to suggest that supervision benefits clients (Alfonsson et al., 2018; Watkins Jr., 2019). Milne (2014) has also identified issues with the conceptualisation of "client outcome" as a singular construct given the many forms it can take. In summary, research studies examining the relationship between supervision and client outcomes are small in number (Kühne et al., 2019), have significant methodological flaws (Watkins Jr., 2011), and/or struggle to account for the many variables characteristic of supervision, therapy, and the context and parties involved (Reiser & Milne, 2014).

One solution to these issues is to design studies controlling for the variables involved between what happens in the supervision room and the therapy room. Milne (2014) usefully suggests that researchers follow a fidelity framework to do so, closely accounting for variances in factors such as 'delivery of supervision' by the supervisor, 'receipt' and 'enactment of supervision' by the trainee, etc. This framework is more applicable to quantitative research, particularly randomised controlled trials (RCTs), where controlling for variables is embedded in the design. Despite the benefits of RCTs, conducting such studies

are resource heavy and the ecological generalisability of findings from highly controlled research to clinical settings can be questionable given the natural variance that occurs outside of experimental controls (Lilienfeld et al., 2018). A complementary approach is one that seeks to better understand the relationship between more proximal variables, and gradually builds a knowledge base about what occurs between supervision and therapy outcomes. Exploring in detail how supervision factors interact with variables that appear to contribute significantly to client outcome, such as the therapeutic alliance, is one such example of this approach.

The Therapeutic Alliance and Client Outcomes

Considering the uncertain picture of the supervision literature discussed above, the evidence base highlights with greater clarity the importance of the therapeutic alliance in predicting therapeutic outcomes. Though definitions of the construct vary, there is broad agreement that the therapeutic alliance comprises (i) the collaborative nature of the relationship between client and therapist, (ii) the affective bond, and (iii) the shared capacity to agree on the goals and tasks of therapy (Bordin, 1979). Across therapeutic models, therapeutic contexts, outcome measures, time of rating and type of rater (observer, client, therapist), there is a “moderate but robust relationship between the alliance and treatment outcome” (Horvath et al., 2011, p. 10; Karver, et al., 2006; Martin et al., 2000). Given the existing struggle to understand the nature of the relationship between supervision and therapy outcome, however, a useful stepping-stone to greater insight could be the exploration of the relationship between supervision and the therapeutic alliance.

Supervision and The Therapeutic Alliance

Some theoretical and empirical work offers perspective on a potential link. Parallel process, the unconscious transfer of conflict between the supervision room and the therapy room (Watkins, 2017), forms a central tenet of the relational psychodynamic model of supervision (Sarnat, 2012). This model views the relationships between supervisor, supervisee, and client as mutually influential. In developing and validating the supervisory relationship questionnaire (SRQ), Palomo and colleagues identified the supervisor's role as a 'safe base' as the best supervision-based predictor of trainee-rated client outcomes (albeit using a single-item measure) (Palomo et al., 2010). In another study, a significant proportion of supervisees receiving what they deemed to be inadequate supervision also judged this experience to be harmful to their clients (Ellis, 2010). Park et al. (2019) reported a small yet statistically significant link between the SWA and the therapeutic alliance, but commented that the nature of the relationship is unclear, and called for further research to understand this association.

Given the highly-regarded position of supervision in clinical practice (BACP, 2018; BPS, 2014; Lucock, Hall & Noble, 2006), and the significant role of the therapeutic alliance in client outcomes (Horvath et al., 2011; Karver, et al., 2006; Martin et al., 2000), there is evident value in examining further the relationship between the two. Doing so may align us with the purported aim of supervision, to support practice that is safe and effective for clients (Bernard & Goodyear, 2004). If this ambition is to be taken seriously, then the ambiguity about what supervision does for clients, and how, must be addressed. In clinical psychology in the UK, supervision is mandated for trainee clinical psychologists (HCPC, 2017), who work therapeutically across multiple different services and with numerous

supervisors throughout their doctoral training, suggesting this group is suitable for examination. The aim of the current study is thus as follows: to qualitatively explore the relationship between clinical supervision and the therapeutic alliance from the perspective of trainee clinical psychologists.

It is hoped that this research may pave the way for future theoretical and empirical knowledge, incorporating supervisor and client experiences of the process. The research is guided by two NHS values: "Working together for patients" and "Commitment to quality of care" (Department of Health, 2015), which promote effective utilisation of resources within accountable services.

Method

Design

A qualitative design, employing semi-structured interviews for data collection and reflexive thematic analysis (TA; Braun & Clarke, 2019), was used. TA is "a method for identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2006). 'Reflexive' refers to the importance of intentional understanding, utilisation, and transparent communication by the researcher of their theoretical and methodological approaches (Braun & Clarke, 2019). TA offers the possibility of exploring specific participant experiences in depth or examining broad patterns of experience across a data set. The latter emphasis is especially suited if the issue is something about which little is known (Braun & Clarke, 2006). Given the dearth of quality research relating to the supervision-alliance relationship, TA was deemed suitable for the current study. The emphasis was on taking an inductive (data-driven) rather than deductive (theory-driven) approach.

Epistemological Position

The current study was carried out from a critical realist position, which understands that research data do not represent or mirror an objective knowable 'reality' (as a strictly realist or positivist position would claim), nor is all experience socially constructed (as a radical social constructionist position would claim). Instead, critical realism suggests that data must be viewed and understood within its wider influencing context (social, historical, political, etc.) (Harper, 2012; Pilgrim & Bentall, 1999).

Participants

Participants were trainee clinical psychologists (second year and above) employed by the National Health Service (NHS), recruited from participating clinical psychology doctorate training institutions across the UK.

Sampling

Though efforts have been made to quantify a 'sufficient' sample size for qualitative research (Fugard & Potts, 2015), Braun and Clarke argue the approach is "implicitly located within the logic of generalisability and replicability" that is more consistent with quantitative research (Braun & Clarke, 2016, p. 741). In the absence of convincing evidence and guidance on sample size feedback (Braun & Clarke, 2019b), the critical realist underpinnings of the author's approach, and the scope of a DClinPsy major research project, the current study aimed to recruit 10 participants.

Participants were recruited using purposive sampling. Participants were selected to reflect the national trainee clinical psychologist population, within the confines of those who expressed interest, in terms of gender and ethnic identities and age (Clearing House for Postgraduate Courses in Clinical Psychology, 2021). One participant withdrew from the study

due the impact of the COVID-19 pandemic, resulting in data being collected for a total of nine participants. Participant demographics are displayed in Table 1.

Table 1

Participant Demographics

Demographic	Category				
Age Group	25-29	30-34			
	7	2			
Gender Identity	Female	Male			
	7	2			
Ethnic Identity*	White (British)	White (European)	White (Other)	Mixed (Other)	South Asian
	5	1	1	1	1
Geographical Area of Training	London	North West	South West	South East	
	4	3	1	1	
Year of Training	Second	Third			
	4	5			

*Individual details concealed for confidentiality

Materials

Interview Schedule

A semi-structured interview schedule was composed in collaboration with the author's supervisor to facilitate a capturing of the breadth and depth of experience in the trainees' supervision and therapeutic alliance work. A pilot interview was conducted with a non-participant trainee. The final schedule (Appendix A) was adjusted based on this experience and trainee feedback.

Procedure

Recruitment

Administrators from each UK clinical psychology doctorate training institution, with the exception of the author's (*n*=29), were contacted with a participant invitation email (Appendix B). The email included a link to an online information sheet and survey where interest could be registered and a consent form could be completed (Appendix C). Demographic data were also collected.

Interviews

Eligible participants who provided consent were contacted to inform them that they may be invited to take part in an interview. Those who were ultimately not invited were contacted again to inform them and thank them for their interest. Interviews were conducted via video call. Interviews, recorded by dictaphone, lasted 50 – 75 minutes. Interested potential and actual participants were provided with a summary of the research findings.

Data Analysis

Interview data was analysed using TA. Braun and Clarke (2006) describe the process of analysis as one that moves from (i) initial data familiarisation, (ii) through labelling raw data using descriptive codes to organise it meaningfully, (iii) collating codes and developing them into themes, (iv) reviewing themes in terms of their relationship with the raw data and codes, developing a thematic 'map', (v) defining and naming themes, to (vi) producing the final report, including the use of extracts to illustrate final themes, and relating findings back to the research question and existing literature. The process is not linear; repeated comparing of relationships between data, codes, and themes is central to the analysis.

Quality Assurance

Prior to data collection, the author took part in a bracketing interview with a trainee colleague. A bracketing interview seeks to identify and reflect on researcher beliefs, feelings, assumptions and biases, and aims to foreground the potential influence of these elements on data collection and analysis. It is a reflexive activity which acknowledges the fact researchers are part of the social world which they are examining (Ahern, 1999), and aids the monitoring of this through the study. Questions about interests and motivation in relation to the subject matter, personal values, relationship with participants, potential conflicts, and expectations were addressed in the interview (Ahern, 1999; Tufford & Newman, 2010). For example, the author's familiarity with and emotional investment in trainee experiences of supervision- particularly negative encounters- were identified as part of his relationship with the study. The author also compiled a research diary (abridged version in Appendix D) to facilitate ongoing reflection as the project progressed.

Memo writing, derived from grounded theory, formed a part of the analytic process. It is a reflexive practice where the researcher details their thoughts, feelings, ideas and questions about the analytic phase (Birks et al., 2008). Reflexive practices support analysis by facilitating researchers' reflective capacity and increasing quality assurance (Charmaz, 2014), discussed further below. Such practice was deemed to be in keeping with a reflexive TA (Braun & Clarke, 2020).

Drafts of data analysis at every stage (transcripts, coding, themes, etc.) were shared and discussed with the study supervisor, which also facilitated the reflexive analytic process.

Ethics

Ethical Approval

This study was given full approval by the Salomons Ethics Panel (Salomons Institute of Psychology, Canterbury Christ Church University; Appendix E). The study was conducted in accordance with the British Psychological Society's *Code of Human Research Ethics* (British Psychological Society, 2014).

Ethical Considerations

Potential participants were given time to consider and discuss with the author the costs and benefits of taking part in the study. An explanation of confidentiality and consent was outlined on the information and consent sheets, and potential participants indicated consent clearly using a simple tick box following the consideration period.

Prior to interview, participants were reminded of the study purposes and invited to ask questions. A debrief space was offered after the interview, giving an opportunity for participants to discuss issues relating to the study or their own wellbeing. As the study

related to a subject matter which could entail discussing distressing working or personal conditions, contact details for relevant services such as university student welfare services, training programme tutors, NHS Trust Human Resources and Occupational Health departments, the British Psychological Society (for access to guidelines), and the Health and Care Professions Council (for professional codes of conduct), were available.

Data Management

Data was collected, stored and managed in line with Salomons Institute of Applied Psychology research guidelines. Confidentiality was protected by initially storing audio recorded data on an encrypted NHS USB stick and anonymising all transcribed data before deleting the recorded data. Participants were made aware of this, as well as the possibility of third-party transcribing services being employed. Both third-party transcribers involved were required to sign a confidentiality agreement (Appendix F).

Results

Reflexive thematic analysis of the interview data resulted in the development of the themes and subthemes displayed in Figure 1. This thematic map illustrates the overarching, primary, secondary, and tertiary themes, which will be described in this section using verbatim quotes from participants[1]. Extracts of the analytic process, including coded interview transcripts, an illustration of theme development, and a sample of analytic memos, is visible in Appendix G.

[1] 'Participant' and 'trainee' used interchangeably

Being Contained to Becoming the Container

The overarching theme developed from the data captures participants' experience of the relationship between supervision and the therapeutic alliance. This relationship appears to entail a process whereby supervision is used as a model for how the trainee can be with clients ('Supervision as a Model of Relating'), or a place where material is introduced or responded to in a way that influences trainees' experience of and contribution to the alliance ('Supervision as a Crucible for Change'). Taken together, these experiences described by participants portray supervision as 'container' for the trainee that comes in many forms- a place for emotional material to be brought and responded to. In turn, shaped by their experience of this container and what is taken from it, the trainee offers varying levels and forms of containment to their clients.

Supervision as a Model of Relating

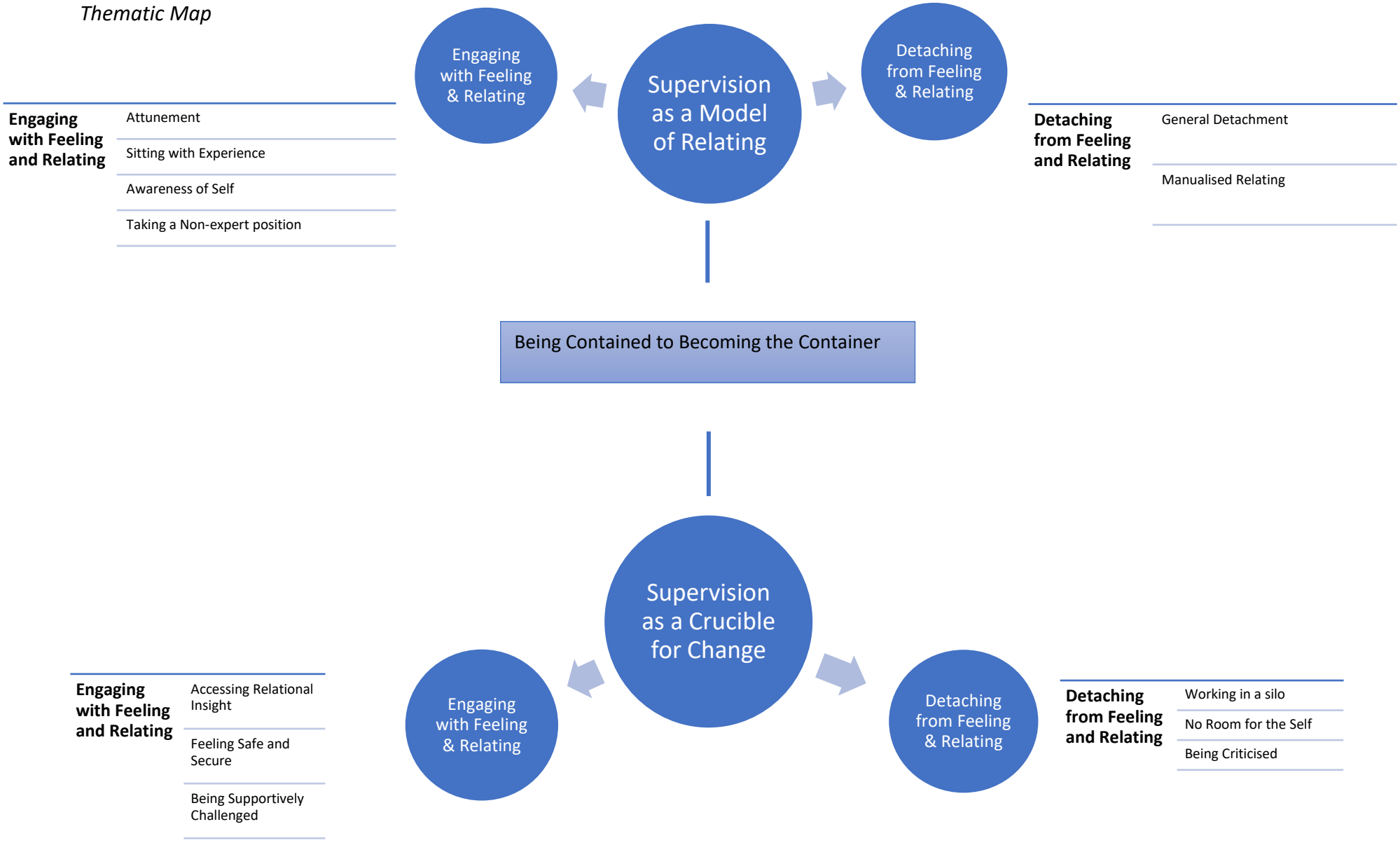
This secondary theme refers to trainees' experience of supervision acting as a model of how to relate to others being translated into their work with clients. This process is reported to occur explicitly, when a trainee reflects on how their supervisor related with them and then intentionally applies this to their relationship with clients. It also appears to occur implicitly, as when trainees' experience with their supervisor is subtly mirrored in the therapeutic alliance. Supervision functions as a model in this way to the benefit and detriment of the therapeutic alliance, according to trainees. When supervision involves engaging with feeling and relating, or when supervision involves detaching from feeling and relating, these characteristics can be seen reflected in the relationship between trainee and client.

Engaging with Relating and Feeling

Supervision scenarios and supervisors tending towards seeking out and addressing emotions and relational content act as templates for the therapeutic alliance in a number of ways, as captured by the following tertiary themes: ‘Attunement’, ‘Sitting with Experience’, ‘Awareness of Self’, and ‘Taking a Non-expert Position’.

Figure 1

Thematic Map



Attunement. This theme refers to supervisors' sensitivity to the emotional and relational atmosphere in the room. P1[2] talks about her supervisor noticing an emotional "shift" when she was struggling with personal issues outside of work. She later recognised opportunity to draw on this attentiveness in therapy with clients: "I think that kind of parallel of recognising shifts in another person kind of naming it […] when you know that you have the capacity to open that and sit with […] what's coming out". Similarly, when P6 emerged from a session in a state of distress, his supervisor's noticing of subtle change enabled him to disclose his feelings: "she kept on plugging away […] she could sense that something wasn't quite right, and […] she just managed to open me up about it". Akin to P1, P6 used this as lesson in tuning in to emotions with clients that might otherwise go untouched: "there's also a lot to be said for, yeah, just, just catching that emotion […] with varied and simple questions, you know, following it through".

Sitting with Experience. Beyond attending to the emotional occurrences in supervision, supervisors' capacity or tendency to 'sit with' material brought by trainees was described as impactful. This applied to issues that were quite personal in nature as well as those that related to client work. A supervisor of P5 initiated contact to offer a supportive space following the reporting of an incident of racism at a professional conference. This trainee noted the power of her supervisor's capacity to do "some of the really basic human stuff", despite her initial fears, which she in turn sought to bring to her alliance with clients:

> throughout the time that we were talking, […] she wasn't trying to formulate what was happening, she wasn't trying to […] give me coping strategies, she was just listening and reflecting back […] just doing some of the really basic human stuff (P5).

[2] 'P' refers to Participant

They added, **“**especially after that... supervision […] I try to sort of model a bit more what she was doing in session with me, with the people that I work with”.

P6, whose supervisor detected his upset following a difficult therapy session, said:

> for her a big thing was, y'know, just being in the room with someone, em, and that, just addressing the emotion that was in the room, and, and then kind of allowing that to be there. Em, and she kind of did that with me (P6).

The felt experience of this “being in the room” with another person gave meaning to the term that previously had felt elusive to P6, to the degree that he could offer this to his clients: “it was really good modelling in a way, because I could see, you know, 'oh, this is how it probably feels for your clients, and this is how you - my clients would feel”.

Awareness of Self**.** A number of trainees spoke about the role of their supervisor’s awareness of their own emotional process in supervision, and the consequences this had for the therapeutic alliance. P1 poses that the importance of supervisors getting in touch with their own internal world lies in the intimate link between feelings in supervision and feelings in the alliance, stressing the importance of self-reflection being modelled for the trainee:

> the way that I understand things is that things happen in the space between two people, that it doesn’t sit with one or the other, but I think sometimes we can say, you know, that that [client is] really sensitive to criticism but it might actually be for example we are coming across as, as quite critical…em and I think that it’s knowing or having an awareness of that (P1).

Taking a Non-expert Position**.** P6 contrasts the tendency of some supervisors to take an “expert” position with those who take a “non-expert” position. The latter, he says,

involves demonstrating that supervisors are flawed beings, a message that can be internalised by the trainee and transmitted in turn to the client through further modelling:

> that has been quite helpful I think, again, from a modelling point of view […] I think that it's kind of transferred to how I am in the room […] with the clients. Em, I'm very comfortable now to make mistakes […] it might open things up for them if, if they just have like a flawed person in front of them (P6).

Detaching from Feeling and Relating

Supervision scenarios and supervisors tending towards keeping a distance or disconnecting from emotions and relational content also act as templates for the therapeutic alliance, as captured by the tertiary themes, 'General Detachment' and 'Manualised Relating'. Rather than being a conscious, intentional transfer to the alliance, detachment of this sort appeared to occur involuntarily in a sort of 'mirroring' of supervision.

General Detachment. A number of trainees spoke about experiencing supervisors as broadly detached from the emotion of the clinical work, from the trainees themselves, and from clients. This had ramifications for the therapeutic alliance, as trainees took on this approach to feeling and relating. P1 talked about how this experience interacted with the alliance, exacerbating an already challenging therapeutic relationship:

> I felt that transfer into that relationship with the client […] I didn't feel like I knew how to elicit the emotions that he needed to express […] because emotions weren't being addressed within the supervisory relationship, they were then quite difficult to deal with in the therapeutic alliance (P1).

P3 found herself taking on her supervisor's passive connection with colleagues and clients, resulting in quite concrete withdrawal: "I didn't have the fire and the passion that I had in

my other placements, em, which meant I probably […] saw patients for fewer sessions because I wasn't as quick to follow up on DNAs [non-attendance]".

Manualised Relating. Participants shared examples of supervisors relating to trainee and client concerns in a rigid fashion, with little room for flexibility of approach. There was a message suggesting that there were strict confines in which to respond to the other, which was then taken on by the trainee. As there was a preoccupation on the part of the supervisor with offering therapy in a very specific, manualised way, trainees found themselves preoccupied with this in the therapy room, particularly when there were relational difficulties with clients: "maybe the quality of my work was fine […] but there was always a doubt in the back of my mind, 'Am I doing this properly? I'm not sure […] I don't know who my role models are here" (P3).

P7 illustrates how the trainee, and in turn the client, were not permitted to have experiences outside of the confines of the designated intervention:

> I think that her kind of approach was just like, well, [the client is] not ready to change, you know, these are the tools that are available to you […] and if he doesn't buy into the model then […] that's just how it is (P7).

This didactic form of supervision resulted in a sense that it was not an authentic, shared endeavour, which was then mirrored in the therapy room:

> I'd just be told, right, do this, do that, do that […] it just feels like the therapy is just being - something that's just being done to them […] And it almost felt like supervision was being done to me […] and that very much then played out with the work with clients (P7).

P9 described how the felt experiences of being responded to in an impersonal way influenced her approach to the therapeutic alliance for the better: “the negative ones feel so jarring, it’s a really big like red flag of like ‘Make sure you never do this with a client’”.

Supervision as a Crucible for Change

This secondary theme refers to the process of trainees taking material to supervision and receiving reflective and emotional input from supervisors, the output of which shapes trainees’ experience of and contribution to the therapeutic alliance. In line with the above secondary theme, ‘Supervision as a Crucible for Change’ involves experiences marked by either moving towards and engaging with feeling and relating or moving away and detaching from feeling and relating.

Engaging with Feeling and Relating

Common experiences from supervision transferred to the alliance are represented in the following tertiary themes: ‘Accessing Relational Insight’, ‘Feeling Safe and Secure’, and ‘Being Supportively Challenged’.

Accessing Relational Insight**.** The data suggest that trainees experienced supervision as a place to obtain insight into the therapeutic relationship with clients. Multiple trainees noted that supervisors picked up on aspects of the alliance that were outside of their own awareness, aiding their formulation. One trainee talked of his supervisor’s seniority being beneficial in bringing alliance dynamics to light that had potential to be harmful to the client:

> because I kind of didn't have that background knowledge of, like, transference and counter-transference, I kind of didn't see it happening, but obviously my supervisors did have that knowledge, probably did have an experience of it happening in the past (P4).

This reportedly impacted his client work at the time as well as leaving an enduring impression on his practice: “now that I've had that experience, em, it was turned into something that I value as kind of a lesson learned, and something that will make me […] a better and a safer clinical psychologist”. P7 shared this sentiment, commenting that relational insight gained in supervision can establish a foundation for exploration with clients:

> when I've had supervision that's paid […] attention to process and the therapeutic relationship and kind of unconscious, em, processes and emotion, I think […] it allows you to explore those things more openly with clients, which I think improves the therapeutic relationship (P7).

Feeling Safe and Secure. This theme refers to supervision as a protective space that allows for trainees to express themselves in a boundaried, reliable environment. In turn their wellbeing is protected, and as a result the alliance is buffered from harm. Supervisors appear to be instrumental in fostering a feeling of containment that gives room for greater understanding of alliance issues and in turn the maintenance of challenging clinical work. Some trainees touched on their own role in assessing safety to share experiences before deciding to do so, further facilitating the construction of a secure environment.

P3 notes how her supervisor set the scene at the beginning of her placement, inviting her to bring difficulties to reflect on: “right from the beginning she introduced, em, talking about the process of supervision […] Em, so it felt really safe to talk with her if I you know didn’t love the way something was going”. She was able to take advantage of this when faced with a client who was upset with a comment she made in therapy, leading to the alliance ultimately being repaired:

> I got really upset and I felt comfortable enough to go to my supervisor and said I can't believe I just made someone feel like that […] And […] she helped me to understand the client's reaction in terms of her previous experiences (P3).

P5, whose supervisor invited her to explore her feelings about racism in the profession, conveyed how closely the relationship between personal welfare and professional work can be. Protecting trainee wellbeing also protects clinical work, in her eyes:

> it could've been actually that that is something I might have taken home and, you know, maybe come back with the next day or the next week, or […] it might have affected me personally but also my ability to kind of work well (P5).

P4 discussed the subtle impact of his supervisor's extensive experience of working in physical health settings, which enabled her to contain his anxieties and sustain client relationships: "being able to talk about it, em, gave me some containment. […] the way that it probably has impacted the therapeutic relationship […] that I had with those people - is probably that it's maintained it" (P4). An experience of being contained in supervision fostering capacity to offer containment to clients was shared across trainees:

> working in trauma like the level of intensity of the horrible things that you hear is really a lot to hold onto and […] being able to sort of have that contained for me, meant like that I felt I had more space to contain that for my clients (P9).

A number of trainees highlighted their own role in judging supervisors' invitations to be safe enough to warrant disclosing personal feelings- a seemingly important step in enabling the supervisors' containing role to be realised. P1 acknowledges this in describing her decision to open up: "my side of being able to kind of articulate that something was happening, em, once that was kind of flagged. Em…and also I suppose like a belief that it would be supported".

Supportive Challenge. The data also suggests supervision can be a place of support and gentle challenge, wherein uncertainty can be transformed into confidence and skill development, to the benefit of the alliance. One trainee captured how her supervisor addressed her developmental needs subtly by fostering a compassionate approach: "somehow without it being explicit we were working on my areas of development […] she had that ability of making you feel really good about your areas of weaknesses and being very understanding" (P3). This led to a greater acceptance from the trainee in terms of her developmental stage, which she saw translating into increased client confidence:

> by me […] still feeling confident that my areas of development are also under control somehow, they are not completely just fears all around. The client feels more confident in what we are doing (P3).

P7 had two supervisors who entrusted her with freedom to "take the lead" and work flexibly- a challenge that paid dividends when it came to a difficult alliance:

> I think what helped with that is that he didn't just say 'oh well you need to do X, Y, and Z,' you know, he, he kind of said what, 'what do you think the best approach we take, perhaps try this, perhaps try that' (P7).

She spoke further about the sense that one supervisor "had my back", and how this gave freedom to think creatively based on client need, taking safe risks rather than being rigidly bound to a prescribed approach: "that therapeutic relationship that I had with them got stronger, and I felt like they had more trust in me and that they were maybe more open in our sessions" (P7).

This trainee also articulates that the nature of the therapeutic alliance also shapes how trainees approach supervision, with close trainee-client bonds encouraging them to

extract additional support: “when I felt very kind of strongly for my client, so when I've kind of been really advocating for my client, em, I think I'm more able to do that in supervision”.

Detaching from Feeling and Relating

Output from supervision that was inclined to detach from feeling and relating transferred to the alliance in a number of ways, as represented in the following tertiary themes: ‘Working in a Silo’ and ‘Being Criticised’.

Working in a Silo. This theme refers to participants’ experiences of feeling their needs were unaddressed and unmet in supervision, resulting in a sense of working in isolation without support or guidance. Examples of trainees withholding information, despite being in a supportive supervisory relationship, were also shared.

“I felt really quite unheard in that supervision. Like I would try like things but then they just seemed to dissipate into the conversation”, said P1. This had implications for returning to supervision with concerns, and a feeling of helplessness in working with clients:

> it made me more hesitant to bring things to supervision, therefore I I kind of almost had a bit of a sense of I’m not entirely sure of what what I’m doing with this person therapeutically. Em…I felt a bit lost, a bit like helpless (P1).

P3, who talked of a supervisor who did not take on board constructive feedback from colleagues in the team, shares a similar experience of being dislocated from the work in the absence of support to think flexibly about clients: “it just left me feeling really alone, and stranded in my clinical practice, very overwhelmed with clients that I didn’t understand because I felt she wasn’t being flexible or open to thinking about them from different perspectives” (P3).

More broadly, if trainees felt their supervisor to be limited in capacity to offer thinking space, the likelihood of bringing material to reflect upon reduced: “what I bring

from my clinical work to my supervision also depends on how much availability I am perceiving the supervisor to have" (P5). Trainees made various efforts to address perceived shortcomings in supervision, in the hope of sustaining the therapeutic alliance. This appeared to typically involve substantial energy, with limited effect:

> I found it took a lot of energy for me to be on that placement because I really didn't want my negative experience of her to impact my actual work […]I was really sticking to the literature […] which probably in turn, you know wasn't as helpful (P3).

Suggestive of an interdependent relationship between the alliance and supervision, some trainees also spoke of managing difficult aspects of client work alone, despite being in a supportive environment. P5 describes this in the context of feeling attracted to a client: "I found it really difficult to bring that to supervision, eh, even though I really liked my supervisor, and I felt like we had […] a good relationship" (P5).

No Room for the Self. Trainees reflected on instances where they wished to bring their personal feelings about their client work to supervision, but found there was no space to do so:

> And in instances where I tried to talk about things where […] like my dad is an older adult so there's kind of things where relationally […] this might be a reason why there's a barrier here […] that was not on the supervisor's like agenda at all (P1).

This sort of response to self-reflection led to the entanglement of feelings, causing confusion in the therapeutic alliance: "I never did quite pinpoint whether frustration […] developed within the therapeutic alliance, or came from the supervisory relationship" (P3). P2 discussed how her supervisor's absence of self-reflection took over the supervision environment, leaving little room for exploration of trainee or client needs:

> I guess she was not able to give a proper supervision because she had a lot of difficulties in her life […] those difficulties were not fully addressed through her supervision […] and they were impacting on our supervision (P2).

P5 reported an experience of racism from a client to her supervisor, who directed her to continue working with the client while offering no room for attending to her personal feelings. This had implications for the trainee, and in turn the alliance: “I didn't find it a helpful response that we didn't really spend any time thinking about, I guess, how I would've received that comment, or, you know, how do I keep working with [client]?”. P5 goes on to articulate how the client ultimately loses out in such scenarios:

> supervision […] should be a space where there's room to reflect, not just on professional things, but also what's coming up personally […] I strongly believe that it does affect what you do in the room with the person, and I think when you're in supervision spaces […] where there's just no room for it […] our clients may be the ones who suffer the consequences (P5) .

Being Criticised. P7 relays a time when her supervisor took a critical approach to supervision, emphasising the perceived limits of this trainee’s practice. This led to a loss of confidence and implications for her connection with clients:

> it made it very difficult for me to kind of do any clinical work, 'cause even when I was with children or with their parents, I felt kind of so on edge and so kind of like I was gonna make a mistake that […] I became very passive (P7).

Another trainee received critical feedback in an assessment of her therapeutic competencies. She described how her fear of repeated criticism motivated her to develop skills, but at a cost to the alliance: “it kind of like wound me up into this anxious ‘I need to

tick box all these things, I need to go through the protocol in the right way" (P8). She adds that she "wasn't in a calm, containing position f-for [clients]" (P8).

Discussion

The current study aimed to better understand how clinical supervision relates to the therapeutic alliance from the perspective of clinical psychology trainees. At the very least, the reported results do not counter Park and colleagues' recent suggestion of a small significant link between these elements of practice (Park et al., 2019). The current study offers some ideas about the nature of this link.

The reported results suggest that supervision can act as an experiential model for trainees which can be translated to the therapeutic alliance. Supervision can also act as a crucible wherein clinical and personal material is used by supervisors and trainees in a way that shapes trainees' experience of themselves and their work with clients.

Participants' experience of supervision acting as a model of relating and a crucible for change links with the supervisory relationship and attachment theory literature. Research into the supervisory relationship identifies the supervisor's role as a 'safe base', providing space for support and learning, as the most beneficial factor in the process of supervision and client outcome from the perspective of trainees (Palomo et al., 2010). The current study's portrayal of the supervisor offering a secure space in which the trainee can access relational insight and be challenged in a supportive environment, adds weight to this perspective.

Trainees in this study suggested that this experience does not simply remain in the supervision room, but is drawn upon as an template for use in the therapeutic relationship.

Supervisors who offered time and space to process emotional and relational material were linked to greater trainee capacity to provide a similar experience to clients. Attachment theory poses that our relationships with significant caregivers lead to internalised working models of how to relate to others. Though these models tend to be established in early life, they are open to change based on subsequent significant close relationships (Fonagy, 2018). Pistole & Watkins Jr. (1995) suggest that the supervisory alliance represents one such relationship, wherein the supervisor acts as a "developmental facilitator", providing a sense of security and support as well as facilitating skills and independence (Beinart & Clohessy, 2017). By contast, in attachment terms, an absence of such a supportive presence in key relationships leads to more anxious relational templates (Fonagy, 2018). Trainees in this study noted a sense of not knowing who too look for as a role model, resulting in an uncertain alliance with clients.

Participants also relayed accounts of such modelling that presented as less intentional or implicit. This form of transmission appeared particularly relevant in the case of transferring unwanted characteristics such as emotional detachment from the supervisor across to the client. The psychodynamic model of supervision (Sarnat, 2012) suggests that in addition to conscious transfer, there is unconscious transfer of relational dynamics between supervision and therapy in a mutually inflencing manner. Though participants' narratives strongly underscored the role of supervisor in the supervision-alliance relationship, the trainee's role in assessing and accessing support to facilitate this relationship, and the influence of client and alliance dynamics in determining trainees' likelihood of actively bringing or withholding information from supervisors, add weight to the theory of a mutually influencing triad.

Setting aside the mode of transfer from supervision to the alliance, supervisors' approach to emotional and relational content appeared key in determining the quality of outcome for trainees and in turn the therapeutic relationship. Consistently noting the interdependence of personal and professional concerns, trainees experienced supervisors' capacity to contain and make use of these issues for better or worse as influential in their capacity to contain clients' needs. One participants' account of contrasting supervisor responses to incidents of racism represents a broader sense of how protective or destructive the 'crucible' of supervision can be for trainee and client. The issue of harmful and inadequate supervision is well-documented (Ellis, 2017; Ellis et al., 2015), and the current study reinforces the feeling from supervisees that substandard supervision can be distressing and dangerous. Reflecting participants' interviews, research suggests that an emphasis on taking an 'expert' position in supervision and lack of emphasis on addressing emotions and relationships is associated with supervisees being less likely to disclose issues of personal and clinical importance to supervisors (Mehr et al., 2015; Spence et al., 2014). As evidenced by this research, trainees and clients appear to suffer the consequences of such silence.

On the whole, the proposal that supervision encompasses normative (quality control), restorative (pastoral support), and formative (therapeutic effectiveness) functions (Bernard & Goodyear, 2004) receives support based on the accounts of the nine participants in this investigation. In addition, the reported results are suggestive of a tightly-knit interdependence between these three functions.

Limitations

There are a number of limitations to consider in the context of this research. The design of the study and interview schedule was executed in an effort to access participants' perspectives on a range of supervision and alliance experiences. However, given the focus

was primarily on two supervision and two alliance experiences, the prevalence of such experiences cannot be inferred. It is possible too that subtle but potentially significant events were less likely to be remembered and reported than more emotionally charged ones when participants are asked to think about “positive” or “negative” experiences.

A defining element of the trainee supervision experience is, by default, the explicit role of supervisor as assessor of the trainee’s competence. This could have been incorporated into the interview schedule and explored in some detail given that it distinguishes the population of interest in this study. Considering participants’ concerns arising from negative supervision experiences, and wishes for those concerns to be addressed, understanding this facet of the supervision relationship could have shed further light on trainees’ internal struggles.

A common thread in participants’ challenging experiences of supervision was the difficulty in being able to express struggles in a transparent manner, despite the desire for them to be addressed. It is possible that participants have had little opportunity to talk openly about their experiences, and so were more likely to take part in the research, safe in the knowledge of anonymity, than others who have had the chance to express supervision difficulties in a satisfactory way.

We also do not know supervisors’ perspectives on the experiences as described by trainees. It is worth bearing in mind that some of the data in the study illustrated that supervisors can offer a mix of satisfactory and unsatisfactory experiences to trainees, though this was not commonly reported, and there was some suggestion that perceived inadequate supervision could improve. Regardless, it would seem that the trainee’s felt experience of supervision is what is translated to the therapy room. Perhaps more important is that we

have no way of knowing clients' experiences of the alliances discussed. It is worth bearing in mind that research suggests impressions of this relationship from observers and therapists are predictive of positive client outcomes (Horvath et al., 2011, p. 10; Karver, et al., 2006; Martin et al., 2000).

Research Implications

The current study offers a number of research avenues to build upon the reported results. As mentioned above, although all participants disclosed both positive and negative supervision and alliance experiences, the prevalence of these is in the trainee population is unclear. Surveying a large sample of trainees may help illustrate this.

Given the absence of a requirement for qualified clinical psychologists to access supervision, and the influence of supervisors and their capacity for emotional containment suggested by this study, investigation into the quantity and quality of supervision for qualified clinicians seems imperative.

Mixed method, longitudinal investigations into the relationship between supervision and the alliance could provide the opportunity to monitor trainees experience of supervisory and therapeutic relationships from beginning to end. This would allow for a greater understanding of how, for example, challenges in either setting are managed and the impact this has on trainee and client welfare. Exploration of supervisor and client experience in a similar manner could complement this work.

Clinical Implications

This study presents supervision as a multifaceted practice that goes beyond discussion of manualised interventions or case management for generic client needs. An

increased understanding of and emphasis on the importance of supervision in trainee and client welfare, both of which this study suggests are intimately linked, seems imperative. Based on participant accounts, devoting time and supportive space to thinking and talking about feelings and relationships is central to positive transfer of experience from supervision to the alliance. Absence of expressed need from trainees does not appear to mean that the need is absent. The data also poses a question about the wisdom of the optional nature of supervisors' access to supervision (HCPC, 2015). Supervisors' own welfare and need for support in processing clinical and personal challenges, which might have implications for trainees and their clients, would appear to be neglected or inadequate in some cases.

Equally from the trainee perspective, an awareness of the role of supervision in trainee and client welfare is important in helping the trainee be aware of what needs can and should be met in supervision, and when to seek additional help. The positive accounts of containing supervision in this study might offer encouragement to those trainees uncertain about bringing anxieties to supervision; equally the more concerning accounts point to a need to access personal and clinical support elsewhere in the event of supervision not meeting needs.

Participants' contrasting experiences of supervision put in stark terms the seriousness of this issue and its impact on trainee and client wellbeing and bond. Despite the need for further research to understand the nature of the supervision-alliance link, it would be wise for services, training institutions, supervisors and trainees to engage together honestly about its potential for distress as well as its potential for safety, support, and development.

Conclusion

This study aimed to qualitatively explore the relationship between supervision and the therapeutic alliance from the perspective of trainee clinical psychologists. Based on nine participants' accounts, it appears that supervision offers a model of relating that can be translated to the therapeutic relationship, and a crucible within which change happens, to the benefit or detriment of the alliance. Supervisors and trainees who engaged together with emotional and relational material were perceived as contributing more positively to the trainee-client relationship, whereas supervision which entailed a more detached and inflexible approach to what was brought by trainees was perceived as limiting or mitigating trainee and client security and development.

Notwithstanding limitations discussed above, the findings of this study suggest support for attachment and supervisory relationship models of supervision, which see the supervisor as a 'base' from which the supervisee can access security, support, and guidance. The psychodynamic model of supervision suggests a transfer of this relationship to the therapeutic alliance and vice versa, a concept which is seemingly supported by the data in this study.

Recommendations for future research include mixed methods longitudinal investigations of trainee experience over time, and concurrent efforts to better understand client and supervisor experinces. Given the substantial evidence base linking a positive therapeutic alliance with positive client outcomes, this study at least offers grounds for further exploration.

The testimony provided by participants in this study illuminates the promise and pitfalls of supervision- its potential to contain so trainees may offer containment to their clients, and its potential to neglect in a way that is felt to be at best limiting and at worst distressing for

trainees and, potentially, for clients. Given the value ascribed to supervision by the BPS (2014, 2017), HCPC (2015), trainee and qualified practitioners (Kühne et al.,2019; Lucock, et al., 2006), paying due attention to and actively engaging with its process could go towards providing for the care of all parties involved.

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Section C: Appendix of Supporting Material

February 2021

Appendix A: Interview Schedule

Briefing

- Introductions
- Reminder of purpose of study, taken from information sheet (brief)
- Reminder of duration (45 - 75) and opportunity to take breaks as needed
- Time for questions from participant (e.g. relating to interview, study, or consent process, etc.)

Warmer

- I'd first like to invite you to briefly mention what type of placements you've had so far on your training (service type, client group, model). As you're doing so, try to internally call to mind your supervision on that placement.

Questions

1. How would you describe clinical supervision, in your own words? (3)
   - What would you say are its functions?

2. Does supervision have any distinct or additional functions in the case of trainee clinical psychologists (2)

3. How would you describe the therapeutic alliance, in your own words? (3)

4. Call to mind a positive experience of supervision (brief or enduring) which you had as a trainee (10)
   - Can you briefly describe this experience for me, in your own words?
   - (Prompt: talk about a particular relationship, session, or moment that captures this)
   - Did this impact your alliance with clients? If so, to what extent/how?
     - Can you give a specific example?
   - Is this typical or untypical of your experience of supervision?

5. Call to mind a less positive or negative experience of supervision (brief or enduring) which you had (10)
    - (Prompt: talk about a particular session or moment that captures this)
    - Can you briefly describe this experience for me, in your own words?
    - Did this impact your alliance with clients? If so, to what extent/how?
        - Can you give a specific example?
    - Is this typical or untypical of your experience of supervision?

6. Call to mind a client with whom you had a positive alliance experience (brief or enduring) (10)
    - (Prompt: talk about a particular session or moment that captures this)
    - Can you briefly describe this experience for me, in your own words?
    - What do you think contributed to the alliance being positive?
    - Can you tell me about the supervision you had for this case/tell me about your experience of supervision for this case?

7. Call to mind a client with whom you had a less positive or negative alliance experience (brief or enduring) (10)
    - (Prompt: talk about a particular session or moment that captures this)
    - Can you briefly describe this experience for me, in your own words?
    - What do you think contributed to the alliance being this way?
    - Can you tell me about the supervision you had for this case/tell me about your experience of supervision for this case?

8. Overall, as a trainee, how has clinical supervision related to your work with clients, and vice versa? (5)
    - Has this changed over the course of your training in any way?

9. Anything else you would like to say – that maybe has not been covered? (5)

Debrief

- Thanks for taking part
- Time for questions or comments from participant, if wanted

- How was it being interviewed? What prompted you to take part?
- Discussion of supports available, e.g. occupational health, if relevant
- Further discussion of purpose of study, if interested
- Reminder of next steps in project process

Appendix B: Participant Invite Email

Dear Trainee,

My name is Iain O' Leary- I am a 3rd year clinical psychology trainee at Salomons Institute for Applied Psychology. My major research project is examining the role of clinical supervision and how it relates to the therapeutic alliance from the perspective of trainee clinical psychologists. I am interested to hear about your experience of this issue.

Clinical supervision is regarded as "a critical element of practice" by the BPS Division of Clinical Psychology (BPS, 2014) and is a Health and Care Professions requirement for DClinPsy training (HCPC, 2017). However, research on the topic is very much in its infancy. By contrast, therapeutic alliance has been well researched and it is regarded as a key ingredient to the process and outcomes of psychological therapies. We know little about the link between these two areas and I am hopeful that this study will contribute to improved understanding and practice of supervision in the NHS, particularly for trainees.

I am therefore interviewing DClinPsy trainees (second year and above) about their experience of clinical supervision and therapeutic work with service users. All interviews will be carried out individually and confidentially. They can take place at your local university site or via Skype and will last between 45 -75 minutes.

The research project has been given ethical approval by the Salomons Institute for Applied Psychology Ethics Panel.

Please follow this link if you are interested in taking part or learning more:

https://cccusocialsciences.az1.qualtrics.com/jfe/form/SV_dhvLfhBSxaMVsWx

If you have any queries, you can email me at io46@canterbury.ac.uk or call the Salomons research 24-hour voicemail phone number (01227 927070), leaving your name and contact details. Please do get in touch so we can discuss any questions you might have.

Warm Regards,

Iain O' Leary

Trainee Clinical Psychologist

Salomons Institute for Applied Psychology

Canterbury Christ Church University

Canterbury Christ Church University

Appendix C: Participant Information Sheet and Consent Form

Participant Information Sheet- Paper Version

Study title: Exploring the relationship between clinical supervision and the therapeutic alliance from the perspective of trainee clinical psychologists.

Information sheet dated: 3/10/2019

Information sheet version number: 2

Introduction

Hello. My name is Iain O' Leary and I am a trainee clinical psychologist at Salomons Institute of Applied Psychology (Canterbury Christ Church University). I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.

There are two parts to this information sheet. Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Part 1

What is the purpose of the study?

The purpose of the study is to better understand trainee clinical psychologists' experience of clinical supervision and how it relates to their alliance with clients in therapy. Although clinical supervision is a mandatory part of training, limited research has been carried out to understand the process.

Why have I been invited?

You have been invited to take part because you are a trainee clinical psychologist employed by the NHS who is over the age of 18.

Do I have to take part?

It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to complete an online consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

If you are eligible to participate, you will take part in an interview with me, approximately 45 – 75 minutes in length, about your experiences of clinical supervision as a trainee clinical psychologist. I will also ask you about your clinical work with clients in therapy.

I can interview you at a university site that is convenient for you. In some circumstances, for confidentiality or logistical reasons, I could interview you over Skype. The interview will be recorded on a dictaphone and stored securely. It will then be transcribed and anonymised to protect your confidentiality.

Expenses and payments

Remuneration for travel up to a cost of £10 is possible for taking part in this study. If travelling for an interview is not possible, the interview can be conducted online by Skype.

What are the possible disadvantages and risks of taking part?

As the interview would entail talking about experiences of supervision and client work experiences, there is a chance that you may find the topic challenging. For this reason you may wish to think carefully about whether to take part or to discuss it first with someone you trust. We can take breaks during the interview. There will be time to debrief after the interview to discuss with me any questions or concerns you might have.

Contact details for relevant services such as your local NHS Trust Human Resources and Occupational Health departments (for workplace wellbeing), the British Psychological Society (for access to professional guidelines), and the Health and Care Professions Council (for professional codes of conduct) will be provided. If necessary, we can also discuss other supports relevant to you.

What are the possible benefits of taking part?

I cannot promise that taking part will help you directly, but the information we get from this study will help inform our understanding of clinical supervision for trainee clinical psychologists. You may also find it beneficial to reflect on your experiences of supervision and therapeutic work.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. There are some rare situations in which information would have to be shared with others. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any point by informing me. If you withdraw before or during your interview, or up until one week after your interview has taken place, you can notify me if you wish to also have your data destroyed. If you withdraw from the study later than one week after the interview has taken place, your data can be retained for use in the study.

What if there is a problem?

If you have any concerns, you can, if you wish, first raise them with me by leaving a message on the Salomons research 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for me, Iain O' Leary, and I will get back to you as soon as possible. A procedure for addressing complaints is detailed below.

Complaints

If you have a complaint and if you remain unhappy after contacting me, and wish to complain

formally, you can do this by contacting Dr. Fergal Jones, Research Director, Salomons Institute of Applied Psychology – fergal.jones@canterbury.ac.uk , tel: 01227 927110.

Will information from or about me taking part in the study be kept confidential?

- Yes. All information which is collected from or about you during the course of the research will be kept strictly confidential, with the exception of a situation arising in which I could be concerned for your safety or the safety of someone else (see the last bullet point in this section for further details)
- Only I (Iain O' Leary) and my research supervisor Dr. Sue Holttum will have access to the data. The only exception to this would be if a third party transcription service is used (details below)
- Your audio data from the interview will be transferred from a dictaphone to a secure encrypted USB drive as soon as possible after your interview. It will then be transcribed and anonymised (removing identifying references such as names, specific services, etc.). Once transcribed, the audio data will be destroyed
- Some of the audio data may be transcribed by a third party transcription service selected by me (Iain O' Leary). If this is the case, the person transcribing will be required to sign a confidentiality agreement ensuring that identifiable information is not shared with anybody other than me
- After completion of the project the anonymised project data will be transferred to a CD and stored in a locked cabinet on Canterbury Christ Church premises for 10 years, in keeping with Medical Research Council guidelines
- It will be destroyed after this time period
- Any personal information you provide via the consent form and screening questionnaire will be stored on Canterbury Christ Church premises, separately to your anonymised interview data, and will be destroyed one year after the project has ended
- The analysis will form part of a major research project, written in report form and assessed at Canterbury Christ Church University as part of my DClinPsy qualification (Doctorate in Clinical Psychology)
- The report may be submitted for publication in an academic journal. If quotations from your interview are used, they will be anonymise with identifiable information removed
- You have the right to check the accuracy of data held about you and correct any errors
- The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something you disclose, I were to become concerned about your safety or the safety of someone else. I would always try to speak with you first, if possible, about any such actions. If you were to discuss something that suggests serious unethical practice (e.g. supervisor practice that might risk the safety of a service user), I would do the following:
    - (I) I would first ask you if the concerning practice (e.g. supervisor malpractice) has been reported to an appropriate senior member of staff, e.g. a manager in the relevant clinical service, or your course manager/tutor
    - (II) If the issue has not been reported, and you have no intention to report it, I will then consult with my MRP supervisor, Dr. Sue Holttum. We will discuss if any further action needs to be taken, e.g. contacting the your training course leader
    - (III) In all instances, unless unsafe to do so, I would speak with you again if I intended to take any further action

What will happen to the results of the research study?

- The results of the research will form part of a major research project, written in report form and assessed at Canterbury Christ Church University
- The report may be submitted for publication in an academic journal
- You will not be identified in any report/publication
- Anonymised quotes from interviews may be included in the major research project and/or published reports

Who is organising and funding the research?

Canterbury Christ Church University.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by The Salomons Ethics Panel, Salomons Institute of Applied Psychology, Canterbury Christ Church University.

Will I get a copy of this information sheet?

You will be given a digital copy of the information sheet and consent form if you wish.

Further information

If you have any further questions about the above information, the research study, or taking part, please do contact me. If you would like to speak to me and find out more about the study of have questions about it answered, you can leave a message for me on the Salomons research 24-hour voicemail phone line at 01227 927070 or contact me by email at io46@canterbury.ac.uk. Please say that the message is for me, Iain O' Leary, and leave a contact number so that I can get back to you.

Participant Consent Form- Paper Version

Title of Project: Exploring the relationship between clinical supervision and the therapeutic alliance from the perspective of trainee clinical psychologists.

Name of Researcher: Iain O' Leary (Trainee Clinical Psychologist)

Consent form dated: 3/10/19

Consent form version number: 2

Please **tick** the corresponding box if you agree

1. I confirm that I have read and understand the information sheet dated 5/9/19, version 1, for the above study. I have had the opportunity to consider the information, ask questions and (if asked) have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
3. If I withdraw before, during or up to one week after my interview, I can choose to have my data withdrawn from the study and destroyed.	
4. If I withdraw from the study more than one week after my interview takes place, my data can be retained and used	
5. I understand that all information which is collected from or about me during the course of the research will be kept strictly confidential. The only exception to this is if the chief investigator (Iain O' Leary) is concerned about the safety of me or somebody else as a result of information I share. In this circumstance, he may be obliged to share information with a third party.	
6. I understand that anonymised data collected during the study may be looked at by the lead supervisor, Dr. Sue Holttum. I give permission for this individual to have access to my data.	
7. I understand that my interview may be transcribed by the chief investigator (Iain O' Leary) or a third party transcription service selected by the chief investigator.	
8. I understand that if my interview is transcribed by a third party transcription service, this person will have signed a confidentiality agreement stating that they will not share confidential information with anyone aside from the chief investigator.	
9. I agree that anonymised quotes from my responses may be used in published reports of the study findings.	
10. I agree for my anonymous data to be used in further research studies.	
11. I agree to take part in the above study.	
12. In typing my name below I am confirming my identity as the person stated.	

☐ ☐

I wish to receive a summary of the outcome of this study when it is completed: Yes No

Name of Participant: _____ Date: _____

Contact details. email address: _____ phone number: _____

Section below for completion by chief investigator

Name of Person taking consent: _____ Date: _____

Signature: _____

Date of interview: _____

Appendix D: Abridged Research Journal

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Appendix E: Ethical Approval

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Appendix F: Third-Part Transcription Confidentiality Agreement

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Appendix G: Extract of Coded transcripts, Theme Development, and Analytic Memos

Extract of Coded Transcripts

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Extract of Theme Development

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Extract of Analytic Memos

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Appendix H: Author Guidelines for Submission to the Journal of Clinical Psychology and Psychotherapy- Extract

2. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research Article: Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).

Comprehensive Review: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).

Measures Article: Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).

Clinical Report: Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

3. PREPARING THE SUBMISSION

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures.

File types

Submissions via the new Research Exchange portal can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) formats.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation “Main Document – LaTeX .tex File” on upload. When submitting a Latex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as “Main Document - LaTeX PDF.” All supporting files that are referred to in the Latex Main Document should be uploaded as a “LaTeX Supplementary File.”

Cover Letters and Conflict of Interest statements may be provided as separate files, included in the manuscript, or provided as free text in the submission system. A statement of funding (including grant numbers, if applicable) should be included in the “Acknowledgements” section of your manuscript.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The authors' complete institutional affiliations where the work was conducted (Institution Name, Country, Department Name, Institution City, and Post Code), with a footnote for an author's present address if different from where the work was conducted;
5. Conflict of Interest statement;
6. Acknowledgments;
7. Data Availability Statement
8. Abstract, Key Practitioner Message and 5-6 keywords;
9. Main text;
10. References;
11. Tables (each table complete with title and footnotes);
12. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

Authorship

On initial submission, the submitting author will be prompted to provide the email address and country for all contributing authors.

Please refer to the journal's **Authorship** policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the **Conflict of Interest** section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

Key Practitioner Message

All articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

Keywords

Please provide five-six keywords (see **Wiley's best practice SEO tips**).

Main Text

1. The journal uses US spelling; however, authors may submit using either US or UK English, as spelling of accepted papers is converted during the production process.
2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the **APA FAQ**.

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486. doi: **10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from *http://www.youtube.com/watch?v=Vja83KLQXZs*

Endnotes

Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. Click **here** for the basic figure requirements for figures submitted with manuscripts

for initial peer review, as well as the more detailed post-acceptance figure requirements.

Figures submitted in color may be reproduced in color online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. The cost of printing color illustrations in the journal will be charged to the author. The cost is £150 for the first figure and £50 for each figure thereafter. If color illustrations are supplied electronically in either TIFF or EPS format, they may be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the Wiley Online Library site.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

General Style Points

The following points provide general advice on formatting and style.

1. **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
2. **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
3. **Numbers:** numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
4. **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

Appendix I: Summary Report for Ethics Committee and Participants

Being Contained to Becoming the Container: A Reflexive Thematic Analysis of the Relationship Between Clinical Supervision and the Therapeutic Alliance from the Perspective of Trainee Clinical Psychologists

Background

Clinical supervision is regarded as a crucial part of psychological therapy practice. However, the evidence base for its effectiveness on key outcomes is limited. This is particularly the case for client outcomes, despite safe and effective practice being purported aims of supervision. Understanding is impeded by the complexity of many variables being involved in the journey between supervision and the therapy room.

Aim

The current study aimed to address this by exploring the connection between supervision and the therapeutic alliance, a variable which research suggests has a significant impact on client outcome.

Method

Interviews were conducted with nine participating trainee clinical psychologists from training regions across the UK, exploring experiences of clinical supervision and therapeutic alliances across a variety of settings. Reflexive thematic analysis was used to analyse the data.

Findings

A primary theme of 'Being Contained to Becoming the Container', was developed from the data, with secondary themes of 'Supervision as a Model of Relating' and 'Supervision as a Crucible for Change'.

Participants were understood to experience supervision as a relational model to draw from and apply to the therapeutic alliance. This occurred explicitly, when trainees actively sought to use their experience of being related to by their supervisor with their clients. It also occurred implicitly, when the alliance relationship appeared to 'mirror' dynamics in supervision. Supervision also acted as a place for trainees to bring personal and clinical material and have it responded to, with the output of this process having implications for the alliance. This mode of transfer saw supervision act as a sort of crucible in which change occurred to the benefit or detriment of the trainee and client.

Supervision environments tending towards engaging with feelings and relationships (personal and clinical) were associated with meeting trainee needs and better alliance conditions. Environments tending to detach from feeling and relating were associated with impeding trainee needs and alliance difficulties. Reported findings suggest an intimate relationship between trainee and client security and development, with the supervisor playing a central role.

Research and Clinical Implications

Reported findings offer support for models of supervision that understand the supervisory relationship in attachment terms as central to the process. The psychodynamic model of supervision, which sees the triad of supervisor, supervisee, and client as mutually influencing through unconscious transfer of dynamics also garners support. Existing literature documenting the deleterious effects of inadequate and harmful supervision is reinforced. The testimony provided by the participants in this study illuminates the promise and pitfalls of supervision- its potential to contain so trainees may offer containment to their clients, and its potential to neglect in a way that is felt to be at best limiting and at worst distressing for trainees and, so it would seem, for clients.

Recommendations for future research include mixed methods longitudinal investigations of trainee experience over time, and concurrent efforts to better understand client and supervisor experiences.

This study presents supervision as a multifaceted practice that goes beyond discussion of manualised interventions or case management for generic client needs. An increased understanding of and emphasis on the importance of supervision in trainee and client welfare, both of which this study suggests are intimately linked, seems imperative. Given the suggested centrality of the role of supervisor in the process, serious reflection on the optional nature of supervision for supervisors is also warranted.

I would like to take this opportunity to sincerely thank the participants in this study for their time, effort, and commitment to their practice and clients. For further information, please email i.oleary@posteo.net

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