

THE UNIVERSITY OF HULL

Developing Clinical Practice:
Personal Therapy and Supervision

being a Thesis submitted for the Degree of Doctor of Clinical Psychology
in the University of Hull

by

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Acknowledgements

This thesis is dedicated to Graeme. I hope you are proud of who I have become and what I have achieved in your absence.

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Overview

This portfolio thesis comprises of four parts: a systematic literature review paper, an empirical paper, a reflective statement and appendices.

Part one is a systematic literature review which examines whether personal therapy is an effective method of professional development for therapists. Quantitative and qualitative literature is critically reviewed. A model of the reported benefits of personal therapy for therapists is proposed. Implications for clinical practice are discussed.

Part two is an empirical paper examining the relationship between stage of development and behaviour in clinical supervision for trainee clinical psychologists. Forty trainee clinical psychologists, from three years of a training course, completed a questionnaire (the SLQ-R[A]) measuring their stage of development as supervisees. A subsample submitted DVD-recordings of their supervision sessions which were coded using the Teacher's PET to analyse the supervision behaviours. Comparisons were made between the supervision behaviour of first ($n = 8$) and third ($n = 3$) year trainee clinical psychologists and their supervisors. Correlations between questionnaire responses and supervision behaviours were examined. Results are discussed in the context of the Integrated Developmental Model of Supervision. Implications for clinical practice are highlighted.

Part three is a reflective statement which considers the process of conducting the research and developing this portfolio thesis.

Part four is the appendices.

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Part One: Systematic Literature Review Paper

*This paper is formatted ready for submission to Psychology and Psychotherapy:
Theory, Research and Practice. Please see Appendix A for the Author Guidelines.*

**Is personal therapy an effective method of professional development
for therapists who work with individuals experiencing mental health
problems? A systematic review of the literature**

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Abstract

Purpose: The value of personal therapy as a method of professional development has been debated. The need for accountability for the time and funds required for professional development, alongside the importance of demonstrating how an activity enables therapists to meet their professional responsibilities, suggests that it is timely to ask how effective personal therapy is as a method of professional development for mental health therapists.

Methods: A systematic literature review was undertaken. Peer-reviewed journal articles published between January 1990 and May 2010 were selected. Inclusion criteria included personal therapy discussed in the context of professional development and a participant population drawn from at least one of the following groups: psychologists, counsellors and psychotherapists. Literature quality was assessed using bespoke quality checklists. A qualitative review was then undertaken.

Results: Twenty-five papers (13 survey, 3 other qualitative methodologies and 9 qualitative) were reviewed. Literature quality was variable and all studies had flaws. Personal therapy is a widely used resource and was reported to impact on aspects of countertransference, therapeutic alliance, provide therapist role models and give experiential learning of the client role.

Conclusions: Therapists have reported personal and professional benefits of personal therapy. At present it is not possible to take a position as to whether personal therapy is an effective method of professional development. The literature has struggled to find measures of personal therapy that are not reliant on self-report. A model connecting the personal and professional benefits of personal therapy for therapists is suggested.

The value of personal therapy for therapists has been debated within professional groups. For the purposes of this article ‘personal therapy’ is used to encompass “psychological treatment...by means of various theoretical orientations” (Geller, Norcross, & Orlinsky, 2005, p. 5) and ‘therapist’ is used to encompass the professions who deliver psychological therapies within mental health services. Freud (1937/1964) is frequently cited as one of the first individuals to make the connection between skills as a therapist and the need for personal therapy.

Historically, therapists have been advised “to seek out analysis or personal therapy in order to become a “better” therapist” (Greenberg & Staller, 1981, p. 1467) as it was perceived to be a fundamental part of therapeutic practice (Strupp, 1955). Therapeutic orientation is linked to participation in personal therapy (Orlinsky, Norcross, Rønnestad & Wiseman, 2005) and it is advocated by existential, humanistic, interpersonal, systemic, relational and other therapeutic models (Geller et al., 2005).

Personal Therapy and Training

Training pathways can be broadly divided into a) those that dictate number of hours and/or duration of personal therapy for therapists in training and b) those that acknowledge that personal therapy may be beneficial but do not make specific recommendations. The Institute of Psychoanalysis, for example, requires students to undertake intensive psychoanalysis. The aims of this intensive therapy are cited as “freeing the student from those unconscious factors that would interfere with his or her ability to feel, think, and work as a psychoanalyst” (The Institute of Psychoanalysis,

Online Prospectus). On the other hand the course curriculum for Improving Access to Psychological Therapies (IAPT) High Intensity Therapies requires students to acquire “... an ability to identify ... CBT’s application to their own lives” (Liness & Muston, 2008, p. 12) but it does not suggest the individuals apply these techniques or gain the experience of personal therapy themselves.

Personal Therapy and Personal Development

Personal therapy has been conceptualised by some as part of an interconnected process of personal and professional development. It has been argued that due to the interpersonal nature of therapy, it is not possible to distinguish personal from professional development (Orlinsky et al., 2005; Rake, 2009). Many therapists enter into personal therapy for varying degrees of personal and professional reasons (Norcross & Connor, 2005).

Personal development includes “self-awareness, spiritual growth, pursuit of happiness, quality of life, making personal changes, gaining meaning and understanding in life, and positive-thinking and goal setting” (Hughes, 2009, p. 25). Personal therapy may be able to contribute toward many of these themes.

Personal Therapy and Self-Care

Practicing as a therapist is demanding. Regulatory and professional bodies recognise this. There is an obligation for therapists to manage demands through self-care ensuring

fitness to practice (British Association for Behaviour and Cognitive Psychotherapies [BABCP], 2009; British Association for Counselling and Psychotherapy [BACP], 2010; British Psychological Society [BPS], 2009; Health Professions Council [HPC], 2009). Personal therapy is one route by which some therapists may opt to manage stressors.

Previous Literature Reviews

Much of the existing literature base is developed from therapist self-report, whether in qualitative studies or through questionnaire methodology. Numerous therapists have undertaken personal therapy and reported positive outcomes. Norcross and Guy (2005) reported around three-quarters of American mental health professionals had undertaken personal therapy. Sixty-eight to ninety-nine per cent of therapists in six studies reviewed by Orlinsky et al. (2005) found personal therapy effective or helpful. These findings have been critiqued as therapists have a vested interest in reporting benefits from therapy. Others have argued therapists are ideally placed to give self-report data due to being discriminating, knowledgeable consumers and that these positive findings cannot solely be accounted for by cognitive dissonance (Orlinsky et al., 2005).

In research reviews (Clark, 1986; Greenberg & Staller, 1981; Orlinsky et al., 2005; Orlinsky, Botermans & Rønnestad, 2001) a lack of good quality research has been highlighted (e.g. a lack of controlled studies, small samples etc.). Empirical evidence has not definitively shown that therapists who have had personal therapy are more effective than those who have not (Atkinson, 2006; Clark, 1986; Greenberg & Staller, 1981; Macaskill, 1988; Macran & Shapiro, 1998), although some evidence has been

presented that in-session behaviour with clients does change when the therapist has undertaken personal therapy (Macran & Shapiro, 1998).

Previous reviews suggest personal therapy may impact on the clinical work of a therapist in the following ways:

- Improving the emotional and mental functioning of the therapist and facilitating the maintenance of good mental health
- Minimising the effect of the therapist's own interpersonal processes on the process of therapy with a client
- Minimising the effect of stress inherent in undertaking clinical work
- Validation of personal therapy as an effective treatment
- Experiential learning from being in the client role
- Provision of a therapist role model

(Macran & Shapiro, 1998; Norcross, Strausser-Kirtland, & Missar, 1988)

It can be suggested that personal therapy may impact on the domains of self-care, experiential learning and self-awareness. These findings concur with predictions made from a theoretical viewpoint.

Rationale for Current Systematic Literature Review

Personal therapy is a considerable investment (e.g. time, finances, emotionally etc.).

Individuals attempting decide whether they should partake in personal therapy as part

of personal and/or professional development can find it difficult to make sense of the existing literature base. Whilst questionnaires have consistently reported positive outcomes of personal therapy, experimental data has been inconclusive. Previous reviews of this literature have not been systematic and have not included qualitative studies.

Method

A systematic literature review was conducted. Searches in the electronic databases PsycINFO, Web of Science (all years) and Medline (1950 – present) were conducted using the terms ‘personal *therapy’, ‘personal counsel*ing’, ‘personal psychotherapy’, ‘clinical psycholog*’, ‘psycholog*’, ‘counsel*or’, ‘psychotherapist’, ‘professional practice’ and ‘professional development’.

Papers published prior to January 1995 were not selected for inclusion due to being reviewed elsewhere (Greenberg & Staller, 1981; Macaskill, 1988; Macran & Shapiro, 1998; Orlinsky et al., 2005; Rake, 2009) and being less relevant to current clinical practice.

Online abstracts generated by searches were reviewed to identify potentially relevant articles. Full text articles were then assessed against the inclusion and exclusion criteria. Full text articles references were hand-searched for other relevant papers. The abstracts of additional studies were reviewed. Full text copies were obtained for relevant articles. Figure 1 shows the article selection process.

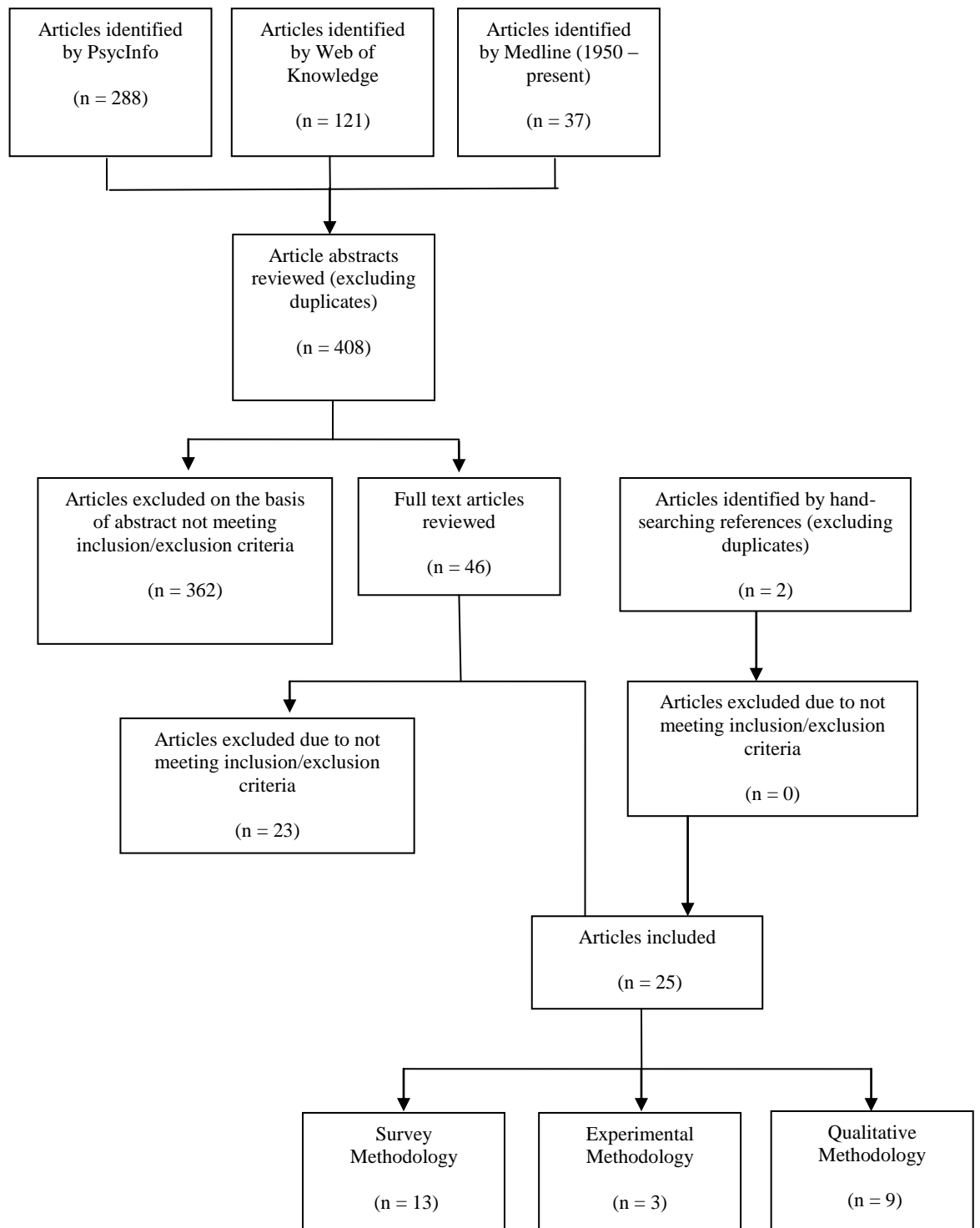


Figure 1 The Article Selection Process

Inclusion Criteria

- Papers written in English
- Papers published in peer-reviewed journals
- Papers published between January 1995 and May 2010.
- The majority of the participant population consists of at least one of the following professions: Clinical Psychologists, Psychologists, Counsellors and Psychotherapists
- Empirical, qualitative and experimental papers
- Papers examining the personal (psycho)therapy of mental health (psycho)therapists

Exclusion Criteria

- Papers not written in English
- Papers published prior to January 1995 or post May 2010
- Review papers
- Case studies (n=1 methodology)
- Papers on measure validation
- Research in unpublished articles, dissertations, meeting abstracts and conference proceedings.
- Papers that do not examine the personal (psycho)therapy of mental health (psycho)therapists
- The majority of the participant population does not consist of at least one of the following professions: Clinical Psychologists, Psychologists, Counsellors and Psychotherapists

Papers that met the inclusion criteria for this review were assessed for quality by the author. As both qualitative and quantitative papers were included different quality checklists appropriate to the respective methodological approaches were used (see Appendices B and C). Data was extracted using a standard form relevant to each approach (see Appendices D and E). A qualitative review was then undertaken as the data generated was unsuitable for further statistical analysis.

Results

Twenty-five papers were included in the review. These were divided into quantitative (n = 16) and qualitative (n = 9) papers for analysis.

Quantitative Studies

Quantitative papers identified for analysis were further divided into survey (n = 13) and other quantitative (n= 3) methodologies which were reviewed separately. Article summaries can be found in Tables 1 and 2.

Survey methodology.

The quality of the survey methodology papers varied from meeting 50.00 to 77.27% of the quality control criteria (mean quality score = 14.08, SD = 1.93, range = 11 - 17). Response rates ranged from 12 to 77%. It has been suggested that surveys with a response rate less than 70% should be treated with scepticism but this figure appears to be arbitrary (Eysenbach, 2004). Only 1 of the 13 survey papers reviewed had a response rate higher than 70%.

Paper	Country	Participants	Response Rate	Participation Population(s)	Measures used	Main Findings	Quality Score [max = 22] (Percentage)
Holzman, Searight & Hughes (1996)	USA	n= 1018 [m = 275, f = 743] <i>Time in practice:</i> Not reported <i>Orientation:</i> 34% eclectic 25% psychodynamic or object – relations 18% cognitive-behavioural <i>Experience of Personal Therapy:</i> 74% had received psychotherapy, 53% had more than one period of therapy	50%	Clinical Psychology Graduate Students	Bespoke questionnaire	Dynamic therapists endorsed personal therapy more strongly than those with CBT orientation, $t(324) = -6.30, p < .001$ Personal therapy sought for personal growth (70%), desire to improve as a therapist (65%) and adjustment/developmental issues (56%) Those who had never received personal therapy rated it as less important for practicing therapists	11 (50.00%)
Mahoney (1997)	USA	n = 155 [m = 70, f = 84, not disclosed = 1] <i>Time in practice:</i> Less than 1 year – 48 years [mean = 12.9 years] <i>Orientation:</i> 54% eclectic 19% psychodynamic 15% cognitive <i>Experience of Personal Therapy:</i> 87.7% reported being in personal psychotherapy	50%	Mental health psychotherapy practitioner attending a conference	Bespoke questionnaire	More women reported being in personal therapy in the past year (46.5%) than men (27.9%), $F(1, 141) = 6.66, p < .01$ Personal therapy amongst least reported forms of self-care Non-doctoral therapists were more likely than doctoral therapists to report currently being in personal therapy	12 (54.55)
Oden, Minder- Holden, & Balkin(2009)	USA	n = 164 [gender split not reported] <i>Time in practice:</i> Not reported <i>Orientation:</i>	62%	Masters Level Counselling Students enrolled in counsellor	Bespoke questionnaire Counsellor Self-Awareness Scale	No significant relationship between internal sub-scale (perception of counselling affecting awareness of one's	12 (54.55)

		Not reported		preparation program		internal experiences) and counselling, $X^2(2) = 2.061, p = .357$ Significant relationship between external scale (perception of counselling affecting awareness of interaction with patients) and counselling, $X^2(2) = 63.085, p = .001$	
Curtis, Field, Knaan-Kostman & Mannix (2004)	USA Norway	n = 75 [m = 41, f = 34] <i>Time in practice:</i> Not reported <i>Orientation:</i> Not reported <i>Experience of Personal Therapy</i> 57% had engaged in 2 or more analyses Mean length of psychoanalysis = 5.29 years (range = 2 – 14 years)	12%	Psychoanalysts [n America = 35, n Norway = 40)	Bespoke questionnaire	Most helpful therapist behaviours relate to interpersonal qualities Positive Active Interventions were the best predictor of perceived change $r = .54, p < .01$ Areas most reported as changed were capacity for emotional intimacy (m = 3.46) and experience fully a wider range of emotions (m = 3.44)	13 (59.09)
Orlinsky, Botermans, & Rønnestad (2001)	Germany USA Norway Sweden Denmark South Korea Belgium France Italy UK Russia Israel	n = 4923 [m = 2288, f = 1249] <i>Time in practice:</i> Less than 1 year – 50 plus years (mean = 11.3 years, s.d. = 8.9, median = 10 years) <i>Orientation:</i> 58% analytic/psychodynamic 31% humanistic 24% cognitive 21% systemic 14% behavioural 14% no salient orientation	62%	Psychology [n = 2810] Medicine [n = 1378] Social Work [n = 280] Lay therapist* [n = 214] Nursing [n = 91] Other [n = 135]	Development of Psychotherapists Common Core Questionnaire (DPCCQ)	N = 3570 Getting personal therapy, analysis or counselling positive experience mean = 2.24 (SD = 1.01) N = 3564 Getting personal therapy, analysis or counselling negative experience mean = 0.02 (SD = 0.20) Getting personal therapy, analysis or counselling ranked within top 3 positive influence, consistent finding across different nations,	13 (59.09)

	Argentina Mexico	<i>Experience of Personal Therapy:</i> 78.4% experienced some form of personal therapy 27.1% presently in personal therapy				profession & career cohort Getting personal therapy, analysis or counselling was ranked in top 4 positive influence, consistent across orientation (except for saliently CB which ranked it 7 th)	
Stevanovic & Rupert (2004)	USA	n = 286 [m = 129, f = 157] <i>Time in practice:</i> Mean = 16.7 years (SD = 10.1) <i>Orientation:</i> Not reported <i>Experience of Personal Therapy:</i> Not reported	52% [48% usable]	Licensed psychologist members of Illinois Psychological Association	Bespoke Survey	Personal therapy ranked 30 out of 34 as a career sustaining behaviour (m score = 3.34, SD = 2.16), ranked higher than peer support (m score = 2.71, SD = 2.07) and regular supervision (m score = 2.69, SD = 1.95)	13 (59.9)
Norcross, Bike, Evans & Schatz (2008)	USA	Therapy Seekers (TS) n = 608 [m = 195, f = 413] <i>Time in practice:</i> Not reported <i>Orientation:</i> 24% cognitive 24% eclectic 12% dynamic <i>Experience of Personal Therapy:</i> Not reported Non-Therapy Seekers (NTS) n = 119 [m = 45, f = 74] <i>Time in practice:</i> Not reported <i>Orientation:</i> 36% cognitive 23% eclectic 15% behavioural	35%	Therapy Seekers Psychologists [n = 218] Social workers [n = 195] Counsellors [n = 195] Non-Therapy Seekers Psychologists [n = 39] Social workers [n = 41] Counsellors [n = 39]	Adapted questionnaire previously used (Norcross et al., 1988; Norcross, Strausser, & Faltus, 1988)	TS & NTS differed in their orientation and professional self-view. CBT therapists differed significantly from humanistic & psychodynamic/psychoanalytic therapists in seeking personal therapy $X^2(2, n = 107) = 25.51, p < .001$ Main reasons for not seeking personal therapy were “dealt with my stress in ways other than therapy” & “received sufficient support from friends, family or co-workers”	14 (63.64)

Lucock, Hall & Noble (2006)	UK	<p>Qualified n = 96 [m = 32, f = 64] <i>Time in practice:</i> not reported <i>Orientation:</i> 32% CBT/Cognitive 20% psychodynamic/psychoanalytic <i>Experience of Personal Therapy:</i> Not reported</p> <p>In Training n = 69 [m = 11, f = 58] <i>Time in practice:</i> not reported <i>Orientation:</i> not reported <i>Experience of Personal Therapy:</i> Not reported</p>	<p>Qualified = 77% Trainee = 40%</p>	<p>Clinical psychology (n = 37) Counselling (n = 30) Nursing (n = 150) Psychotherapy (n = 6) Medicine (n = 4) Occupational Therapy (n = 1) Not specified (n = 3) Trainee clinical psychologists (n = 69]</p>	<p>The Questionnaire of Influencing Factors on Clinical Practice in Psychotherapies (QuIF-CliPP)</p>	<p>Qualified therapists (n=67) rated personal therapy influence mean = 4.0 (s.d. = 1.9) Trainees (n=27) rated personal therapy influence mean = 2.4 (SD = 0.2) 39% CBT therapists received personal therapy compared to 100% psychodynamic/analytic, 100% person centred therapists, 63% eclectic/varied therapists CBT who had received PT rated it as lower influence than other therapists, $F(4, 52) = -32.8 p < .001$</p>	15 (68.18)
Pelling, Brearer & Lau (2006)	Australia	<p>n = 317 [m = 94, f = 223] <i>Time in practice:</i> Mean = 14.8 years (SD = 8.9) <i>Orientation:</i> 24.6% eclectic: 8.5% cognitive-behavioural <i>Experience of Personal Therapy:</i> Not reported</p>	62.2%	Counsellors	Bespoke Questionnaire	<p>Personal counselling was actively engaged in by 60.3% to support their development</p>	15 (68.18)
Williams, Coyle & Lyons (1999)	UK	<p>n = 84 [m = 27, f = 57] <i>Time in practice:</i> 0 – 37 years [median = 8] <i>Orientation:</i></p>	<p>60% [44% usable]</p>	Chartered counselling psychologists	Bespoke questionnaire	<p>89% reported positive outcomes to personal therapy 6% reported negative effects of personal therapy</p>	15 (68.18)

44% psychodynamic
 26% humanistic
 19% integrative
Experience of Personal Therapy:
 Mandatory for training
 Range = 0 – 300 hours, median = 40
 29% currently in personal therapy
 61% had been in personal therapy prior to training

Those who had clear aims for their therapy did not report more positive contributions than those who did not, $t(51) = .263$, ns
 The more motivated individuals were for personal therapy the higher their outcome ($r = .559$, $p < .01$) and process ratings ($r = .563$, $p < .01$)

Dearing, Maddux & Tangney (2005)	USA	<p>n = 262 [m = 61, f = 201] <i>Time in practice:</i> Not reported <i>Orientation:</i> 17.3% Psychodynamic/psychoanalytic 29.1% cognitive-behavioural 38.6% eclectic 15.0% other <i>Experience of Personal Therapy:</i> 70.2% had been in therapy prior to/during graduate school Mean number of therapy hours during graduate school = 61.54 (SD = 83.16)</p>	35.7% [useable 27.3%]	Clinical Psychology Graduate Students [n = 163] Counselling Psychology Graduate Students [n = 74] Other [n = 25]	Bespoke questionnaire Attitude Toward Seeking Professional Psychological Help (ATSPPH) [10 item version]	Cost, time and confidentiality were the main barriers identified to seeking personal therapy Student attitudes towards seeking personal therapy were positive (mean = 4.21, SD = 0.51) Students endorsed the necessity of personal therapy to training (mean = 3.71, SD = 1.22)	16 (72.73)
Bae, Joo & Orlinsky (2003)	South Korea	<p>n = 538 [m = 350, f = 188] <i>Time in practice:</i> 2 months – 33 years [mean = 5.6 years, SD = 5.9, median = 3.1 years] <i>Orientation:</i></p>	Wave 1 = 25% Wave 2 = 38%	Psychiatrists [n = 346] Psychologists [n = 70] Counsellors [n = 43]	Development of Psychotherapists Common Core Questionnaire (DPCCQ)	36% of Korean therapists have had personal therapy/counselling Counsellors have the highest rates of personal therapy (69.8%), psychologists (48.6%), psychiatry (32.1%), social workers (25%),	17 (77.27%)

39% saliently analytic/psychodynamic, 36% saliently humanistic 10% no strong orientation
Experience of personal therapy
 193 ever experience personal therapy (36.1%)
 26 currently undergoing personal therapy (6.2%)
 (Note participants also form part of sample in Orlinsky et al., 2001)

Nurses [n = 38]
 Social workers [n= 32]
 Other [n = 9]

Nursing (21.1%)

Bike, Norcross & Schatz (2009) USA

n = 727 [m = 239, f = 488] 35%
Time in practice:
 Not reported
Orientation:
 24% eclectic-integrative
 24% cognitive
 12% psychodynamic
Experience of Personal Therapy
 608 (84%) have sought therapy
 Mean number of hours in personal therapy = 103
 Median number of hours in personal therapy = 20

Psychologists [n = 261]
 Social Workers [n = 234]
 Counselors [n = 232]

Adapted previously questionnaire (Norcross et al., 1988)

Reasons for entering most recent personal therapy: personal reasons 60%, professional reasons 5% and both 35%
 5% perceived they had experienced harm from personal therapy
 Personal therapy reinforced the importance of therapist reliability & commitment (m = 4.56, SD= .70), competence & skill (m = 4.44, SD = .77), warmth & empathy (m = 4.42, SD = .83) and patience & tolerance (m = 4.16, SD = .97)

*Psychotherapist, psychoanalyst or counsellor with no profession specified

Table 1 Summary of Survey Methodology Papers

Measures used in survey methodology.

Nine out of thirteen survey papers used bespoke questionnaires or surveys. Frequently questionnaire development was not described and it was unclear whether the questionnaire/survey had been piloted prior to its usage. Two sister papers used the Development of Psychotherapists Common Core Questionnaire (DPCCQ) (Bae et al., 2003; Orlinsky et al., 2001). Bae et al. (2003) described a subsection of the population used in Orlinsky et al. (2001) in further detail. Two papers (Bike et al., 2009; Norcross et al., 2008) adapted a previous questionnaire used in an earlier study (Norcross et al., 1988). Again these were sister papers with Bike et al. (2009) exploring personal therapy of therapists and Norcross et al. (2008) focusing on a subset who reported abstaining from personal therapy.

Likert scales were the most common method of measuring participant responses (n = 12). Although some of the anchors used were questionable e.g. 'yes' and 'no' as poles on a 7 point Likert scale (Holzman et al., 1996).

The majority of the survey papers were dedicated to describing participant populations rather than exploring relationships between variables.

Participation in personal therapy.

Four papers (Lucock et al., 2006; Norcross et al., 2008; Pelling et al., 2006; Stevanovic & Rupert, 2004) did not report their participants experience of personal therapy. Of the remaining nine, participation in at least one course personal therapy was consistently high (range 36% - 100% of participants, mean = 81.1%, SD = 20.36, median = 84%). The exception to this was Bae et al.'s (2003) study, which was aimed to provide a detailed, contextualised description of therapists practicing in South Korea (a participant subgroup in Orlinsky et al.'s (2001) study). Personal therapy had been utilised by 36% of therapists. Bae et al (2003) note that legally in South Korea only psychiatrists are allowed to practice psychotherapy. Other professionals are required to describe their practice using terms like “lay counseling [*sic*]” (p. 303). The majority of participants in this sample were psychiatrists (n = 346, 64%) of whom 32% had experienced personal therapy. When examining psychology (n = 70, 13%) and counselling (n = 43, 8%) 48.6% and 69.8% of therapists had experienced personal therapy. These rates are similar to those of their Western counterparts.

Cultural factors in the use of personal therapy for therapist have not thoroughly been examined in the literature reviewed. Only two studies, both with moderate (59.9%) quality scores, used participants from more than one country. One was a large scale survey encompassing 14 countries where between-group comparisons were reported (Orlinsky et al., 2001) although recruitment methods were variable and unsystematic. The conclusions that can be drawn from this study are limited. The other study (Curtis et al., 2004) made no reference to group differences in the analysis.

One of the highest quality survey papers (Bike et al., 2009) with seven hundred and twenty-seven participants reported that therapists had undertaken a mean of 2.8 courses of personal therapy (SD = 1.6, range 1 – 10 episodes, median = 2). Forty-seven percent of participants had three or more courses of personal therapy. Despite the large number of respondents, these figures were based on a response rate of 35%. Bike et al. (2009) suggested that their participant demographics were representative of the populations they were recruited from.

Participation in personal therapy was strongly linked to therapeutic orientation. As with previous literature, there was a continuum: cognitive-behavioural or behavioural therapists being the least likely and psychodynamic or psychoanalytic therapists being the most likely to seek and endorse the value of personal therapy (Orlinsky et al., 2001; Bike et al., 2009; Holzman et al., 1996; Lucock et al., 2006; Norcross et al., 2008; 2001). This appears to be a robust and stable finding across time and papers examined. The literature reviewed does not permit one to confidently state uptake of personal therapy by orientation, due to a reliance on unsystematic recruitment methods like opportunity sampling.

Reasons for entering personal therapy.

Three papers (Bike et al., 2009; Dearing et al., 2005; Holzman et al., 1996) examined the reasons as to why professionals enter personal therapy. It appears that therapy is sought for a mixture of personal and professional reasons. However, more than this is difficult to draw from the literature as quality was variable, there were a small number

of papers and response rates were low. Future research would benefit from examining whether there are differences in reasons for entering personal therapy based on stage of practice.

Personal therapy during training.

Three papers (Dearing et al., 2005; Holzman et al., 1996; Oden et al., 2009), all American, used participants who were in training. One British paper (Lucock et al., 2006) involved trainee clinical psychologists as a participant sub-group. Only the participants in Oden et al.'s (2009) study were required to undertake personal therapy as a compulsory component of training.

Students had a largely positive view of personal therapy. Personal therapy was seen to be an important part of training (Dearing et al., 2005; Oden et al., 2009) and ongoing practice (Holzman et al., 1996). Views varied as a function of therapeutic orientation. Those who experienced personal therapy whilst training were more likely to view personal therapy as an important aspect of training (Bike et al., 2009; Dearing et al., 2005; Holzman et al., 1996; Oden et al., 2009; Williams et al., 1999). Perceived faculty opinion influenced students' decisions to undertake personal therapy, both directly and indirectly (Dearing et al., 2005).

The influence of personal therapy on professional development.

Five papers (Bike et al., 2009; Lucock et al., 2006; Oden et al., 2009; Orlinsky et al., 2001; Williams et al., 1999) explicitly examined the influence of personal therapy on professional development. In a multinational survey (Orlinsky et al., 2001) personal therapy was rated as one of the top three factors influencing the professional development of therapists. The others were ‘experience in therapy with clients’ and ‘formal supervision or consultation’. In one UK study it was rated as twelfth most influential factor, below factors like supervision, training and peer discussion (Lucock et al., 2006). Therapeutic orientation was not controlled for in these studies.

Personal therapy was seen to facilitate ‘understanding the working alliance’ and ‘understanding the therapeutic process’ (Williams et al., 1999), improving awareness of interactions with clients (Oden et al., 2009), and reminding therapists of perceived important therapist qualities. Examples included ‘competence and skill’, ‘warmth and empathy’ and ‘patience and tolerance’ etc. (Bike et al., 2009).

There is some consensus that personal therapy has a positive impact on professional development, particularly therapeutic relationship and engagement. Although to what extent and the mechanisms by which this occurs is unclear. Further research is required to clarify these issues.

Therapists who do not participate in personal therapy.

One paper (meeting 63.64% of quality criteria) specifically focused on therapists who abstained from personal therapy (Norcross et al., 2008). Those who had never participated in personal therapy were in the minority (n = 116, 16% of participant sample). When comparing those who had and had not sought personal therapy, there were differences in the professional self-view and therapeutic orientation. Despite having similar professional training pathways (psychology, counselling and social work) a smaller percentage of non-therapy seekers (n = 81, 68%) saw themselves as clinical practitioners when compared to therapy seekers (n = 492, 81%). Non-therapy seekers endorsed a professional self-view of ‘academician’ and ‘administrator’. Those with a cognitive-behavioural or behavioural orientation made up 51% (n = 61) of non-therapy seekers compared to 33% (n = 208) of the therapy seekers. The most strongly endorsed reasons for not seeking therapy were ‘dealing with stress in other ways’, ‘receiving sufficient support from others’ and ‘coping effectively on their own’.

Other quantitative methodology.

As shown in Table 2, other quantitative methodology papers met 73.68 – 84.21% of quality control criteria (mean quality score = 14.67, SD = 1.15 , range = 14 - 16). These papers attempted to demonstrate experimentally some of the benefits attributed to personal therapy for therapists in the domains of countertransference, therapeutic alliance and client treatment outcome.

Paper	Participants	Participant Population	Measured Used	Key Findings	Quality Score [max = 19] (Percentage)
Dubé & Normandin (1999)	n = 23 [m = 4, f = 23] <i>Time in practice:</i> Not reported <i>Orientation:</i> Not reported <i>Experience of personal therapy</i> 13 undergoing or completed personal therapy [m = 2, f = 11] Range = 0.5 – 4.5 years (mean = 1.27 years, SD = 1.1, median = 1 year)	Masters Degree in Clinical Psychology	5 clinical vignettes The Countertransference Ratings System (CRS)	There was a significant effect of personal therapy on ‘blocked’ and ‘acted-on emergence’ reactions, $F(1, 25) = 4.16, p < .05$ Those who had personal therapy elaborated on the counter transference to a greater extent than those who had not had personal therapy $F(1, 25) = 4.39, p < .05$ There was a significant effect of age on elaboration – younger participants elaborated less $F(1, 25) = 5.21, p < .03$	14 (73.68)
Gold & Hilsenroth (2009)	Personal Therapy Group (PT) n = 18 [m = 9, f = 9] <i>Time in practice</i> Average of 1 year supervised psychotherapy <i>Orientation:</i> Not reported <i>Experience of personal therapy:</i> Not reported No Personal Therapy Group (NPT) n = 7 [m = 3, f = 4] <i>Time in practice:</i> Average of 1 year supervised psychotherapy <i>Orientation:</i> Not reported <i>Experience of personal therapy:</i> None	Trainee Clinical Psychologists enrolled in an APA-approved Clinical Ph.D programme	Combined Alliance Short Form – Patient Version (CASF-P) Combined Alliance Short Form – Therapist Version (CASF-T)	There was no significant difference in patient ratings of therapeutic alliance between PT and NPT ($p = .92, d = 0.15$) PT reported feeling significantly more confident in their ability to help their patients than NPT (Therapist confidence, $p = .005, d = .68$) Patients of PT were in therapy twice as long as those treated by NPT ($f = 4.10, p = .04, d = .54$)	14 (73.68)

Sandell et al. (2006)	<p>n = 167 [m = 40, f = 127]</p> <p><i>Time in practice:</i> Mean years post licensing = 10 (SD = 4)</p> <p><i>Orientation:</i> 95% rather strongly/strongly psychoanalytic/psychodynamic 16% rather strongly/strongly eclectic</p> <p><i>Experience of personal therapy:</i> Mean duration of training therapy = 10 years (SD = 4) Mean total number of sessions = 1012 (SD = 592)</p>	<p>Therapists Licensed by the National Board of Health and Social Welfare</p> <p>77% psychologists 10% social workers</p>	<p>Well-Being Questionnaire included:</p> <ul style="list-style-type: none"> • The Symptom Checklist-90 (SCL-90) • Social Adjustment Scale (SAS) • Sense of Coherence Scale (SOCS) 	<p>16% of therapists had non-improvement with their patients</p> <p>Best patient change was achieved by therapists (n = 38) who had 7 – 8 years in training therapy ($b = -.081$)</p> <p>Worst patient change was achieved by therapists (n = 37) who had 13 - 14 years in training therapy ($b = -.036$)</p>	16 (84.21)
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Table 2 Summary of Other Quantitative Papers

Personal therapy and countertransference.

Dubé & Normandin (1999) examined the written responses of Canadian clinical psychology trainees to written clinical vignettes using The Countertransference Ratings System (CRS). This appeared to indicate that personal therapy had a significant effect on emerging countertransference, particularly acted-on and blocked emergence countertransference. Those who had received personal therapy elaborated more than those who did not. This was potentially confounded by age, which was also found to have a significant effect on elaboration, with younger participants elaborating less. Clinical supervision was not controlled for in this study. It is possible that this may confound findings as individuals who have experienced describing transference processes in supervision may be more comfortable with this practice than those who have not.

Personal therapy and therapeutic alliance.

Gold & Hilsenroth (2009) examined the impact of personal therapy for therapists on early therapeutic alliance between trainee clinical psychologists in America and their clients using the Combined Alliance Short Form (CASF). Due to very high ratings of therapeutic alliance ratings from the client perspective, no significant difference was found between the therapists' therapy group and no therapists' therapy group, suggesting a ceiling effect.

Differences were identified between the therapist ratings on the CASF by group. Those who had undertaken person therapy reported less disagreement about the goals and tasks of therapy and feeling more confident in their ability to help their clients. However despite each group assessing the same number of clients, there were fewer therapists in the no therapy group (n = 7) when compared to the personal therapy group (n = 18). All of the therapists in the no therapy group treated more than one client whereas this was only true for eight of the personal therapy group. The authors report that clients were assigned in “an ecologically valid manner” (Gold & Hilsenroth, 2009, p. 162) but this discrepancy between the groups does not appear to have been controlled for and may be a significant flaw in the research design, confounding results.

Personal therapy and client outcomes.

Sandell et al. (2006) endeavoured to explicitly explore the impact of the therapists personal therapy on client outcomes in Sweden. Their results appeared to suggest that there was an ‘optimum’ level of personal therapy as clients with the ‘best’ outcomes, as measured using the General Symptom Index (GSI) of the SCL-90, were obtained for therapists with 7-8 years of personal therapy.

There are several drawbacks to this paper. Primarily, the style of reporting used is unclear e.g. use of ‘case’ without clarifying whether this refers to clients, therapists or therapist-client dyads. Client outcomes were only measured from the client’s point of view and thus may not be representing the full clinical picture. Furthermore it is unclear as to how therapist therapies were analysed. Therapists were reported to have

undertaken multiple periods of personal therapy (median = 2). It is not clear whether the personal therapy undertaken was using the same model or whether therapists experienced different therapeutic approaches. This may have confounded results as part of the analysis examined 'dose' (total number of personal therapy sessions) as a way to differentiate between psychoanalysis and other psychotherapies. Based on these factors, further work would need to be undertaken to clarify and validate the findings reported by Sandell et al. (2006).

Qualitative Studies

The quality of the 9 papers included varied from meeting 22.92 to 89.58% of the quality control criteria (mean quality score = 29.50, SD = 10.47, range = 11 - 43).

The qualitative approaches used included Interpretative Phenomenological Analysis (IPA) (n = 4), Constant Comparative Method of Grounded Theory (n = 2), Consensual Qualitative Research (CQR) (n = 1) and Thematic Analysis (n = 1). One paper (Bellows, 2007) appeared to have developed an idiosyncratic approach which did not appear to be allied with any mainstream methodology. The majority of data in this study was collected via semi-structured interviews (1:1 = 6, group = 1). Two papers reported data generated from open-ended survey questions.

Paper	Country	Participants	Methodology	Main Findings	Quality Score [maximum = 48] (%age)
Bellows (2007)	USA	20 psychodynamic psychotherapists [gender split not specified] Time in personal therapy not specified	Idiosyncratic	<p>Those that reported personal therapy highest level of influence on clinical work</p> <ul style="list-style-type: none"> used therapists as a professional role model especially when uncertain with own clients felt personal therapy enhanced their professional identity & enhanced interpersonal relationships reported lowest level of harmful effects from personal therapy <p>Personal therapy facilitated acceptance of personal imperfection and enhanced empathy for difficulties inherent in achieving change “good enough” endings promoted the internalisation of the therapeutic relationship</p>	11 (22.92)
Murphy (2005)	UK	MA in Counselling Students [1 male, 4 female] Time in personal therapy 40 hours – 4 years	Constant comparative method of grounded theory	<p>Reflexivity</p> <ul style="list-style-type: none"> Unresolved personal issues often emerge during training, practice & personal therapy Training can raise issues in relationships with others on the course & personal life <p>Growth</p> <ul style="list-style-type: none"> To be effective as a counsellor requires holding particular attitudes to the self and other (inc. unconditional positive self regard, empathic understanding) The expansion of self-awareness, and awareness of self as a counsellor, is essential for good practice and can be achieved through personal therapy <p>Authentication</p> <ul style="list-style-type: none"> The experience of personal therapy for becoming a counsellor is able to offer confirmation of the self as a valid and acceptable tool for practice Experiencing personal therapy is a way of having the approach validated as an effective psychological intervention <p>Prolongation</p> <ul style="list-style-type: none"> Despite not being a guarantee for producing ethical counsellors, it would be useful to extend the therapy beyond 40 hours Although there was not always a presenting issue, in general it has been a positive experience Personal therapy has helped to develop my skilfulness 	19 (39.58)

Daw & Joseph (2007)	UK	48 NHS Therapists (34 Clinical Psychologists, 8 Counsellors, 2 Psychotherapists, 1 Counselling Psychologist, 6 other) [10 male, 38 female] 66.7% had personal therapy (range 5 – 728 sessions, mean = 153.72, SD = 207.98, median = 47.50, mode = 50)	IPA	<p>Impact on the person</p> <ul style="list-style-type: none"> • therapists self-care, both professionally and personally, through containing, work through or off-load work-related issues • personal development through personal growth and insight into personal vulnerabilities and drives <p>Impact on the professional</p> <ul style="list-style-type: none"> • experiential learning regarding the therapy process • learning from the client role by gaining greater understanding of process issues, models and therapeutic techniques by experiencing them 	26 (54.17)
Rizq & Target (2008a) Parallel paper to Rizq & Target (2008b)	UK	9 chartered counselling psychologists [3 male, 6 female] Time in personal therapy 15 months – 14 years	IPA	<p>Personal therapy provides an area for intense self-experience</p> <ul style="list-style-type: none"> • Attachment experiences: parenting and models of parenting • Feeling and being real • Experiential vs. intellectual understanding • Safety, power and boundaries <p>Personal therapy as an arena for professional learning</p> <ul style="list-style-type: none"> • Therapist as a professional role model • Emotional resilience <p>Personal therapy is integral to training</p> <ul style="list-style-type: none"> • Reflection, self-awareness, courageous self-reference • Mandatory vs. self-choice • Definitions vs. Limitations 	31 (64.58)

Grimmer & Tribe (2001)	UK	Undertaken MSc in Counselling Psychology (5 graduates, 2 in procedure of completing) [7 female] Time in personal therapy at least 40 hours	Constant comparative method of grounded theory	Experience <ul style="list-style-type: none"> • Reflection on being in the role of the client • Socialisation experiences • Support for the emerging professional • Interaction of personal and professional development Processes characteristic of the experience of personal therapy <ul style="list-style-type: none"> • Greater reflexivity about the process and content of therapy • Validational experiences of gaining support and making psychological change • Normalisation as a person 	32 (66.67)
Rizq & Target (2008b) Parallel paper to Rizq & Target (2008a)	UK	9 chartered counselling psychologists [3 male, 6 female] Time in personal therapy 15 months – 14 years	IPA	Personal therapy establishes self-other boundaries <ul style="list-style-type: none"> • Seeing the client in the self: recovering, acknowledging and tolerating all aspects of the self • Seeing the self in the client: distinguishing between self and client issues • Kinship with clients The significance of self-reflexivity <ul style="list-style-type: none"> • Early experience and the search for meaning • Coherence and generativity 	37 (77.08)
Wiseman & Shefler (2001)	Israel	5 psychotherapists (4 clinical psychologists, 1 psychiatrist) [2 male, 3 female] <i>Time in personal therapy</i> all had experienced personal therapy	Consensual qualitative research	Importance of personal therapy for therapists: past and current attitudes Entry point and initial stance on personal therapy <ul style="list-style-type: none"> • Reasons for entry to first personal therapy and re-entry: training reasons as inseparable from growth and personal reasons • Current attitudes towards the importance of personal therapy for therapists • Attitudes towards the duration of personal therapy Impacts of personal therapy on the professional self: identity <ul style="list-style-type: none"> • Imitation and identification with the personal therapist • Process from impostership to self-hood • Personal therapy as the royal road to improving self-knowledge Impacts of personal therapy on one's being in session: process <ul style="list-style-type: none"> • Increasing empathic capacity and tuning into the client's experience 	37 (77.08)

- The freedom to be authentic and spontaneous with patients in the session
- The therapist as patient: experiences in past and current personal therapy
- Reflections on previous experiences of personal therapy
 - Experiences in current personal therapy
 - Shifting from the patient role to the therapist role
- Therapist as patient: self in relation to the personal therapist
- Therapist as a good mother
 - From imitation and identification toward individuation
- Mutual & unique influences of didactic learning, supervision & personal therapy
- The training triad
 - The mutual influences of personal therapy and supervision
 - Bringing the experience of supervision into personal therapy
 - Personal therapy versus supervision: empathy vs. understanding
 - Personal therapy vs. didactic learning: experiential learning and self-knowledge vs. conceptual knowledge
 - Supervision providing ongoing support
 - Personal therapy as the star

Moller, Timms & Alilovic (2009) UK

11 Trainee Clinical Psychologists
 13 Doctorate in Counselling Psychology Trainees
 13 Counselling Diploma Trainees [6 male, 30 female]
 Time in personal therapy
 17 (47%) no personal therapy
 19 some experience, range =

Thematic Analysis

Personal therapy makes me be a better practitioner

- Experiential learning
- Personal growth and development
- Protecting clients (and trainees) in therapy
- Protecting/supporting trainees and their learning

Personal therapy 'costs me'

- Financial
- Potentially opening 'a can of worms'
- Personal therapy can have a negative effect on the course

39 (81.25)

		4 – 289 hours (mean = 44, SD = 79.51)			
Macran, Stiles & Smith (1999)	UK	7 practicing therapists [2 male, 5 female] Time in personal therapy 2 – 13 years	IPA	<p>Orienting to the therapist: humanity, power, boundaries</p> <ul style="list-style-type: none"> • Know how it feels to have therapy • Taking care of self • Therapists can be clients • Providing a role model • Learning to be one's real self • Knowing one's boundaries and limitations • Knowing what not to do <p>Orienting to the client: trust, respect, patience</p> <ul style="list-style-type: none"> • Giving clients space • Holding back from jumping in to help <p>Listening with the 3rd ear</p> <ul style="list-style-type: none"> • Separating own feelings and client's feelings • Working at a deeper level <p>Judging the pace of therapy</p>	43 (89.58)

Table 3 Summary of Qualitative Papers

Therapist as a role model.

The main theme that emerged from the qualitative studies was using one's personal therapist as a role model for their own professional practice. This appeared in the narratives of both professionals in training (Moller et al., 2009; Murphy, 2005) and experienced qualified professionals (Macran et al., 1999).

The concept of "internalising" their therapist was present in many of the studies reviewed (Bellows, 2007; Grimmer & Tribe, 2001; Macran et al., 1999; Rizq & Target, 2008a; Wiseman & Shefler, 2001). Individuals appeared to use their 'internalised therapist' on a conscious level, i.e. asking themselves 'what would my therapist say/do now' or using them as a figure with whom one "metaphorically consults during their own practice" (Grimmer & Tribe, 2001, p. 293). Bellows (2007) observed this phenomenon to have occurred particularly when faced with uncertainty in client work, and when personal therapy was felt to strongly influence the therapist's clinical work. This finding came from the lowest quality study reviewed (22.92%), thus it requires further investigation.

Therapist models were used to guide practice in terms of specific therapeutic techniques, interpersonal techniques and behaviours. It was not a case of indiscriminate imitation; individuals were selective in what was incorporated into their own repertoire. Rizq and Target (2008a) identified narratives where there was an explicit choice to not incorporate techniques even when they had personally experienced them as being helpful. When this was the case other factors (e.g. teaching on professional ethics) had greater influence.

Being in the client role.

Seven papers (Daw & Joseph, 2007; Grimmer & Tribe, 2001a; Macran et al., 1999; Moller et al., 2009; Rizq & Target, 2001; 2008b; Wiseman & Shefler, 2001), including all of the most methodologically robust papers, identified themes around being in the 'client role'. Participants seemed to make a clear distinction between factual understanding of therapy and experiential learning of therapy – “internal as opposed to cerebral learning” (Macran et al., 1999, p. 423). Personal therapy was seen to contextualise intellectual understanding providing a “deeper understanding of process issues, models, and techniques through experiencing them” (Daw & Joseph, 2007, p. 230). This greater understanding was then perceived to impact on the therapists' own work via increasing capacity for empathy and ability to identify with the client's experience. This theme appeared across literature quality and participant groups. It may benefit from further investigation to examine whether it can be demonstrated empirically.

Differences between supervision, didactic learning and personal therapy.

One qualitative article (Wiseman & Shefler, 2001), of an acceptable quality (77.08%), specifically addressed what distinguished personal therapy from other learning experiences, namely didactic learning and supervision. This was referred to as the “training triad” (Wiseman & Shefler, 2001, p. 136).

There were some inconsistencies in the views of participants: one stated that personal therapy “was the star”. Another stated that whilst her personal life was stable, clinical

supervision was the biggest influence on her practice. One participant explained the difference as affective experience and intellectual understanding – “my position [with clients] is very much influenced by my personal therapy, especially my experience with empathy and providing a holding environment ... my understanding is influenced by my supervision” (Wiseman & Shefler, 2001, p. 136).

A further difference between personal therapy and supervision was noted by another paper. Grimmer and Tribe (2001) discussed how personal therapy, unlike supervision, could provide a form of support where disclosures would not rebound on their professional practice. This would be particularly salient to therapists in training whose supervisors are gatekeepers – deciding whether trainees should ‘pass’ or ‘fail’.

Macran et al. (1999), the highest quality qualitative paper reviewed (89.58%), noted the differences between didactic learning and personal therapy, reporting that “Personal growth and reciprocal role learning ... are not easily accomplished by academic study - though some intensive supervisory experiences may contribute ... our participants felt strongly that personal therapy had made a positive and unique contribution to their professional practice” (p. 429)

The relationships between personal therapy, supervision and didactic learning are neglected areas of research. Qualitative research exploring the similarities and differences between these factors may illuminate what it is about personal therapy that

distinguishes it from supervision or didactic learning (which are standard to training and ongoing practice).

Discussion

The aim of this review was to examine whether personal therapy was an effective method of professional development for therapists working with individuals experiencing mental health issues. Survey, experimental and qualitative studies were reviewed. These papers encompassed professionals at different stages of their career and following different qualification pathways. All of the papers reviewed had flaws. Survey papers typically suffered from low response rates, using bespoke measures where validity and reliability were not reported, and failing to clearly describe their participant population. Limitations in experimental papers included small participant numbers and failure to control for factors such as age and clinical experience. Areas of weakness for qualitative studies included unclear reporting of data collection, and not ensuring reliability of analysis through participant feedback and triangulation of findings. Across all types of papers examined, reporting of research ethics was poor or absent.

Personal therapy is a widely used resource. Survey data consistently shows that therapists undertake and identify benefits from personal therapy. Reported benefits concur with previous research reviews (Macran & Shapiro, 1998; Norcross et al., 1988) and can broadly be divided into personal and professional domains. Figure 2 shows a model of the reported benefits of personal therapy and how they may relate to each

other. Career stage may affect how important the different aspects are to the individual therapist. For example, providing a therapist role model may be a more important function for therapists in training than for established professionals.

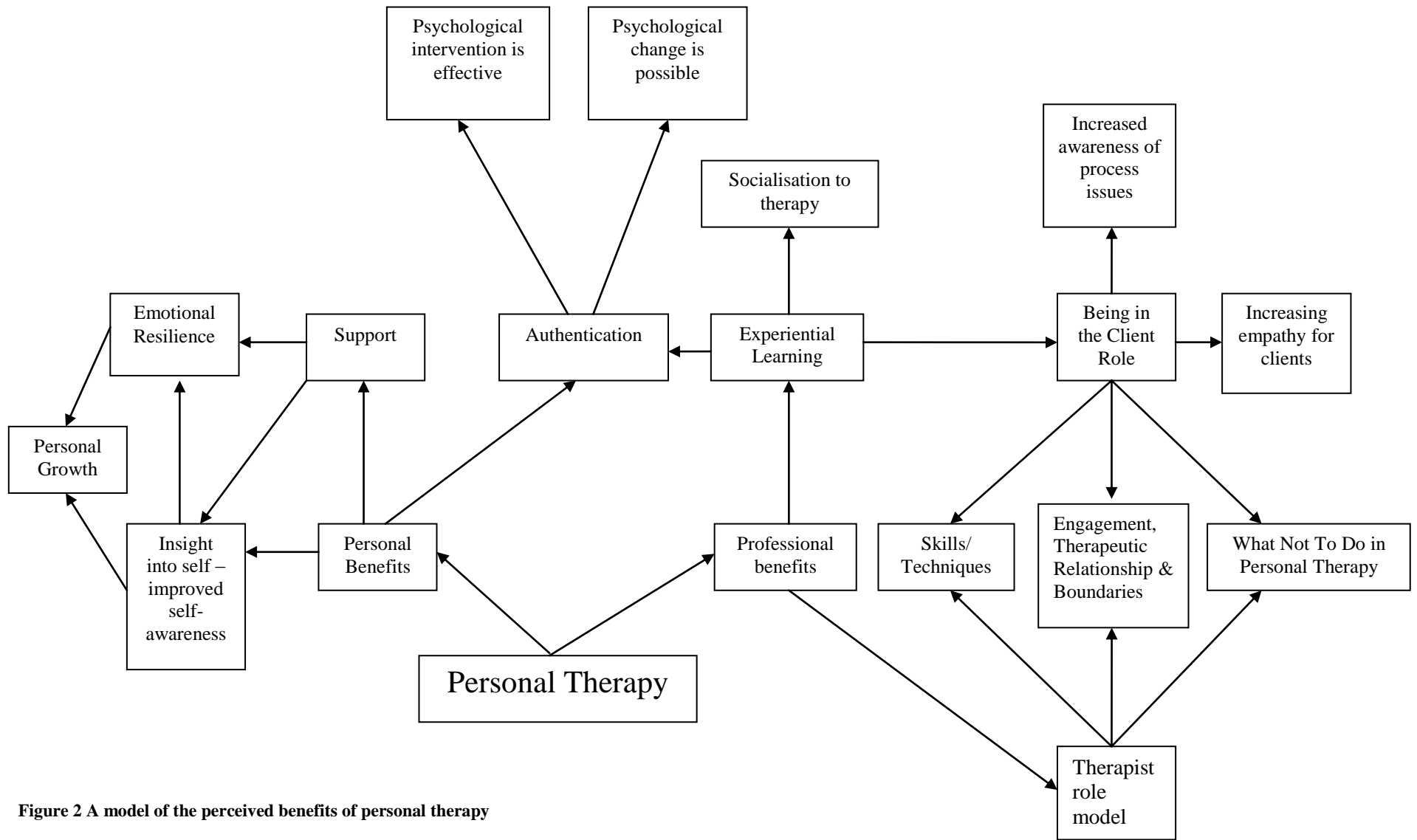


Figure 2 A model of the perceived benefits of personal therapy

With regards to professional development, qualitative data suggests that therapists value the experiential learning of the client role and the ability to use one's therapist as a role model for their own practice. The empirical picture is less clear. The small number of empirical papers suggest that personal therapy may have some impact on some aspects of transference and the therapists' perception of the therapeutic relationship. It is suggested that there may be an 'optimum' level of personal therapy which facilitates the best client outcomes. This finding requires replication, as the study on which it is based has methodological limitations. Survey data suggests that therapists use personal therapy to support their professional development in relation to building the therapeutic relationship, facilitating their understanding of the therapeutic process and important therapist characteristics.

Research on personal therapy for therapists should now move away from survey methodology solely aiming to produce simple descriptive data. It has been clearly and consistently established that therapists, with orientation as a mediating variable, who undertake personal therapy generally report finding it beneficial and will often undertake more than one period of therapy. There is scope for systematic surveys establishing the prevalence of personal therapy within different orientations.

Personal therapy is considered to be part of a triad of training alongside didactic training and supervision (Orlinsky et al., 2001). As these are not being taken into consideration and controlled for in studies, it is impossible at this stage to demonstrate the extent to which personal therapy may add value to the other two components. Age and

experience of personal therapy and professional practice are often interlinked. These need to be controlled for in future research.

For therapists post-qualification, greater understanding is needed as to why practitioners choose or decline to undertake personal therapy. A population of particular interest are therapists who have had only one experience of personal therapy, as the literature reviewed showed people frequently undertake multiple courses throughout their careers. Similarly, as with therapists in training, there is a need to examine how personal therapy is different to other forms of development, such as supervision and continuing professional development.

There are some limitations to this review. The available literature did not permit the research question to be fully answered, particularly in relation to efficacy. Literature quality was only assessed by the author. A second rater would have provided greater rigour.

Clinical Implications

Many therapists have undertaken personal therapy and found it to be beneficial both personally and professionally. A small minority have reported negative and/or harmful consequences (e.g. Orlinsky et al., 2005). Due to the interpersonal nature of delivering therapy, it appears that undertaking personal therapy will impact on both professional and personal domains. The extent of this impact appears variable and may be

idiosyncratic to the individual and his or her motivation for undertaking personal therapy.

Personal therapy can provide experience of the client position. This may provide a form of experiential learning that is inaccessible through other forums, and consequently influence the therapist's future practice. As with other sources of learning, reflective and critical thinking must be employed when deciding to integrate experiences into practice.

Ultimately further research is needed before a firmer position can be taken as to the value of personal therapy as an effective method of professional development. This research needs to move away from descriptive data, based on self-report, and use creative, meaningful ways of measuring outcomes that enables variables like age and clinical experience to be controlled for. This may then facilitate an understanding of the underlying mechanisms, and permit research into the efficacy of different development techniques.

Personal therapy for therapists highlights some of the issues between evidence-based practice, practice-based evidence (Margison et al., 2000) and values-based practice. It is not the only area of mental health practice where there is a lack of evidence demonstrating impact of practice on client outcome, but it is endorsed nevertheless by professionals. Similar issues are also present in clinical supervision research (Ellis & Ladany, 1997; Milne, 2009a). Both supervision and therapy have multiple functions, some of which, such as managing distress and clinical accountability, are self-evidently

valid reasons for engaging in these activities. Unlike personal therapy, there is an expectation, and in some cases a mandatory obligation (e.g. BACP, 2010), to undertake clinical supervision (Department of Health, 2007) driven by practice-based evidence. Practitioners who engage in mandatory personal therapy have chosen particular pathways that privilege its contribution to professional practice. For those outside these pathways, the existing research contributes little to assisting a decision as to whether personal therapy would be beneficial to them. The model presented above provides some information about the potential areas of benefit. It remains however up to the individual to weigh up the potential added value of engaging in personal therapy, over and above the other forms of personal and professional development available (e.g. supervision and didactic teaching).

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Part Two: Empirical Paper

*This paper is formatted ready for submission to British Journal of Clinical Psychology.
Please see Appendix F for the Author Guidelines.*

Supervision for Trainee Clinical Psychologists: The relationship between stage of development and behaviour in supervision

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Abstract

Objectives. Developmental models of supervision have face validity but efforts to validate them have been hampered by poor quality research and an over-reliance on self-report data. This study examined whether, using self-report and observational data, evidence could be found to support The Integrated Developmental Model of Supervision using UK trainee clinical psychologists.

Design. A two-stage between-groups cross-sectional quantitative design was adopted.

Methods. Stage 1 – forty trainee clinical psychologists (15 first year, 13 second year and 12 third year) completed the Supervisee Levels Questionnaire – Revised [Amended]. Stage 2 – eleven trainee clinical psychologist – supervisor dyads (8 first year and 3 third year) filmed a routine clinical supervision session. DVD-recordings were then analysed using the Teacher’s PET coding scheme.

Results. There were significant differences between year of training and responses on the questionnaire. No significant differences were observed between behaviours demonstrated in first and third year supervision sessions. Significant negative correlations were identified between score on the questionnaire and the supervisor behaviours ‘guided experiential learning’ and ‘informing’ and the trainee behaviour ‘other – listening’.

Conclusions. The results provide some support for the Integrated Developmental Model of Supervision. Further research using observational data with larger samples and using a longitudinal design would be beneficial. Clinical implications are discussed.

Clinical supervision is *“The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague/s”* (Milne, 2007, p. 440). It has been identified as being essential for good practice (British Psychological Society [BPS], 1995; Health Professions Council [HPC], 2009; Roth & Fonagy, 2006), yet it is a neglected area of research (Milne, 2009a). Existing research has sought to clarify the variables thought to facilitate the delivery of effective supervision. It has been criticised for poor scientific rigour and questionable findings. Common faults include a lack of clear hypotheses, failure to control for Type I and Type II errors, violation of statistical assumptions and limited outcome measures (Ellis, Krenzel, Ladany, & Schult, 1996; Ellis & Ladany, 1997; Freitas, 2002).

Research on clinical supervision has predominantly emerged from America. This limits its application to British clinical psychologists (Fleming & Steen, 2004). For example, there are differences in the environments in which clinical psychologists work and their training pathways (Norcross, Karpiak, & Santoro, 2005). These factors may influence how supervision is modelled. Given the importance of clinical supervision, there is a need for good quality research conducted in the UK to help inform clinical psychologists about factors that are important in effective supervision, for both supervisor and supervisee.

The literature has generated a number of models to describe the complex, multifaceted process of clinical supervision. These were initially based on psychotherapeutic theories and have evolved into supervision specific models (Beinart, 2004) which are not allied

with specific psychotherapeutic orientations (interested readers are directed to Watkins, 1997b).

This research is based on a developmental model of supervision, the Integrated Developmental Model (IDM). Developmental models suggest that supervisees pass through a number of stages developing skills and knowledge, progressing from novice to expert therapists. Developmental models of clinical supervision became popular due to their face validity (Holloway, 1987); people believe that they become increasingly skilled with experience (Milne, 2009a; Scaife, 2001). There is a lack of good quality research to support this common-sense appeal (Beinart, 2004; Ellis et al., 1996). The central premises at the heart of developmental models remain untested (Ellis & Ladany, 1997).

The Integrated Developmental Model

The IDM (Stoltenberg & Delworth, 1987) built on a previous developmental model, The Counselor Complexity Model (CCM) (Stoltenberg, 1981). The IDM proposes that supervisees pass through 3 levels of development in the following areas: self and other awareness, motivation, and autonomy (Stoltenberg & McNeill, 1997). These areas, argued to be representative of therapist characteristics, are evidenced across 8 domains conceptualised to represent the professional activities of therapists (Stoltenberg & McNeill, 1997). The IDM suggests developmental levels can vary across skills (e.g. a supervisee could be a level 3 in ‘assessment skills’ but a level 2 in ‘professional ethics’). The IDM suggests supervisors have different tasks to complete for each stage

of development and supervision should be structured to meet the development needs of the supervisee. This mirrors the importance of the zone of proximal development (Vygotsky, 1978) in educational literature (Chaiklin, 2003).

The main problem with the IDM has been how to operationalise it to accurately identify a therapist's stage of development for any given domain. Self-report questionnaires, such as the Supervisee Levels Questionnaire – Revised (SLQ-R) (McNeill, Stoltenberg, & Romans, 1992), have been the main method used. However being solely reliant on self-report data limits attempts to validate the model

The Circumplex Model of Supervision

Recently another model of supervision, developed from a systematic literature review, has been proposed. The Circumplex Model of Supervision (CMS) (Milne, 2009a; Milne & Westerman, 2001) is influenced by Kolb's (1984) experiential learning theory. The model attempts to illustrate different factors that interact as part of the supervisory process. The CMS holds that supervisors should aim to demonstrate a range of behaviours (e.g. listening and summarising) which help the supervisee move through an experiential learning cycle. Milne (personal communication, 2009b) has suggested that the CMS is a developmental model that examines micro-development, whereas other developmental models examine macro-development.

It has been noted that what is lacking from the supervision literature is an examination of the behavioural components of a supervision session (i.e. what do supervisors actually do in supervision with their supervisees) (Watkins, 1995). Measuring

observable behaviours in supervision would help ease some of the criticisms levelled at current research (e.g. Ellis et al., 1996; Ellis & Ladany, 1997; Watkins, 1995).

An observation tool, the Teacher's Process Evaluation of Training and Supervision (PET) (Milne, 2004; Milne, James, Keegan, & Dudley, 2002), that examines supervisor and supervisee behaviours has been developed. This offers an opportunity to use observational data to improve our understanding of clinical supervision. It also offers researchers a new way of testing models like the IDM that suggest certain behaviours that should be present at different developmental stages. The integration of self-report and observational data enables the collection of more robust information that can facilitate examination of models of supervision, like the IDM and CMS. Such research would contribute to the existing knowledge base, refining understanding about variables in supervision.

The present research aimed to address the following research questions:

- Do trainee clinical psychologists report changes in their self-other awareness, motivation and dependency-autonomy as they progress through their clinical training?
- Does stage of development (as indicated by SLQ-R[A] total score) show a relationship to the frequency of specific supervisor and supervisee behaviours in supervision?
- Do supervisor supervision behaviours, as measured by the Teacher's PET (Milne, 2004; Milne et al., 2002), differ depending upon their supervisee's year of training?
- Do trainee supervision behaviours, as measured by the Teacher's PET (Milne, 2004; Milne et al., 2002), differ depending upon their year of training?

Hypotheses

- 1) Scores on the SLQ-R[A] scales will differ significantly depending upon year of training.
- 2) SLQ-R[A] total score will show a significant relationship with the supervisor 'managing', 'informing' and 'guided-experiential learning' and trainee 'planning', 'experimenting', 'other-listening', 'reflecting' and 'conceptualising' supervision behaviours.

Furthermore the following exploratory hypotheses will be examined.

- 3) First year supervisors will have a significantly greater percentage of 'managing', 'informing' and 'guided experiential learning' behaviours than third year supervisors.
- 4) First year trainees will have a significantly greater percentage of 'planning', 'experimenting' and 'other – listening' behaviours than third year trainees.
- 5) Third year trainees will have a significantly greater percentage of 'reflecting' and 'conceptualising' behaviours than first year trainees.

Method

Design

The study used a between-groups, cross sectional design, incorporating mixed methods (survey-based and observational). With a p -value of .05 and power set at 80%, the second stage of the study required a sample size of 20 participant dyads to confidently state that there was a meaningful difference between the groups.

Participants

Stage 1.

Forty-five trainee clinical psychologists (comprising of 16 first year, 15 second year and 14 third year trainees) from a 3 year doctoral programme in Britain were approached to participate in the first stage of the study. The course was selected for study as their trainees are recruited to the course directly from their undergraduate B.Sc. Psychology degrees. A small number complete 1 year as a graduate mental health worker. Limiting recruitment to this course aimed to minimise extraneous variables via a homogenous sample and capture very early development.

Forty trainees (a response rate of 89%) agreed to participate in Stage 1 (comprising of 15 first year, 13 second year and 12 third year trainees). Trainee demographics are reported in Table 1. As expected, trainee age significantly varied by year group ($t^* = 4.11$, 2-tailed $p < .001$). Therapeutic Orientations of trainee placements are reported in Table 2. Thirty-two trainees reported that they did not use a model of supervision on

their current placement. Six trainees (1 first year, 2 second year and 3 third year) reported using a supervision model (Table 3).

Year of Training	<i>n</i>	Age	
		Mean (SD)	Range
1 st		23.87 (5.91)	21 – 45
Male	3		
Female	12		
2 nd		23.50 (0.97)*	22 – 25
Male	3		
Female	10		
3 rd		25.42 (2.50)	23 - 33
Male	1		
Female	11		

Note. * Three participants did not disclose this information

Table 1 Stage 1 Participant Demographics by Year

Placement Orientation	Year		
	1 st (<i>n</i> = 15)	2 nd (<i>n</i> = 11)*	3 rd (<i>n</i> =12)
CBT	10	1	2
Behavioural Therapy		1	
Psychodynamic		1	2
CAT			1
Social Constructionism		1	
Psychoanalytic	1		1
Integrated		3	
More than 1 endorsed	3	3	4
Other	1	1	2

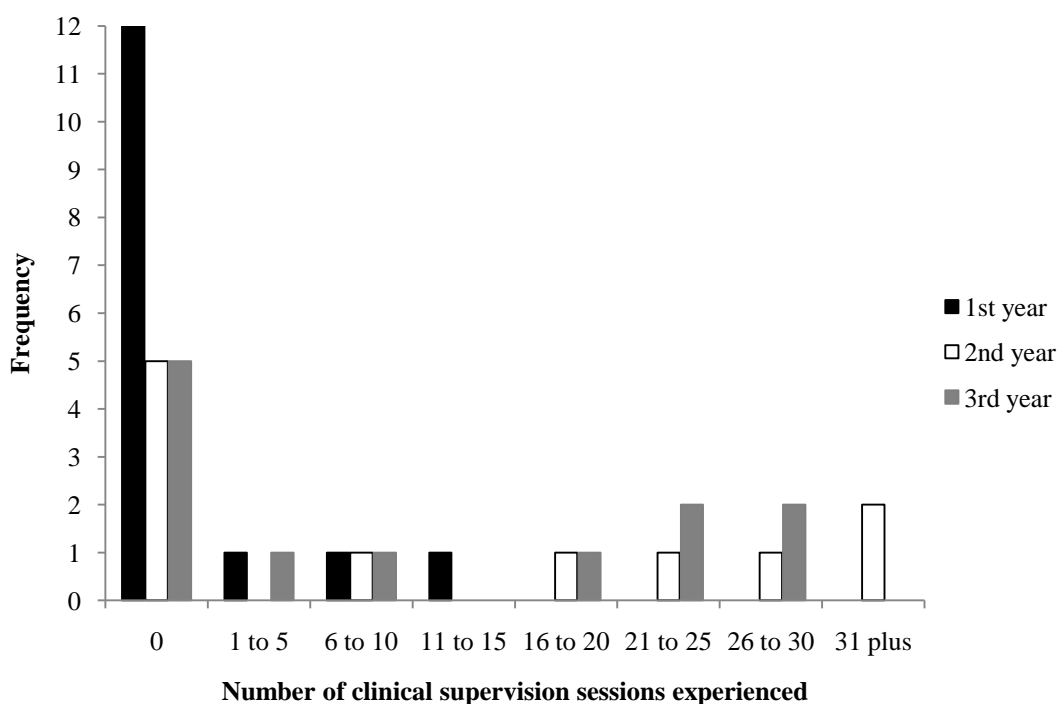
Note. * two trainees did not disclose this information

Table 2 Stage 1 Trainee placement therapeutic orientation by year of training

Year	Model of Supervision
1st	CBT
2nd	Parallel Process Seven 'I' model
3rd	Gestalt Psychoanalytic Informed Psychodynamic and Systemic

Table 3 Models of supervision reported to be used on placement by Stage 1 trainees

Twenty-two (out of thirty-eight trainees who disclosed this information) reported not experiencing clinical supervision prior to commencing training (Figure 1). Of the 16 who reported experiencing supervision, 14 had received 30 or fewer sessions.



Note. Two second year trainees did not report this information

Figure 1 Number of clinical supervision sessions experienced prior to training by year group

Stage 2.

From the sample identified at Stage 1, thirty first and third year trainee clinical psychologists were invited to participate in Stage 2. These year groups were chosen to represent the greatest difference in stage of training on the course (i.e. those beginning training and those about to complete). Eleven agreed to participate.

Placement supervisors for trainees who agreed to participate were contacted via email. Stage 2 trainee and supervisor data by trainee year group can be found in Tables 4 and 5.

Supervisee Year	<i>n</i>	Age			<i>n</i> prior supervision	<i>n</i> model of supervision
		Mean	SD	Range		
1st		22.86	0.90	22 - 24	2	0
Male	1					
Female	7					
3rd		25	0.00		1	0
Male	1					
Female	2					

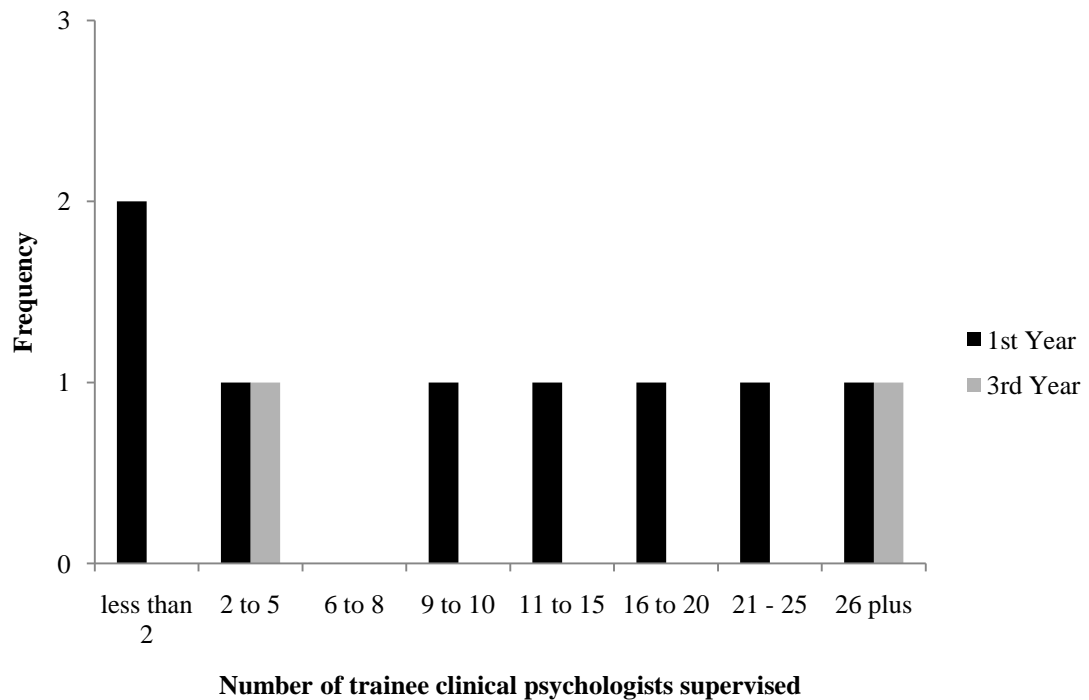
Table 4 Stage 2 Trainee Information by Year of Training

Seventy-three per cent of Stage 2 trainees had not experienced clinical supervision prior to training.

Supervisee Year	<i>n</i>	Age			Years Qualified		
		Mean	SD	Range	Mean	SD	Range
1 st		41.63	10.64	28 - 55	15.13	9.49	2 – 30
Male	5						
Female	3						
3 rd		35.00	3.61	31 - 38	11.00	3.61	7 – 14
Male	0						
Female	3						

Table 5 Supervisor Demographics by Year of Training

Supervisors reported using CBT (n = 5) and integrated (n = 2) therapeutic models in their clinical work. Two supervisors reported using more than one therapeutic model. Two supervisors, both supervising first year trainees, reported using a specific model of supervision – namely the Double Matrix Model (Hawkins & Shohet, 2006). Nine reported they did not use a supervision model. The number of trainees supervised is reported in Figure 2. Six supervisors had attended training or workshop relating to supervision in the last 3 to 5 years, four in the past 2 years and one supervisor over 5 years ago.



Note. One third year supervisor did not disclose this information

Figure 2 Number of trainee clinical psychologists supervised by trainee year

Measures

Supervisee Levels Questionnaire – Revised (SLQ-R) (McNeill et al., 1992)

The SLQ-R is a 30-item questionnaire based on the IDM. Respondents are required to rate 30 statements on a 7-point Likert scale ranging from 1 – ‘Never’ to 7 – ‘Always’. The statements are derived to tap the three domains of the IDM (Self and Other Awareness, Motivation and Dependency-Autonomy) with a focus on ‘intervention competence’, ‘client conceptualisation’ and ‘interpersonal assessment’ (McNeill et al., 1992). The SLQ-R generates 4 scores, one for each of the domains and a total score (Table 6).

Scale	Maximum Score	Cronbach's Alpha reliability Co-efficient*
Total	210	.88
Self and Other Awareness	84	.83
Motivation	56	.74
Dependency-Autonomy	70	.64

Note. * as reported in McNeill et al. (1992)

Table 6 SLQ-R Subscales and Reliability Co-efficients

The authors of the SLQ-R found that SLQ-R total score significantly differed depending upon trainee experience (where experience was calculated using semesters counselling experience, semesters of supervision experience and years of graduate education) indicating validity (McNeill et al., 1992). It has been suggested that higher SLQ-R total score is indicative of higher development as conceptualised by the IDM (McNeill et al., 1992). The SLQ-R has been used to distinguish between Level 1 trainees and Level 2 counselling trainees by Leach and Stoltenberg (1997).

For this study minor amendments, unlikely to significantly impact on validity and/or reliability, were made to the SLQ-R. These emphasised the therapist role and omitted the counselling role in the statements, consistent with the participant group. The revised version is referred to as the Supervisee Levels Questionnaire – Revised [Amended] (SLQ-R[A]) (Appendix M).

The Teachers' Process Evaluation of Training and Supervision (Teacher's PET)
(Milne, 2004; Milne, Claydon, Blackburn, James, & Sheikh, 2001; Milne et al., 2002; Milne & James, 2002)

The Teachers' PET is an observational instrument which uses time sampling. It is administered by coding, in 15 second intervals, the alternating behaviours of the

supervisor and the supervisee. The supervisors behaviours are coded as being one of the following: Listening/Observing, supporting, questioning (open or closed), needs assessing, goal-setting, restating, reflecting, interpreting, formulating, managing, informing, guided experiential learning, self-disclosing, challenging, disagreeing, evaluating, feeding back or other behaviour that cannot be categorised using the other codes (Milne, 2004). The supervisee's behaviours are coded as being either: reflecting, experimenting, conceptualising, experiencing, planning or other behaviour that cannot be categorised using existing codes (Milne, 2004).

Previous studies that have used the Teacher's PET have demonstrated that it is possible to obtain good inter-rater reliability ($K = 0.87$ (Milne & Westerman, 2001), $K = 0.84$ (Milne et al., 2002) and $K \geq 0.81$ (Milne & James, 2002)). The Teacher's PET has evolved from the applied psychology literature. It is thought to have content validity (Milne, 2004). Predictable changes following an intervention have been demonstrated using the Teacher's PET (Milne et al., 2002; Milne & James, 2002; Milne & Westerman, 2001) indicating predictive validity (Milne, 2004).

Following a training period the authors made minor changes, unlikely to change reliability or validity, to the categories of the Teacher's PET. Changes included qualification of the behaviour definition and addition of subcategories under the 'Other' coding (Appendix N). For supervisor behaviours the category 'Other – Case Information' was added. For trainee behaviours the categories 'Other – Giving Information', 'Other – Listening' and 'Other – Asking for Supervisor Action' were added. Coding definitions, including amendments, can be found in Appendix N.

Procedure

Written informed consent was obtained from all participants prior to participation. The study was approved by an NHS Ethics Committee.

Stage 1

A presentation about the research was given to all trainee clinical psychologists on the training course. Trainees were then given an information pack about the research, including a consent form, demographic data collection sheet (including age, gender, experience prior to commencing the course, etc.), and the SLQ-R [A]. After consenting, trainees completed the information packs.

Stage 2

First and third year trainees, recruited as part of Stage 1, were invited to participate in the second stage. This involved recording one routine clinical supervision session between the trainee and their placement supervisor, a qualified clinical psychologist. Participants were asked to make the recording between April and June 2010.

The placement supervisors of consenting trainees were invited to participate via email. If the supervisor consented to participation they completed a consent form and a demographic data collection sheet (including age, gender, number of years qualified, number of trainee clinical psychologists supervised etc.).

One supervision session was recorded by the trainee using a DVD-camcorder. Instructions and equipment were provided by the researcher, who was not present during the recording. Pseudonyms were used to protect client confidentiality. After reviewing the recording to ensure client confidentiality had not been breached, it was given to the researcher for analysis using the Teacher's PET (Milne, 2004; Milne et al., 2002). For inter-rater reliability three supervision recordings were analysed by the author's research supervisor. Inter-rater reliability was calculated using intraclass correlations (Appendix O). A range of .80 - .95 was achieved for supervisor behaviours under investigation. A range of .50 - .92 was achieved for examined trainee behaviours under investigation.

Data Analysis

Due to the small sample used in this study, non-parametric tests were planned to be used in analyses. In all analyses the independent variable was the year of training. The dependent variables were the scales on the SLQ-R[A] and the frequency of behaviours observed using the Teacher's PET codings. As there were a large number of behaviours coded by the Teacher's PET (19 for supervisors and 9 for trainees) specific Teacher's PET codings, based on the IDM conceptualisation of level 1 and level 2 supervision behaviours, were selected for analysis to reduce the likelihood of Type I error. Hypotheses were based on a review of the previous literature.

For Hypothesis 1 Jonckheere-Terpstra tests were planned to test for trends between independent groups that allows for order effects. For Hypothesis 2, correlational

analyses were planned to assess the relationships between the responses on the SLQ-R[A] and supervision behaviour. For Hypotheses 3, 4 and 5 Mann-Whitney U tests were planned for between-group comparisons of supervisor and trainee supervision behaviours.

Results

Hypothesis 1

Table 7 shows the mean scale scores by year group.

Year of Training	Total Score		Self-Other Awareness		Motivation		Dependency – Autonomy	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1 st (<i>n</i> = 15)	135.93	14.09	56.20	6.60	35.20	6.06	44.53	5.58
2 nd (<i>n</i> = 13)	142.92	12.74	59.15	4.43	36.92	6.01	46.85	4.91
3 rd (<i>n</i> = 12)	159.50	17.74	65.92	8.34	42.75	6.33	50.83	5.51

Table 7 SLQ-R[A] scale scores by year of training

To examine whether questionnaire responses varied by year of training, Jonckheere-Terpstra tests were conducted between year of trainee and the SLQ-R[A] subscales. One-tailed significance levels were chosen for the Total Score, Self-Other Awareness and Dependency-Autonomy as the literature suggests that increasing development is thought to be represented by increasing score. The IDM suggests one of the markers of transition from Level 1 to Level 2 is fluctuating motivation. Therefore a 2-tailed significance level was used for the Motivation subscale, as this allowed for changes in the unexpected direction.

Significant results were found for all scales: Total Score ($t^* = 3.49$, 1-tailed, $p = 0.001$), Self-Other Awareness ($t^* = 3.15$, 1-tailed $p = .001$), Motivation ($t^* = 2.85$, 2-tailed, $p = .004$) and Dependency-Autonomy ($t^* = 2.53$, 1-tailed, $p = .005$).

Supervision Sessions

Supervision session duration ranged from 39 minutes 4 seconds to 61 minutes 35 seconds. There were no significant differences between the length of supervision by year of training ($U = 9.00$, 2-tailed, $p = .540$). To ensure between-group comparisons were made on a like-for-like basis, behaviour frequencies were converted into percentages, which were used in further analyses. Mean supervisor and trainee observed behavioural percentages can be found in Tables 8 and 9.

Behaviour	Year			
	First (n = 8)		Third (n = 3)	
	Mean	SD	Mean	SD
Listening/Observing	21.29	11.87	26.11	9.55
Supporting	10.68	6.55	18.07	6.81
Questioning	11.67	5.17	8.52	2.85
Needs Assessing	0.39	0.77	0.00	0.00
Goal Setting	1.09	2.69	1.25	1.28
Restating	5.19	6.49	1.05	1.19
Reflecting	0.50	0.54	0.43	0.74
Interpreting	1.69	2.11	0.85	1.49
Formulating	5.98	5.94	2.61	1.13
Managing	10.05	6.87	13.45	6.26
Informing	16.28	11.88	13.52	3.11
Guided Experiential Learning	1.16	1.39	0.27	0.47
Self-disclosing	0.26	0.49	0.00	0.00
Challenging	0.14	0.40	3.71	3.32
Disagreeing	0.00	0.00	0.00	0.00
Evaluating	1.22	2.39	0.00	0.00
Feedback	1.85	1.55	2.07	1.94
Other – not otherwise specified	6.54	3.86	8.21	1.78
Other – case information	2.25	6.37	0.00	0.00

Table 8 Mean Supervisor Behaviour by Trainee Year of Training

Behaviour	Year			
	First (n = 8)		Third (n = 3)	
	Mean	SD	Mean	(SD)
Experiencing	2.91	2.13	2.6	0.76
Reflecting	14.44	10.65	9.80	6.88
Conceptualising	10.87	5.21	17.70	6.19
Planning	4.36	4.75	3.42	0.94
Experimenting	0.26	0.49	0.43	0.74
Other – not otherwise specified	6.04	3.19	7.70	2.80
Other – informing	20.56	9.13	28.47	9.12
Other – listening	39.39	16.64	29.99	12.89
Other – asking for supervisor action	0.91	1.57	0.43	0.74

Table 9 Mean Trainee Behaviour by Trainee Year of Training

Hypothesis 2

Correlations between trainee SLQ-R[A] total score and the percentage of supervisor supervision behaviours ‘managing’, ‘guided experiential learning’ and ‘informing’ were calculated using Spearman’s rho (Table 10), as were correlations between trainee SLQ-R[A] total score and the percentage of trainee supervision behaviours ‘planning’, ‘experimenting’, ‘reflecting’, ‘conceptualising’ and ‘other – listening’ (Table 11). Significant negative correlations were found between SLQ-R[A] and the supervisor ‘guided experiential learning’ and ‘informing’ behaviours. A significant negative relationship was found between SLQ-R[A] and the trainee ‘other – listening’ behaviour.

	Managing	Guided Experiential Learning	Informing
SLQ-R[A] Total Score	-.264	-.718*	-.620*

Note * Correlation is significant at the .05 level (2-tailed)

Table 10 Correlation Between Trainee SLQ-R[A] Total Score and Percentage of Supervisor Supervision Behaviour

	Planning	Experimenting	Reflecting	Conceptualising	Other - Listening
SLQ-R[A] Total Score	.091	-.260	.291	.446	-.609*

Note. *correlation is significant at the .05 level (2-tailed)

Table 11 Correlations between trainee SLQ-R[A] total score and percentage of trainee behaviour

Hypothesis 3

Mean supervisor ‘managing’, ‘informing’ and guided experiential learning’ behaviours are reported in Table 8. Mann-Whitney U tests found that there were no significant differences between the percentage of ‘managing’ ($U = 6.00$, 1-tailed, $p = .279$), ‘informing’ ($U = 10.00$, 1-tailed, $p = .776$), and ‘guided experiential learning’ ($U = 6.00$, 1-tailed, $p = .279$) supervisor behaviours.

Hypothesis 4

Mean trainee ‘planning’, ‘experimenting’ and ‘other-listening’ behaviours by year of training can be found in Table 9. Mann-Whitney U tests found that there were no significant differences between the percentage of ‘planning’ ($U = 10.50$, 1-tailed, $p =$

.776), 'experimenting' ($U = 10.00$, 1-tailed, $p = .776$), and 'other - listening' ($U = 6.00$, 1-tailed, $p = .279$) trainee behaviours.

Hypothesis 5

The mean 'reflecting' and 'conceptualising' trainee behaviours are reported in Table 9. Mann-Whitney U tests found that there were no significant differences between the percentage of 'reflecting' ($U = 9.00$, 1-tailed, $p = .630$) and 'conceptualising' ($U = 4.00$, 1-tailed, $p = .133$) trainee behaviours.

Discussion

Clinical supervision is an important but under-researched area of clinical practice (Milne & Westerman, 2001). Existing research has been criticised for poor rigour and an over-reliance on self-report data (Ellis & Ladany, 1997) which has made it difficult to test and validate models of supervision. Much of the research has been conducted in America limiting its application to those working in Britain. This study endeavoured to address these gaps by examining i) whether a group of trainee clinical psychologists, the majority of whom had no supervision experience prior to training, reported development on the SLQ-R[A] depending on their year of training, ii) whether behavioural differences would be observed in the supervision of first and third year trainees and iii) whether there would be a relationship between in-supervision behaviour and trainee responses on the SLQ-R[A]. In order to do this self-report questionnaire and observational data were examined. The second stage of the study was under-powered,

thus only tentative conclusions can be drawn. Given the small numbers involved in this study there is a likelihood of type I and type II error.

This study has shown that on a self-report measure designed to measure development (as conceptualised by the IDM), there were differences between year groups of trainee clinical psychologists. This suggests that trainees experience and perceive increasing development as they progress through training thus providing support for Hypothesis 1. This result mirrors previous findings amongst American counselling trainees (Leach & Stoltenberg, 1997; McNeill et al., 1992). Using the same criteria as Leach and Stoltenberg (1997), first and second year trainees would be conceptualised to be Level 1 (i.e. mean total SLQ-R[A] score ≤ 146) and third years trainees would be conceptualised as Level 2 (i.e. mean total SLQ-R[A] > 146) of the IDM. This finding may suggest that the underlying principles of supervision may not be dependent on cultural and/or professional factors. Thus psychotherapeutic supervision may be broadly similar across therapeutic professions.

Change in motivation is one of the markers in the transition from Level 1 to Level 2 in the IDM. According to Stoltenberg and McNeill (1997), Level 1 trainees are conceptualised as being highly anxious and highly motivated. Level 2 trainees reportedly experience fluctuating motivation as increasing client complexity challenges confidence (Stoltenberg & McNeill, 1997). The trainees in this study showed increased motivation by year of training. This may reflect increasing trainee confidence in their abilities and a reduction in performance anxiety (Rønnestad & Skovholt, 2003). By

using a single-time point, between groups design it was not possible to monitor changes in motivation over time, and in relation to other factors, within the groups.

Hypothesis 2 was partly supported. There were significant negative correlations between the percentages of supervisor 'informing' and 'guided experiential learning' behaviours and trainee SLQ-R[A] total score. This suggests that the more developed trainees perceive themselves to be, the less time supervisors spend directly teaching theory and therapeutic skills. There was a significant correlation between the SLQ-R[A] total score and the trainee behaviour 'other – listening'. This suggests that the more developed trainees perceive themselves to be, the less time they spend listening to information transmitted by their supervisor. Hence there is some evidence to support the IDM that beginning trainees are very dependent on their supervisors to provide structure alongside education and training in skills, theories and concepts. This concurs with the earlier findings of Stoletenberg and McNeil (1997). As correlation does not imply causation, further research would be required to explore this finding.

The third hypothesis was rejected as although first year supervisors demonstrated a higher percentage of 'informing' and 'guided experiential learning' behaviours than third year supervisors, this failed to reach significance. Contrary to predictions, third year supervisors showed a greater percentage of 'managing' behaviours than first year supervisors. This trend failed to reach significance but may be explained by third year trainees demonstrating increasing autonomy, as shown in their SLQ-R[A] Dependency-Autonomy score, and confidence in their clinical practice. Whilst third year trainees may be more able to develop client conceptualisations and intervention plans than first

year counterparts, supervisors may be required to offer explicit direction to ensure that the trainee offers best possible client care. This is a process elaborated in the IDM (Stoltenberg & McNeill, 1997)

Hypothesis 4 was rejected. First year trainees demonstrated more ‘planning’ and ‘other-listening’ behaviours than third year trainees, but this did not reach significance. Third year trainees demonstrated more ‘experimenting’ behaviours than first year trainees. This did not reach significance. It is possible that third year trainees were more comfortable in using supervision as a space to experiment than their first year counterparts. This may be due to feeling less anxious about their own competence (Rønnestad & Skovholt, 2003).

The low percentages of supervisor ‘guided experiential learning’ and trainee ‘experimenting’ behaviours, particularly for the first year group, were unexpected. The IDM suggests that for early stages of development (Level 1) “skill development...is important...via observation (of the supervisor and others), role-playing, practice, and repetitions” (Stoltenberg & McNeill, 1997, p. 193). It is possible that this low percentage may reflect a preference or greater confidence in using didactic teaching techniques compared to collaborative experiential techniques.

Hypothesis 5 was rejected. Third year trainees showed a greater percentage of ‘conceptualising’ behaviours than first year trainees, but this did not reach significance. First year trainees were observed to have a higher percentage of ‘reflecting’ behaviours

than third year trainees. This did not reach significance. This may be explained by the 'reflecting' coding on the Teacher's PET not distinguishing between self-reflection and reflection on process. The first year of training involves rapid knowledge acquisition and development of basic skills. First year trainees are likely to use reflection about the self (Lavender, 2003) to integrate this new information into their understanding. Third years may have integrated this understanding and are actively using it to reflect on their clinical practice and process with their clients.

The rejection of Hypotheses 3, 4 and 5 may be the result of the second stage being underpowered. Alternatively this may be due to other factors impacting on supervision behaviour that have not been analysed in this study. For example researchers have identified that the supervisory relationship is an important factor in effective supervision (Ladany, Ellis, & Friedlander, 1999) which is not necessarily accounted for within models of supervision (Palomo, Beinar, & Cooper, 2010). Larger scale studies would provide greater opportunities to study how these variables may impact on the supervision session, and then statistically control for their effect.

On average, the dominant supervisor behaviours in both first and third year supervision sessions were 'listening/observing', 'supporting', 'informing', 'managing' and 'questioning'. The most dominant trainee behaviours were 'reflecting', 'conceptualising', 'other – informing' and 'other – listening'. The percentage of the supervision spent demonstrating these behaviours differed between year groups but was not significant. When considering these behaviours in the context of the CMS (Milne, 2009a; Milne & Westerman, 2001), it would suggest an imbalanced profile (Milne &

James, 2002) as trainees were not experiencing the complete experiential learning cycle the model proposes. Supervisor and trainee behaviours tended to focus on intellectual understanding and information transmission. In doing this there was less scope to explore the experiential components of the cycle (i.e. 'experimentation' and 'experiencing').

Upon completion of training trainees should have developed the core competences necessary to practice clinical psychology (Latham & Toye, 2006). Supervisors may be particularly mindful of their role as gatekeepers (Milne, 2007; Watkins, 1997a) when supervising trainees. They may place more emphasis on intellectual understanding. Alternatively using the IDM framework, the use of emotional responses to explore processes is a skill that develops later, typically at the end of Level 2 and throughout Level 3 (Stoltenberg & McNeill, 1997). A greater focus on 'conceptualising' and 'reflecting' may be most appropriate to the trainee's developmental stage (i.e. Levels 1 and 2).

Most supervisors and trainees reported not using a model of supervision. This may reflect a lack of awareness, by both parties, regarding supervision models available (Beinart, 2004). Supervisor training is a relatively new development in the UK and there is not currently a consensus as to how much training a supervisor should undertake (Wheeler, 2004). Alternatively supervisors may be guided by principles suggested in a variety of models, thus adopting an 'eclectic' approach rather than subscribing to a specific model.

Supervisors were engaged in continuing professional development regarding their supervisory practice, as most had engaged in training or workshops within the past 5 years. This may reflect the growing appreciation that practicing as a supervisor requires its own competencies. This change has been emphasised by the BPS who has created a voluntary Register of Applied Psychology Practice Supervisors (RAPPS) (BPS, RAPPS online).

Limitations

A significant limitation of this study was the lack of participants in Stage 2. A small population was chosen to minimise extraneous variables and focus on a particular group that were thought to be supervision naive. This resulted in a smaller margin for drop-out and low power. Although the majority of trainees had not experienced clinical supervision prior to training, 42% did have some experience. It may be more accurate to describe the population in this study as inexperienced rather than supervision naive.

With hindsight, given that the trainee responses on the SLQ-R[A] mirrored results obtained elsewhere, it may have been better to use a larger sample encompassing several training courses who recruit via the traditional route. This is a notable flaw in the research design. Practical issues (e.g. availability of recording equipment) may have hampered research with larger samples. Alternatively, following one cohort using a longitudinal design would have provided the opportunity to show how development

occurs across the training and how it impacts on supervision behaviour rather than using between group comparisons. Time-constraints did not permit this approach.

A further limitation of this study was the availability of tools to assess development (as conceptualised by the IDM) and effectively describe supervision behaviour. The SLQ-R[A] measured the domains of the IDM in three (out of the eight) 'professional activities' proposed by Stoltenberg and Delworth (1987) and as such does not fully capture all the elements of the IDM. Published research to date using the SLQ-R was with counselling students (Leach & Stoltenberg, 1997; McNeill et al., 1992). It did not appear to have been used with other professional groups, however in this study it did appear to distinguish between trainees at different stages of training. This questionnaire may benefit from i) developing a supervisor version to measure whether there is a consensus in perception of the trainee's development and ii) undertaking validation within other therapeutic professions and cultures.

The Teacher's PET also had notable limitations. Time sampling did provide an opportunity to examine, in detail, supervision behaviour. However whilst there was an extensive range of supervisor behaviour codes (perhaps too many), the trainee behaviour codes were limited. This resulted in the researcher extending the range of 'other' codes to describe trainee behaviours that did not appear to fit with the existing coding frame. Despite modifying some of the definitions it could still be unclear as to how to classify certain behaviours. This was particularly problematic for the trainee behaviours. There was not always a high level of consensus in the inter-rater reliability across all the behaviour codes. This may be the result of a small sample analysed for

inter-rater reliability. Alternatively further work may be required to improve the specificity of behavioural definitions.

Trainee clinical psychologists undertake placements in a variety of settings with diverse client groups. The Teachers PET was initially designed to capture common interactions in applied psychology (Milne et al., 2002). It seemed to have more of a cognitive-behavioural focus suited to therapeutic work with adults. This may not have adequately represented some supervision styles and the settings in which supervision was taking place (e.g. child services). With refinement the Teacher's PET has potential to be a useful, although time-consuming, measure for examining supervision behaviours.

Strengths

A particular strength of this study was the use of both self-report and observational data. The existing supervision literature has been criticised for its reliance on self-report data (Ellis et al., 1996; Ellis & Ladany, 1997). Using more than one type of data makes findings more robust and enables a more effective way of testing supervision models. This study suggests that future research into developmental models may benefit from using observational data in conjunction with self-report data to further test their validity.

The use of genuine supervision interactions in the analysis was a further strength. However, this was a single session per dyad and can only provide a snap-shot. It is possible that both parties were on their 'best' behaviour for the recording and as such it

may not represent a 'routine' supervision session. As most participants reported forgetting that the recording equipment was present, this is unlikely.

Implications

This study suggests that UK trainee clinical psychologists do report becoming more developed as they progress through doctoral training and appear to progress at similar rates to those reported for American counselling trainees. Differences in supervision behaviour were noted between first and third year supervision dyads, although these were not found to be statistically significant. Some support was found for the IDM's suggestion that as trainees progress they require less didactic teaching and technique modelling.

Models of supervision like the IDM and CMS may be helpful in guiding both supervisors and trainees in their supervisory practice. Notably when supervisors reported using a model of supervision their trainees appeared to be unaware of this. It would be advisable, as part of supervision contracting, to explicitly discuss whether models of supervision will be used. Developmental perspectives may help both parties focus on tasks that are appropriate to the trainee and their stage of training. As trainees become more advanced it may be important to ensure that supervision encompasses information transmission, intellectual understanding and experiential processes. Supervisors and trainees may benefit from increasing their awareness of the different models of supervision as part of their professional development.

Until clinical supervision is researched more rigorously, its evidence-base will remain inadequate. In the present NHS context, where funding is tight and evidence-based practice is privileged, this could be a difficult position.

Further Research

Future research efforts need to primarily be focused on developing measures that are valid, reliable and capture the process of supervision without being reliant solely on self-report. Areas that would benefit from further investigation include examining supervisor and trainee awareness and perceptions about models of supervision and their use in supervisory practice, examining changes in behaviour supervision post-qualification and using longitudinal designs both within the UK and internationally. This would facilitate understanding of whether cultural differences impact on supervision. Finally research into how supervision behaviours change throughout a clinical psychologist's career would also be advantageous.

In conclusion this study examined stage of development and supervision behaviour in a group of British trainee clinical psychologists using self-report and behavioural observation. Although it did not obtain many significant results, it did demonstrate that using multiple sources of data can help augment understanding of supervision practice, and contribute to validating existing models of supervision. Clinical supervision is a key component of training and ongoing clinical practice as a clinical psychologist. It is identified as a marker of 'best-practice'. Until more research is carried out in this complex and challenging field, the evidence-base will remain under-developed.

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Part Three: Reflective Statement

Conducting this doctoral research, both the empirical work and systematic literature review (SLR), has been a challenging process. It has provided many opportunities for learning and presented many barriers to be overcome. This reflective statement provides an opportunity to consider the journey that I have undertaken and the gains achieved through completing this portfolio thesis.

I have not found this research journey to be an easy one. In fact it has been much harder than I could have imagined. I feel I have spent a lot of time hitting barriers, picking myself up again and formulating ways to overcome them. This has required a lot of tenacity. I remember several occasions when my research supervisor would state that research is an iterative process. Only looking back now can I fully appreciate how much that this is the case. Sometimes you can only really learn by doing! Research is not as simple as coming up with an idea and then investigating it. There are many false starts, u-turns and hurdles. At times these can leave you feeling somewhat battered and bruised. Although between these rough times, research can be exciting and fascinating. Research is not a straight journey from A to B. It is more like climbing a spiral staircase with a very shallow gradient. Sometimes it feels like you are just going round in circles but slowly you do make progress.

The topics of personal therapy for therapists and supervision are both under-researched. I found this highly surprising, given the prominence that supervision in training and ongoing practice and the importance some orientations place on personal therapy. However, as I read more and developed this portfolio thesis it became more apparent as to why this is the case. Supervision and personal therapy for therapists both encompass

a number of variables (e.g. individual personalities of each member of the dyad, environmental factors, supervisory/therapeutic relationships etc.). It can be extremely difficult to isolate and control for these variables as part of an experimental paradigm.

At present there can be a gulf between expert consensus, qualitative research and empirical investigations. This in itself brings around interesting questions given the current emphasis on evidence-based practice. Where do practitioners go when the evidence-base runs out? I suspect that expert consensus and personal values then guide the way. However given the current financial climate within the NHS, it may become the case that this is simply not sufficient and practices without a clear and strong evidence-base are no longer funded. However how can you gain an evidence base if you are not given the opportunity to trial new approaches?

As identified in my SLR much of the literature that was published was based on self-report, whether that was interview or questionnaire data. This is far from the 'gold-standard' of double-blind randomised controlled trials. This made me think about the issues of trying to apply techniques honed through the traditional sciences to social sciences. It seems that there may be a double bind. It is very difficult to produce research in a domain like psychology in such a way that all variables are controlled for. On the other hand it is not desirable to unconditionally accept an idea without subjecting it to scrutiny. This is incongruent with the scientist-practitioner ethos. I am aware that others have questioned whether the empiricist methods are the best for examining psychological phenomenon (e.g. Boon & Gozna, 2009). When raising this

issue with others during training there appears to be a consensus of opinion that empiricism 'is not ideal but it's the best we've got at the minute'.

One of the difficulties that I was surprised by in conducting my empirical research was the resistance to recording supervision sessions. Despite consulting with my participants prior to and during the research development, where no issues were raised, I experienced difficulties in recruitment. Anxiety about being recorded was not limited to trainees, as I had predicted, but was also prevalent within the supervisor group too. Part of this anxiety appeared to be around the visual DVD recording. I found myself having to justify the use of visual recordings to both participants and throughout the ethical review. It seemed like audio recording was more palatable but provided a data that was not as rich. Wanting to use visual recording seemed to break some sort of taboo.

When speaking to individuals after participating many reported that the process was not as bad as they anticipated it to be. In my experience this process appeared to parallel the emotional journey clients tend experience in undertaking therapy.

A second source of anxiety appeared to come from apprehension about being evaluated. This seemed to be particularly prevalent amongst the supervisors. Despite stressing that the focus of the analysis was solely observing behaviours that occurred during the supervision session, there was still a fear that I would evaluate their supervision practice as being 'good' or 'bad'. One particular supervisor commented that they had never received any feedback about their practice as a supervisor. Although feedback on

recordings is routinely offered at the end of 'Introductory Supervisor Training' in the area this study was undertaken, the uptake of this option is reported to be minimal.

It is possible that, as identified above, the limited literature base for supervision adds to a lack of confidence in supervisory skills. The limited literature base also encompasses supervisor training, as this was an early SLR idea which had to be rejected due to the paucity of research available.

Another ethical issue raised was the fact that my peers were participants. I found it relatively easy to manage these dual roles for some aspects of the research. For example the supervision coding process was so intensive I did not really attend to who was in the recording but became very focused on the behaviours. At other times the dual role was more challenging. The aspect that I found most difficult was recruitment. Whilst I accepted that individuals may not want to participate, I found it frustrating, particularly for stage 2 of the research. Research supervision was a helpful space to reflect on these issues. In hindsight, whilst research on peers can be done ethically, I would advise others to avoid this wherever possible. It can add an extra layer of complexity which can make conducting the research more difficult.

This research has taught me a lot. It has piqued an interest in supervision that was not there prior to setting out on this journey. It has highlighted to me the need for good quality research literature to back-up practices that clinical psychologists perhaps take for granted. It has also challenged some of my own personal issues about being reliant

on other people. It is not possible to conduct research in isolation. This current research involved two LREC committees, five NHS R&D departments, the department statistician, the department research coordinator, my research supervisor and the departmental peer review panel, not to mention the participants. At times I found being reliant on other people extremely difficult. It meant that I had to plan a lot and constantly adjust my plans. This tested my time-management skills. At times these were not as good as they could have been. Ultimately everything takes much longer than you initially expect and there will be times where things are beyond your control. This can be petrifying, especially when so much rides on the outcome. Research is never going to be simple but is worth doing. Although the outcome of it may not always look like you hoped, but valuable lessons will have been, and continue to be, learnt from going through the process.

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Part 4: Appendices

Appendix A: Systematic Literature Review Author Guidelines for Psychology and Psychotherapy: Theory, Research and Practice

Notes for Contributors

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Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via our [online peer review system](#). The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

<http://www.bpsjournals.co.uk/journals/paptrap/notes-for-contributors.cfm>

22/03/2010

- ▶ Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- ▶ Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- ▶ Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- ▶ For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. For further details please see the document below:

[Psychology and Psychotherapy: Theory, Research and Practice - Structured Abstract Information](#)

- ▶ For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- ▶ SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- ▶ In normal circumstances, effect size should be incorporated.
- ▶ Authors are requested to avoid the use of sexist language.
- ▶ Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.

5. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

6. Publication ethics

All submissions should follow the ethical submission guidelines outlined in the documents below:

[Ethical Publishing Principles – A Guideline for Authors](#)

[Code of Ethics and Conduct \(2006\)](#)

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the [British Library Document Supply Centre](#). Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material

should be submitted to the Editor together with the article, for simultaneous refereeing.

8. Copyright

On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form. To find out more, please see our [Copyright Information for Authors](#).

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Appendix B: Quantitative Quality Checklist

Quantitative Quality Checklist

Author: _____
 Year: _____
 Title: _____
 Date: _____

Criterion	Yes	No	Unclear
Is the hypothesis/aim/objective of the study clearly described?	1	0	0
Are the main outcomes to be measured clearly described in the introduction or methods section? <i>If main outcomes first mentioned in results then score as 'No'</i>	1	0	0
Was the study subjected to ethical review?	1	0	0
Is the participant sample and/or target population clearly described?			
<ul style="list-style-type: none"> • Inclusion/Exclusion criteria • Type of therapist (e.g. counsellor, psychologist, psychotherapist) • Theoretical Orientation (of participant) • Experience working as a therapist • Experience of personal therapy (duration, multiple experiences, orientation of PT Therapist)? • Response rates (if questionnaire based) • Response rate greater > 70% 	1 1 1 1 1 1 1	0 0 0 0 0 0 0	0 0 0 0 0 0 0
Is it clearly described how participants were:			
<ul style="list-style-type: none"> • Identified? • Recruited? 	1 1	0 0	0 0
Is methodology suitable to meet the hypotheses/aim/objectives of the study?	1	0	0
Were the main outcome measures used valid and reliable?			
<ul style="list-style-type: none"> • Idiosyncratic to the study? • Validated in other studies? • Reliability reported (directly or via reference)? • For questionnaire studies is questionnaire development described or referred to? 	0 1 1 1	1 0 0 0	0 0 0 0
main findings			
<ul style="list-style-type: none"> • clearly described? • Simple outcome data reported for all major findings so that reader can check major analyses and conclusions 	1 1	0 0	0 0
Are statistical tests used appropriate?	1	0	0
Have strengths of study been considered?	1	0	0
Have weaknesses of study been considered?	1	0	0

Notes:

Based on

Downs, D.H. & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology and Community Health*, 52(6), 377 - 384

Eysenbach, G. (2004). Improving the quality of web-surveys: The checklist for reporting results of Internet e-surveys (CHERRIES). *Journal of Medical Internet Research*, 6(3), 12 -16.

Appendix C: Qualitative Quality Checklist

Qualitative Quality Checklist

Author: _____
 Year: _____
 Title: _____
 Date: _____

Criterion	Yes	No	Unclear
Is a qualitative approach appropriate?			
<ul style="list-style-type: none"> • <i>Seeks to understand processes/structures/subjective experiences/meanings</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Better addressed by a quantitative methodology?</i> 	0	1	0
Is the study clear in what it seeks to do?			
<ul style="list-style-type: none"> • <i>Purpose of study addressed?</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Appropriate reference to the literature?</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Underpinning values/assumptions/theory discussed</i> 	1	0	0
How defensible/rigorous is the research design/methodology?			
<ul style="list-style-type: none"> • <i>Design appropriate to research question?</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Rationale for qualitative approach given?</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Clear rationale for sampling/data collection and analysis techniques used?</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Selection of cases/sampling strategy justified?</i> 	1	0	0
How well was the data collection carried out?			
<ul style="list-style-type: none"> • <i>Data collection methods clearly described</i> <ul style="list-style-type: none"> ○ How data was collected ○ How the data was recorded & transcribed (if verbal) ○ How the data was stored ○ What records kept of the data collection 	1	0	0
<ul style="list-style-type: none"> ○ How data was collected 	1	0	0
<ul style="list-style-type: none"> ○ How the data was recorded & transcribed (if verbal) 	1	0	0
<ul style="list-style-type: none"> ○ How the data was stored 	1	0	0
<ul style="list-style-type: none"> ○ What records kept of the data collection 	1	0	0
<ul style="list-style-type: none"> • <i>Appropriate data collected to address research question</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Data collection and record keeping systematic</i> 	1	0	0
Is the role of the researcher clearly described?			
<ul style="list-style-type: none"> • <i>Relationship between researcher and participant adequately considered</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Describe how the research was explained and presented to participants</i> 	1	0	0
Is the context clearly described?			
<ul style="list-style-type: none"> • <i>Characteristics of the participants and settings clearly defined</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Observations made in a sufficient variety of circumstances</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Was context bias considered</i> 	1	0	0
Were the methods reliable?			
<ul style="list-style-type: none"> • <i>Data collected by more than one method</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Justification for triangulation/not triangulating</i> 	1	0	0
<ul style="list-style-type: none"> • <i>Do the methods investigate what they claim to</i> 	1	0	0

Is the data analysis sufficiently rigorous?			
• <i>Is the procedure explicit?</i>	1	0	0
• <i>How systematic is the analysis – procedure reliable/dependable?</i>	1	0	0
Is the data 'rich'?			
• <i>How well are the contexts of the data described</i>	1	0	0
• <i>Has the diversity of perspective and content been explored</i>	1	0	0
• <i>How well have the detail and depth been demonstrated?</i>	1	0	0
• <i>Are responses compared and contrasted across groups/sites</i>	1	0	0
Is the analysis reliable?			
• <i>did more than 1 researcher theme and code transcripts/data?</i>	1	0	0
• <i>How were differences resolved</i>	1	0	0
• <i>Did participants feedback on the transcripts/data</i>	1	0	0
• <i>Were negative/discrepant results addressed</i>	1	0	0
Are the findings convincing?			
• <i>Are findings clearly presented</i>	1	0	0
• <i>Are the findings internally coherent</i>	1	0	0
• <i>Are extracts from the original data included</i>	1	0	0
• <i>Is the data appropriately referenced</i>	1	0	0
• <i>Is the reporting clear and coherent</i>	1	0	0
Are the findings relevant to the aims of the study?			
1 0 0			
Are the conclusions adequate?			
• <i>Clear links between data, interpretation and conclusions</i>	1	0	0
• <i>Conclusions plausible and coherent</i>	1	0	0
• <i>Alternative explanations explored and discounted</i>	1	0	0
• <i>Does the study enhance understanding of the research subject</i>	1	0	0
Is there adequate discussion of any limitations encountered			
1 0 0			
How clear and coherent is the reporting of ethical considerations?			
• <i>Have ethical issues been taken into consideration</i>	1	0	0
• <i>Are ethical issues discussed adequately – consent & anonymity</i>	1	0	0
• <i>Have the consequences of the research been discussed e.g. raising expectations</i>	1	0	0
• <i>Was the study approved by an ethics committee</i>	1	0	0

Notes:

Based on

NICE methodology checklist (2009): Appendix I – Qualitative Checklist

Appendix E: Quantitative Data Extraction Form

Quantitative Article Summary

Author: _____
Year: _____
Title: _____

Participants	
Sampling Procedure/Recruitment	
Measures used	
Response rate (where applicable)	
Methodology	
Main Findings	
Quality Score	
Notes	

Appendix F: Qualitative Data Extraction Form

Qualitative Article Summary

Author: _____
Year: _____
Title: _____

Participants	
Recruitment	
Qualitative Approach	
Methodology	
Findings	
Quality Score	
Notes	

Appendix F: Empirical Paper Author Guidelines for the British Journal of Clinical Psychology

Notes for Contributors

Page 1 of 3

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British Journal of Clinical Psychology (BJCP)

Notes for Contributors

The **British Journal of Clinical Psychology** publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- ▶ Papers reporting original empirical investigations
- ▶ Theoretical papers, provided that these are sufficiently related to the empirical data
- ▶ Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- ▶ Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via our [online peer review system](#). The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

<http://www.bpsjournals.co.uk/journals/bjcp/notes-for-contributors.cfm>

22/03/2010

- ▶ Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- ▶ Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- ▶ Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- ▶ For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. Please see the document below for further details:

[British Journal of Clinical Psychology - Structured Abstracts Information](#)

- ▶ For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- ▶ SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- ▶ In normal circumstances, effect size should be incorporated.
- ▶ Authors are requested to avoid the use of sexist language.
- ▶ Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

6. Publication ethics

All submissions should follow the ethical submission guidelines outlined in the documents below:

[Ethical Publishing Principles – A Guideline for Authors](#)

[Code of Ethics and Conduct \(2006\)](#)

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the [British Library Document Supply Centre](#). Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

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Appendix G: Letter of Ethical Approval



National Research Ethics Service

Hull & East Riding Research Ethics Committee

Research Ethics Office
Humber Mental Health Teaching NHS Trust HQ
Willerby Hill Business Park
Willerby
HULL
HU10 6ED

Telephone: 01482 389246
Facsimile: 01482 303908

05 March 2010

Ms Siobhan Hughes
Trainee Clinical Psychologist
Humber Mental Health NHS Teaching Trust
Department of Clinical Psychology
University of Hull, Cottingham Road
Hull
HU6 7RX

Dear Ms Hughes

Study Title: Supervision for Trainee Clinical Psychologists: The relationship between Stage of Development and Behaviour in Supervision
REC reference number: 10/H1304/3
Protocol number: v4

Thank you for your letter of 12 February 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H1304/3

Please quote this number on all correspondence

Yours sincerely


Dr David Horton
Chair

Email:

Enclosures: *List of names and professions of members of the subcommittee via correspondence*

"After ethical review – guidance for researchers"

Copy to: *Mr S Walker, Humber Mental Health Teaching NHS Trust.*

Hull & East Riding Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 18 February 2010

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr David Horton	Consultant Radiologist / Chair of the REC	No	Review Via Correspondence
Mrs Sally Floyd	Health Visitor	No	Review Via Correspondence

Appendix H: Ethical Approval for Amendment 1



National Research Ethics Service Hull & East Riding Research Ethics Committee

Research Ethics Office
Humber Mental Health Teaching NHS Trust HQ
Willerby Hill Business Park
Willerby
HULL
HU10 6ED

Tel: 01482 389246
Fax: 01482 303908

09 March 2010

Ms Siobhan Hughes
Trainee Clinical Psychologist
Humber Mental Health NHS Teaching Trust
Trainee Clinical Psychologist
Department of Clinical Psychology
University of Hull, Cottingham Road
Hull
HU6 7RX

Dear Ms Hughes

Study title: Supervision for Trainee Clinical Psychologists: The relationship between Stage of Development and Behaviour in Supervision
REC reference: 10/H1304/3
Amendment number: Amendment 1
Amendment date: 08 March 2010

The above amendment was reviewed at the meeting of the Sub-Committee held on 09 March 2010

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Consent Form: Clin Psychols stages 1 and 2	Am 1 v4	07 March 2010
Participant Information Sheet: Clin Psychols Stages 1 and 2	Am 1 v4	07 March 2010
Participant Information Sheet: Supervisors	Am 1 v4	07 March 2010
Protocol	Relevant revised text from Protocol Am 1 v 4	07 March 2010
Notice of Substantial Amendment (non-CTIMPs)	Amendment 1	08 March 2010

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1304/3:

Please quote this number on all correspondence

Yours sincerely



Mrs Louise Hunn
Committee Co-ordinator

E-mail:

Enclosures: List of names and professions of members who took part in the review

Copy to: Mr S Walker, Humber Mental Health Teaching NHS Trust.

Hull & East Riding Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 09 March 2010

Dr David Horton Chair
Mr Amr Mohsen Vice Chair

Appendix I: NHS Research and Development Approval

Humber 
NHS Foundation Trust
Research & Development Department
Trust Headquarters
Willerby Hill
Beverley Road
WILLERBY
HU10 6ED

Friday, 05 March 2010

Siobhan Hughes
Department of Clinical Psychology
University of Hull
Cottingham Road
Hull
HU6 7RX

Dear Siobhan Hughes

Re: R&D ID: 09/12/429 REC ID: 10/H1304/3

Supervision for trainee clinical psychologists: The relationship between stage of development and behaviour in supervision

I am please to notify you formally that this study has been approved by the Humber NHS Foundation Trust and may now begin. This approval is ONLY for Humber NHS Foundation Trust.

The research can only be undertaken by gaining the consent of BOTH the supervisor and supervisee. You must follow the trust guidance on video usage.

Humber Mental Health Teaching NHS Trust conducts all research in accordance with the requirements of the Research Governance Framework, and the NHS Intellectual Property Guidance. In undertaking this study you agree to comply with all reporting requirements, systems and duties of action put in place by the trust to deliver research governance, and you must comply with the Trust information management and data protection policies. In addition, you agree to accept the responsibilities associated with your role that are outlined within the Research Governance Framework as follows:

- The study follows the agreed protocol
- Participants should receive appropriate care while involved in the study
- The integrity and confidentiality of clinical, other records and data generated by the study will be maintained
- All adverse events must be reported to the Trust and other authorities specified in the protocol
- Any suspected misconduct by anyone involved in the study must be reported

You must ensure that the protocol is followed at all times. Should you need to amend the protocol, please follow the national research ethics service procedures. You should forward a copy of all amended versions of the protocol and/or documentation together with written confirmation that a favourable opinion has been given by the REC, to the R&D office at the trust.

At the end of a research study, a final summary report will be requested so that findings are made available to local NHS staff. The details of this report may be published on the Trust website to ensure findings are disseminated as widely as possible to stakeholders.

I would like to wish you every success with this project

Yours sincerely


Duncan Courtney
Clinical & Research Governance Manager

NHS permission letter (Non-CTIMP) R&D/T01

York Hospitals 
NHS Foundation Trust

R&D Unit reference: NYY-P01510

North and East Yorkshire Alliance R&D Unit

Ms Siobhan Hughes
Department of Clinical Psychology
University of Hull
Cottingham Road
Hull HU 6 7RX

Main Office: Learning and Research Centre
York Hospitals NHS Foundation Trust
York
YO31 8HE

9th March 2010

Tel: (01904) 726996
Fax: (01904) 731297

www.northyorksresearch.nhs.uk

Dear Ms Hughes

NHS Permission to undertake a research study

Trust: North Yorkshire and York PCT

Study Title: Models of Supervision and Trainee Clinical Psychologists

Thank you for submitting details of this study for NHS Permission from the above-named Trust, which is a member of the North and East Yorkshire R&D Alliance.

I confirm that the study has NHS Permission and can now begin in the Trust.

Please note that the study must be conducted in accordance with the approved protocol, the Department of Health Research Governance Framework for Health and Social Care and any applicable legislation.

Please check that you are aware of the sponsor's Standard Operating Procedures that are applicable to this study. If your study is sponsored by the Trust, please refer to the Standard Operating Procedures published on the Unit's website www.northyorksresearch.nhs.uk. These should also be used as a default for externally sponsored studies where the sponsor does not have its own procedure or where there are gaps in the sponsor's procedure due to local circumstances.

Please ensure that you notify me if there are any amendments to the study or when the study has ended and send me details of any publications that result from it.

May I wish you every success with the study.

Yours sincerely



Caroline Mozley
Head of Research and Development
On behalf of North Yorkshire and York PCT

The R&D Service for: East Riding of Yorkshire Primary Care Trust
Hull Teaching Primary Care Trust
Scarborough and N. E. Yorks Health Care Trust

Harrogate and District NHS Foundation Trust
North Yorkshire and York Primary Care Trust
York Hospital NHS Foundation Trust



Rotherham Doncaster and South Humber Mental Health

HO/CAE

NHS Foundation Trust

Clinical Effectiveness Department
Birch View, St Catherine's, Tickhill Road,
Balby, Doncaster. DN4 8QN
Telephone: 01302 796726
Fax: 01302 796729

E.mail: helen.oldknow@rdash.nhs.uk

16th March 2010
Ms Siobhan Hughes
Trainee Clinical Psychologist
Humber Mental Health NHS Teaching Trust
Department of Clinical Psychology
University of Hull, Cottingham Road
Hull
HU6 7 RX

Information for ID Badge if required:

Research Project Ref No:

Expiry Date:

Information to be added

You must take this letter with you.

Title of project: **Supervision for Trainee Clinical Psychologists: The relationship between Stage of Development and Behaviour in Supervision**

REC reference number: **10/H1304/3**

Dear Ms Hughes

Rotherham Doncaster & South Humber Mental Health NHS Foundation Trust has reviewed your above project for Organisational approval. We can confirm that the research project meets the requirements for Research Governance and we now give you Trust approval.

However if the protocol should change you would have to re-submit your new proposal. May we remind you that you are obliged to adhere to the Research Governance Framework for Health and Social Care.

In the interest of ensuring the Trust receives maximum benefit from co-operating with research projects such as your own, the Trust places great importance on disseminating findings and conclusions. Therefore we would welcome a short summary of the findings of this project, once completed, along with any formal publications resulting from this work.

May I take this opportunity to wish you well with your project. If you have any concerns please do not hesitate to contact Helen Oldknow on 01302 796762.

Yours sincerely

Dr Riadh Abed

Medical Director/Research Director

Serving people from all walks of life

Lincolnshire Partnership 
NHS Foundation Trust

Our ref: 10/H1304/3
Date: 6th April 2010
Ms Siobhan Hughes
Trainee Clinical Psychologist
Humber Mental Health NHS Teaching
Trust
Department of Clinical Psychology
University of Hull
Cottingham Road
Hull
HU6 7RX

Research and Effectiveness Department
Lincolnshire Partnership NHS Foundation Trust
Unit 8, The Point
Lions Way
Sleaford
Lincolnshire
NG34 8GG
Tel: 01529 222206
Fax: 01529 222217

Dear: *Siobhan Hughes*

Re: Trust Approval for Research Study titled; Supervision for trainee Clinical Psychologists: The relationship between stage of development and behavior in supervision

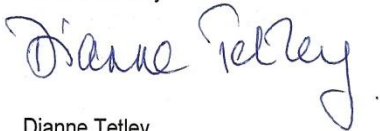
REC Reference: 10/H1304/3

In addition to your approval by the Hull & East Riding Research Ethics Committee on 9th March 2010 we are pleased to notify you that Trust approval has now also been granted. We are pleased to inform you that you may now commence your research. Please retain this letter to verify that you have Trust approval to proceed.

We may contact you from time to time to monitor progress with your work. If the research is terminated or you complete this work, please let the Research and Effectiveness Department know so they can amend their records.

Do contact us if you require any further advice. We wish you every success with your work.

Yours sincerely



Dianne Tetley
Assistant Director for Research and Effectiveness

Enc: Data Protection Guidance on the transportation of personal identifiable data

Email:
(SEC):

1 Prince Albert Gardens
Grimsby
N E Lincs
DN31 3HT

Our Ref: MG/ID

15 April 2010

Ms S Hughes
Trainee Clinical Psychologist
Humber Mental Health NHS Teaching Trust
Department of Clinical Psychology
University of Hull
Cottingham Road
HU6 7RX

Dear Ms Hughes

Re: Application for research approval

**Project Ref: Supervision for Trainee Clinical Psychologists:-
The Relationship between stage of development and behaviour in supervision.**

Project Ref No: 10/H1304/3

Further to your recent request I am writing to inform you that NHS North Lincolnshire give research governance approval for the above study.

In accordance with the Trust policy for research governance you are required to inform Dr Marie Girdham (Research Governance Manager) at the Trust of any significant proposed challenges to the original protocol, adverse events or issues of safety.

In addition NHS North Lincolnshire, Quality & Standards Director will require progress reports and end of study notification.


Marie's contact details are as follows:

Dr Marie Girdham
Research Governance Manager
NHS North Lincolnshire
Health Place
Wrawby Road
Brigg
North Lincolnshire
DN20 8GS

Email:
Tel:

Wishing you every success with your study.

Yours sincerely



**Dr Marie Girdham
Research Governance Manager**

CC: Ms Sue Clement

Appendix J: Participant Information Sheets



Information about the study – Trainee Clinical Psychologists (Stage 1 only)

Study Title: Stage of Development and Supervision Behaviour

We would like you to participate in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. The researcher will answer any questions you may have. We would suggest this should take about 10 minutes.

Please ask if anything is not clear.

What is the purpose of this study?

This study is being undertaken as part of the researcher's Doctorate in Clinical Psychology. It will look at the relationship between the supervisee's stage of development and the behaviour of the supervisor and supervisee in supervision.

Why have I been invited to participate?

You have been invited to participate because you are a Trainee Clinical Psychologist who is in the process of completing their Doctorate in Clinical Psychology.

Do I have to take part?

Participation in this study is entirely voluntary. If you agree to take part we will ask you to sign a consent form. You are free to withdraw at any time without giving a reason. If you choose to withdraw, your data will not be included in the study and will be destroyed.

In the unlikely event that you lose capacity to consent during participation you will be withdrawn from the study. Any data collected prior to the loss of capacity will be retained and used in the study.

What will happen to me if I take part?

You will be asked to complete a demographic information sheet and questionnaire under a participant number which the researcher will be blind to. The only person able to connect you to your participant number will be Tim Alexander (Research Tutor).

The Supervisee Levels Questionnaire – Revised (SLQ-R) [amended] is a 30 statement questionnaire designed to look at the behaviours of therapists and how these change as they develop. This should take around 10 minutes to complete. Once you have completed the SLQ-R [amended] this will conclude your participation in the study.

All Trainee Clinical Psychologists in the current cohort will be invited to participate in Stage 1.

The study is expected to run from January 2010 to September 2011

Information - Trainee Clinical Psychologists
(Stage 1 only)
V2 12/11/2009
Models of Supervision and Trainee Clinical
Psychologists
Page 1

University of Hull
Hull Campus
Cottingham Road
Hull, HU6 7RX
www.hull.ac.uk

Will my taking part in the study be kept confidential?

Yes. All information which is collected about you during the course of the research will be kept strictly confidential.

All data gathered as part of this study will be stored securely. Individuals that will have access to your data include Siobhan Hughes (Researcher), Sue Clement (Research Supervisor) and Tim Alexander (Research Tutor). The data may also be audited by the NHS Research and Development Department for monitoring the quality of the research.

The supervision DVD will be securely destroyed after it has been analysed. The rest of the data collected as part of this research will be stored in a locked filing cabinet by Sue Clement (Research Supervisor) for 5 years after the study is complete. After this it will be destroyed.

What will happen to the results of the research study?

The intention is to publish the results of this study in a journal. Findings will also be presented at a Research Conference and may be included in teaching within the Department of Clinical Psychology and Psychological Therapies. You will not be individually identified in any future publication of this research.

If you would like an electronic copy of the completed research please contact the researcher using the details given below.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by and given favourable opinion by Hull and East Riding Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to the researcher or their supervisor who will do their best to answer your questions. Contact information can be found at the end of this information sheet.

If you remain unhappy and wish to complain formally you can do this by either contacting Professor D. Lam (Head of Department of Clinical Psychology and Psychological Therapies, University of Hull) on _____ or Humber Mental Health NHS Teaching Trust Complaints Manager on _____ who will provide you with details of how to do this.

Further Information and Contact Details

Should you require further information please contact the researcher using the information given below.

Siobhan Hughes Trainee Clinical Psychologist, Researcher Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX Tel:	Sue Clement Clinical Psychologist, Research Supervisor Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX Tel:
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**Information about the study –
Trainee Clinical Psychologists (Stages 1 and 2)**

Study Title: Stage of Development and Supervision Behaviour

We would like you to participate in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. The researcher will answer any questions you may have. We would suggest this should take about 10 minutes.

Please ask if anything is not clear.

What is the purpose of this study?

This study is being undertaken as part of the researcher's Doctorate in Clinical Psychology. It will look at the relationship between the supervisee's stage of development and the behaviour of the supervisor and supervisee in supervision.

Why have I been invited to participate?

You have been invited to participate because you are a Trainee Clinical Psychologist in either your first or third year of training. These years have been selected as they represent Clinical Psychologists at the very beginning of their training and those almost ready for qualification.

Do I have to take part?

Participation in this study is entirely voluntary. If you agree to take part we will ask you to sign a consent form. You are free to withdraw at any time without giving a reason. If you choose to withdraw, your data will not be included in the study and will be destroyed. If you chose to participate in Stage 2 and then withdraw your Supervisor's data will also be withdrawn and destroyed.

In the unlikely event that you lose capacity to consent during participation you will be withdrawn from the study. Any data collected prior to the loss of capacity will be retained and used in the study.

What will happen to me if I take part?

There are 2 stages to this study. They are outlined below.

Stage 1

You will be asked to complete the demographic information sheet and questionnaire under a participant number which the researcher will be blind to. The only person able to connect you to your participant number will be Tim Alexander (Research Tutor).

The Supervisee Levels Questionnaire – Revised (SLQ-R) [amended] is a 30 statement questionnaire

designed to look at the behaviours of therapists and how these change as they develop. This should take around 10 minutes to complete.

All Trainee Clinical Psychologists in the current cohort will be invited to participate in Stage 1.

Stage 2

You then have the option of participating further by completing Stage 2. We would like 20 supervisor and supervisee pairs to participate in this stage of the study. 10 pairs will involve a 1st year trainee and 10 pairs will involve a 3rd year trainee.

Stage 2 will involve recording, using a DVD camcorder, of one of your supervision sessions between February and March 2010. The researcher will not be present at the recording but will provide you with the necessary equipment. The recording should not take any longer than a routine supervision session (between 60 and 90 minutes approximately).

To protect client confidentiality we would request that you use pseudonyms when you discuss client work. Otherwise the supervision session should represent a 'typical' session. The DVD should be reviewed by you to ensure that client confidentiality has not been breached. This should take no longer than the time of your supervision session (between 60 and 90 minutes approximately).

If you and your supervisor are both happy with the recording you will be responsible for transferring the recording from the DVD to an encrypted memory stick provided by the researcher and deleting the DVD. Instructions how to do this will be provided. You will then be asked to bring the encrypted memory stick to the Department of Clinical Psychology and Psychological Therapies, University of Hull within 48 hours of the recording to comply with data protection principles. If this does not occur the researcher will contact you, individually, via your University email address.

The researcher will analyse the recording using a tool called The Teacher's PET. This codes the behaviour of the supervisor and supervisee. The coding will **not** comment on how 'good' you are as a Clinical Psychologist. A small random sample of recordings will also be analysed by Sue Clement, Research Supervisor, to that there is agreement in how the recordings are rated.

A full breakdown of the coding scheme are available from the researcher upon request.

If you would like a copy of your supervision session ratings please contact the researcher using the details given below.

The research is expected to run between January 2010 and September 2010.

Will my taking part be kept confidential?

Yes. All information which is collected about you during the course of the research will be kept strictly confidential. DVD recordings will comply with guidelines detailed in the NHS Audio and Visual Recording Policy for Service Users.

Confidentiality will only be broken in the unlikely event that in analysing the supervision session the researcher identifies any ethical issues that are not addressed within the supervision session. The researcher will raise this concern with both your Supervisor and yourself. It will also be raised with the Department of Clinical Psychology and Psychological Therapies.

It is not possible to rate your supervision DVD anonymously. To protect your identity, the researcher will send your supervision session ratings to Tim Alexander (Research Tutor) who will then replace identifying information with your participant number before returning them to the researcher. The researcher will then link, via participant number, your Teacher's PET ratings to your scores on the SLQ-R [amended] as part of the analysis. Your data will only be referred to by participant number after that point.

All data gathered as part of this study will be stored securely. Individuals that will have access to your data include Siobhan Hughes (Researcher), Sue Clement (Research Supervisor) and Tim Alexander (Research Tutor). The data may also be audited by the NHS Research and Development Department for monitoring the quality of the research.

The supervision DVD will be securely destroyed after it has been analysed. The anonymised data collected as part of this research will be stored in a locked filing cabinet by Sue Clement (Research Supervisor) for 5 years after the study is complete. After this it will be destroyed.

What will happen to the results of the research study?

The intention is to publish the results of this study in a journal. Findings will also be presented at a Research Conference and may also be included in teaching within the Department of Clinical Psychology and Psychological Therapies. You will not be individually identified in any future publication of this research.

If you would like an electronic copy of the completed research please contact the researcher using the details given below.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by and given favourable opinion by Hull and East Riding Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to the researcher or their supervisor who will do their best to answer your questions. Contact information can be found at the end of this information sheet.

If you remain unhappy and wish to complain formally you can do this by either contacting Professor D. Lam (Head of Department of Clinical Psychology and Psychological Therapies, University of Hull) on _____ or Humber Mental Health NHS Teaching Trust Complaints Manager on _____ who will provide you with details of how to do this.

Further Information and Contact Details

Should you require further information please contact the researcher using the information given below.

Siobhan Hughes Trainee Clinical Psychologist, Researcher Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX Tel: _____	Sue Clement Clinical Psychologist, Research Supervisor Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX Tel: _____
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**Information about the study –
Supervisors**

Study Title: Stage of Development and Supervision Behaviour

We would like you to participate in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. It may be helpful for you and your Trainee to discuss participation. If you have any further questions please contact the researcher using the contact details given at the end of this information sheet.

What is the purpose of this study?

This study is being undertaken as part of the researcher's Doctorate in Clinical Psychology. It will look at the relationship between the supervisee's stage of development and the behaviour of the supervisor and supervisee in supervision.

Why have I been invited to participate?

You have been invited to participate in this study as your supervisee, has indicated that they would like to participate.

We would like 20 supervisor and supervisee pairs to participate in this stage of the study. 10 pairs will involve a 1st year trainee and 10 pairs will involve a final year trainee.

Do I have to take part?

Participation in this study is entirely voluntary. It will not affect your relationship with the University of Hull.

If you agree to take part we will ask you to sign a consent form. You are free to withdraw at any time without giving a reason. If you chose to withdraw, your data will not be included in the study and will be destroyed. Your Trainee Clinical Psychologist's data for this stage of the research will also be destroyed. The Trainee Clinical Psychologist's data collected as part of a previous stage will be retained and used within the study.

In the unlikely event that you lose capacity to consent during participation you will be withdrawn from the study. Any data collected prior to the loss of capacity will be retained and used in the study.

What will happen to me if I take part?

Your involvement involves completing a brief demographic information sheet and consenting to one supervision session between your supervisee and yourself being recorded using a DVD camcorder by the supervisee. Your supervisee will provide you with a consent form and demographic information sheet should you wish to participate.

If you consent to participate, the researcher will contact both your supervisee and you to arrange a date for the DVD recording to take place between February and March 2010. Recording equipment will be provided by the researcher. The recording should not take any longer than a routine supervision session (between 60 and 90 minutes approximately).

To help protect client confidentiality we would request that you use pseudonyms when discussing client work. Otherwise the recording should represent a 'typical' supervision session.

If you and your Trainee are both happy the recording, your Trainee will be responsible for securely transferring the recording to encrypted memory stick and bringing it to the Department of Clinical Psychology and Psychological Therapies, University of Hull within 48 hours of the recording being made due to data protection.

The researcher will analyse the recording using a tool called the Teacher's PET. This tool codes the behaviour of the supervisor and the supervisee. A small sample of the recordings will also be coded by Sue Clement (Research Supervisor) to check that there is agreement in how the recordings are rated.

A full breakdown of the coding scheme is available from the researcher upon request.

If you would like a copy of your supervision session ratings please contact the researcher using the details provided below.

The research is expected to run between December 2009 and September 2010.

Will my taking part be kept confidential?

Yes. All information which is collected about you during the course of the research will be kept strictly confidential. DVD recordings will comply with guidelines detailed in the NHS Audio and Visual Recording Policy for Service Users.

Confidentiality will only be broken in the unlikely event that in analysing the supervision session the researcher identifies any ethical issues that are not addressed within the supervision session, they will raise this concern with both your Trainee Clinical Psychologist and yourself. It will also be raised with the Department of Clinical Psychology and Psychological Therapies.

It is not possible to rate your supervision DVD anonymously. To protect your identity, Tim Alexander (Research Tutor) will keep a list that connects you to your participant number. The researcher will not have direct access to this list. After the researcher has coded your supervision DVD, the codings will be sent to Tim who will replace identifying information with your participant number, before returning to the researcher. Your data will only be referred to by participant number after that point.

All data gathered as part of this study will be stored securely. Individuals that will have access to your data include Siobhan Hughes (Researcher), Sue Clement (Research Supervisor) and Tim Alexander (Research Tutor). The data may also be audited by the NHS Research and Development Department for monitoring the quality of the research.

The supervision DVD will be securely destroyed after it has been analysed. The anonymised information collected as part of this research will be stored in a locked filing cabinet by Sue Clement (Research Supervisor) for 5 years after the study is complete. After this it will be destroyed.

What will happen to the results of the research study?

The intention is to publish the results of this study in a journal. Findings will also be presented at a Research Conference. Findings may also be used as part of the Supervisor Training Course run by the Department of Clinical Psychology and Psychological Therapies. You will not be individually identified in any future publication of this research.

If you would like an electronic copy of the completed research please contact the researcher using the details given below.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by and given favourable opinion by Hull and East Riding Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to the researcher or their supervisor who will do their best to answer your questions. Contact information can be found at the end of this information sheet.

If you remain unhappy and wish to complain formally you can do this by either contacting Professor D. Lam (Head of Department of Clinical Psychology and Psychological Therapies, University of Hull) on _____ or Humber Mental Health NHS Teaching Trust Complaints Manager on _____ who will provide you with details of how to do this.

Further Information and Contact Details

Should you require further information please contact the researcher using the information given below.

Siobhan Hughes Trainee Clinical Psychologist, Researcher Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX Tel: _____	Sue Clement Clinical Psychologist, Research Supervisor Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX Tel: _____
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Appendix K: Participant Consent Forms



Consent Form – Trainee Clinical Psychologist: Stage 1

Study: Stage of Development and Supervision Behaviour

Participant Number: _____

Name of Researcher: Siobhan Hughes

		Please Initial the box
1.	I confirm that I have read and understood the information sheet dated _____ (version _____). I have had the opportunity to consider the information, ask questions and have these answered satisfactorily.	
2.	I understand that my participation in voluntary and that I am free to withdraw at any time without giving any reason without any adverse consequences.	
3.	I understand that data collected during the study, may be looked at by individuals from the Department of Clinical Psychology and Psychological Therapies (University of Hull), from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4.	I agree to complete the Supervisee Level Questionnaire – Revised.	

Name of Trainee Clinical Psychologist

Date

Signature

Please keep 1 copy and return 1 copy to Tim Alexander, Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX

Consent Form – Trainee Clinical
Psychologist: Stage 1
V3 01/02/2010
Stage of Development and Supervision
Behaviour

University of Hull
Hull Campus
Cottingham Road
Hull, HU6 7RX
www.hull.ac.uk

**Consent Form – Trainee Clinical Psychologist:
Stage 2**

Study: Stage of Development and Supervision Behaviour

Participant Number: _____

Name of Researcher: Siobhan Hughes

		Please Initial the box
1.	I confirm that I have read and understood the information sheet dated _____ (version _____). I have had the opportunity to consider the information, ask questions and have 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 without any adverse consequences.	
3.	I understand that data collected during the study, may be looked at by individuals from the Department of Clinical Psychology and Psychological Therapies (University of Hull), from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4.	I give the researcher permission to contact my supervisor regarding participating in this research.	
5.	I agree that one supervision session between _____ (name of supervisor) and I may be recorded using a DVD camcorder. I agree to this recording being viewed and coded by the researcher and their research supervisor for the purposes of this research study.	
6.	To protect the anonymity of clients who may be discussed during that supervision session, I agree to using pseudonyms. I will check the recording before handing to the researcher to ensure confidentiality is not breached.	
7.	I give the researcher permission to access my scores for the Supervisee Levels Questionnaire – Revised.	
8.	I agree to take part in stage 2 of the study.	

Name of Trainee Clinical Psychologist Date Signature

Please keep 1 copy and return 1 copy to Tim Alexander, Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX

Consent form Trainee Clinical
Psychologist: Stage 2
V4 07/03/2010
Stage of Development and Supervision
Behaviour

University of Hull
Hull Campus
Cottingham Road
Hull, HU6 7RX
www.hull.ac.uk

Consent Form – Supervisor

Study: Stage of Development and Supervision Behaviour

Participant Number: _____

Name of Researcher: Siobhan Hughes

		Please Initial the box
1.	I confirm that I have read and understood the information sheet dated _____ (version _____). I have had the opportunity to consider the information, ask questions and have these answered satisfactorily.	
2.	I understand that my participation in voluntary and that I am free to withdraw at any time without giving any reason without any adverse consequences.	
3.	I understand that data collected during the study, may be looked at by individuals from the Department of Clinical Psychology and Psychological Therapies (University of Hull), from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4.	I agree that one supervision session between _____ (name of supervisee) being recorded using a DVD camcorder. I agree to this recording being viewed and coded by the researcher and their research supervisor for the purposes of this research study.	
5.	To protect the identity of clients who may be discussed during that supervision session, I agree to using pseudonyms.	
6.	I agree to take part in the study.	

Name of Supervisor

Date

Signature

Please keep 1 copy and return 1 copy to Tim Alexander, Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX

Appendix L: Demographic Information Sheet

Demographic Data Collection Sheet – Trainee Clinical Psychologist

Participant Number: _____

Gender: Male/Female (please circle)

Age: _____ years

Year of Training: 1st/2nd/3rd (please circle)

What is the main therapeutic model used on your current clinical placement?

- | | |
|--|--|
| <input type="checkbox"/> Cognitive Behavioural Therapy | <input type="checkbox"/> Behavioural Therapy |
| <input type="checkbox"/> Cognitive Therapy | <input type="checkbox"/> Psychodynamic |
| <input type="checkbox"/> Cognitive Analytical Therapy | <input type="checkbox"/> Narrative Therapy |
| <input type="checkbox"/> Social Constructionism | <input type="checkbox"/> Psychoanalytic |
| <input type="checkbox"/> Integrated | |
| <input type="checkbox"/> Other – Please state | |
-
-
-

Do you use a specific model of supervision on your current clinical placement?

Yes/No (please circle)

If **YES** please detail below:

Did you have any experience of clinical supervision prior to beginning your Clinical Psychology training?

Yes/No (please circle)

If **YES** approximately how many sessions of supervision did you receive prior to beginning your Clinical Psychology training?

- | | | | | | |
|---------|--------------------------|---------|--------------------------|---------|--------------------------|
| 1 – 5 | <input type="checkbox"/> | 6 – 10 | <input type="checkbox"/> | 11 – 15 | <input type="checkbox"/> |
| 16 – 20 | <input type="checkbox"/> | 21 – 25 | <input type="checkbox"/> | 26 – 30 | <input type="checkbox"/> |
| 31+ | <input type="checkbox"/> | | | | |

Please return this completed form to Siobhan Hughes, Department of Clinical Psychology and Psychological Therapies, University of Hull, HU6 7RX

**Demographic Data Collection Sheet –
Supervisor**

Participant Number: _____

Gender: Male/Female (please circle)

Age: _____ years

How many years have you been a qualified Clinical Psychologist? _____ years

How many Trainee Clinical Psychologists have you supervised over your career to date?

Less than 2	<input type="checkbox"/>	2 – 5	<input type="checkbox"/>	6 – 8	<input type="checkbox"/>
9 – 10	<input type="checkbox"/>	11 – 15	<input type="checkbox"/>	16 – 20	<input type="checkbox"/>
21 – 25	<input type="checkbox"/>	26 plus	<input type="checkbox"/>		

What is the main theoretical model you use in your current clinical work?

<input type="checkbox"/> Cognitive Behavioural Therapy	<input type="checkbox"/> Behavioural Therapy
<input type="checkbox"/> Cognitive Therapy	<input type="checkbox"/> Psychodynamic
<input type="checkbox"/> Cognitive Analytical Therapy	<input type="checkbox"/> Narrative Therapy
<input type="checkbox"/> Social Constructionism	<input type="checkbox"/> Psychoanalytic
<input type="checkbox"/> Integrated	
<input type="checkbox"/> Other – Please state	

Do you use a specific model of supervision with your current Trainee Clinical Psychologist?

Yes/No (please circle)

If yes please detail below:

When did you last attend any training or workshop in relation to clinical supervision?

Within the last 2 years	<input type="checkbox"/>
3 – 5 years	<input type="checkbox"/>
More than 5 years ago	<input type="checkbox"/>

**Please return this completed form to Siobhan Hughes, Department of Clinical Psychology and
Psychological Therapies, University of Hull, HU6 7RX**

Demographic Data Collection Sheet –
Supervisor
V2 12/11/2009
Stage of Development and Supervision Behaviour

Appendix M: Supervisee Levels Questionnaire – Revised [Amended]

The Supervisee Levels Questionnaire – Revised (McNeill et al., 1992)

[amended]

Participant No: _____

Year of Training: 1st/2nd/3rd (please circle)

The following instrument is designed to study the behaviours of therapists in training. Your total honesty will be appreciated.

In terms of your **current** behaviour please rate the following items according to the following scale. Please circle your response.

- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|-------|--------|-----------|---------------|-------|------------------|--------|
| Never | Rarely | Sometimes | Half the Time | Often | Most of the Time | Always |
1. I feel genuinely relaxed and comfortable in my therapy sessions.
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|-------|---|---|---|---|---|--------|
| Never | | | | | | Always |
2. I am able to critique therapy tapes and gain insights with minimum help from my supervisor.
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|-------|---|---|---|---|---|--------|
| Never | | | | | | Always |
3. I am able to be spontaneous in therapy, yet my behaviour is relevant.
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|-------|---|---|---|---|---|--------|
| Never | | | | | | Always |
4. I lack self-confidence in establishing therapeutic relationships with diverse client types.
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|-------|---|---|---|---|---|--------|
| Never | | | | | | Always |
5. I am able to apply personalised therapeutic models of human behaviour in working with my clients.
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|-------|---|---|---|---|---|--------|
| Never | | | | | | Always |

21. I believe that I know my strengths and weaknesses as a therapist sufficiently well to understand my professional potential and limitations.

1	2	3	4	5	6	7
Never						Always

22. Regarding therapy, I view my supervisor as a peer/colleague.

1	2	3	4	5	6	7
Never						Always

23. I think I know myself well and I am able to integrate that into my therapeutic style.

1	2	3	4	5	6	7
Never						Always

24. I find I am able to understand my client's view of the world, yet help them objectively evaluate alternatives.

1	2	3	4	5	6	7
Never						Always

25. At my current level of professional development, my confidence in my abilities is such that my desire to do therapy doesn't change much from day to day.

1	2	3	4	5	6	7
Never						Always

26. I find I am able to empathise with my client's feeling states, but still help them focus on problem resolution.

1	2	3	4	5	6	7
Never						Always

27. I am able to adequately assess my interpersonal impact on clients and use that knowledge therapeutically.

1	2	3	4	5	6	7
Never						Always

28. I am adequately able to assess the client's interpersonal impact on me and use that knowledge therapeutically.

1 2 3 4 5 6 7

Never

Always

29. I believe that I exhibit a consistent professional objectivity, and ability to work within my role as a therapist without undue over-involvement with my clients.

1 2 3 4 5 6 7

Never

Always

30. I believe that I exhibit a consistent professional objectivity, and ability to work within my role as a therapist without excessive distance from my clients.

1 2 3 4 5 6 7

Never

Always

Please return completed questionnaire to Siobhan Hughes, Department of Clinical Psychology and Psychological Therapies, University of Hull, Cottingham Road, Hull. HU6 7RX.

Appendix N: Teacher's PET Coding Guidelines (Milne, 2004)

Supervisor Behaviour	Description
1. Listening/Observing	(LO): Active listening, through non-verbal attention to the leader's/learners' speech and behaviour. Watching relevant activity.
2. Supporting	(S): Non-specific reassuring, agreeing and encouraging e.g. statements such as 'that's right', 'good', 'well done'; responsive rapport including non-verbal gestures such as nodding of the head; 'holding' or 'containing' (steers steady course); collaborating (fitting in); empathy, warmth and genuineness; motivating; rewarding. A 'nurturing' mode, linked to learning relationship enhancement. Encompasses non-verbal reinforcement that the trainee is doing the 'right' thing
3. Closed questioning	(CQ): A data gathering enquiry that requests a one or two word answer, a yes or no etc. For example: 'Is that clear?' An 'inquiring' mode.
4. Open questioning	(OQ): A probe that requests a clarification or exploration of a situation or feelings (inc. Socratic and 'awareness-raising' questions). For example; 'What will you do next?' An 'exploring' mode
5. Needs assessing	(NA): determining what needs to be tackled; agreeing broad aims; reflect views of both parties (e.g. based on 'daily diary' or other assessment tool); as appropriate, taking account of 3 rd party's wishes.
6. Goal-setting	(GS): defining objectives, e.g. based on needs assessment; agenda-setting; pinpointing or specifying goals (inc. a 'homework' assignment). Specifically setting client-centred goals
7. Restating	(RES): A rephrasing or summarising of other's statement(s). a 'reframing' mode
8. Reflecting	(REF): A repeating or rephrasing that contains a reference to stated or implied feelings; indicates deliberation or recall of relevant material (e.g. 'sounds like you earlier point').
9. Interpreting	(INT): Establishes connections between seemingly isolated statements or events; interprets defences, feelings, resistances, etc. An 'interpreting' mode
10. Formulating	(FM): Defining and making sense (e.g. Re-interpreting the past); exploring or offering an understanding; re-framing; heightening grasp or awareness of issue.
11. Managing	(MAN): Structuring; establishing order (e.g. introducing topic or creating task); setting up learning situations (e.g. creating or arranging teaching materials); assuming responsibility ('in charge'). Making decisions unilaterally (e.g. giving directions); e.g. prioritising tasks (such as a PSI assessment). Making decisions collaboratively; includes providing a rationale for an action (explaining why an action is important); grading tasks/hierarchy of learning objectives; activity scheduling; co-ordinating and liaising.

	Relates to workload managing. Code if supervisor is setting specific goals for the trainee
12. Informing	(INF): Teaching; providing abstract (not personal) information; 'information transmission' (e.g. facts and figures, theories and ideas, methods); didactic approach (e.g. traditional teaching); directive; indicates what other might do to achieve goals (e.g. how to complete own 'daily diary', ensuring other understands). 'Symbolic' learning emphasised. An 'explaining' or 'story-telling' mode Giving information in relation to clinical work, giving context to clinical work/theory/model
13. Guiding experiential learning	(GEL): Leading practical 'iconic' and/or 'enactive' learning activities in which the other actively develops competence (e.g. demonstrating correct performance); observing model (video/audio tape or live); simulations (e.g. role play exercise); behavioural rehearsal or tests. Problem-based, active learning approach in which the other shares responsibility for his/her own learning (e.g. 'live' supervision or joint working). A 'prescribing' mode.
14. Self-disclosing	(SD): Leader/learner refers to self, in order to reveal something about self (e.g. personal experience, limitation or goal). A 'revealing' mode.
15. Challenging	(CHA): Helpfully creating optimal anxiety, uncertainty or perplexity; skilfully and constructively de-stabilising or shifting other's understanding/grasp/constructs.
16. Disagreeing	(DIS): Reaction to other's opinion or grasp of facts. Constructive, 'healthy' disagreement or dissent, designed to aid improved understanding. (e.g. 'I can't see why you think that'; I don't agree at all')
17. Evaluating	(EVA): Explicitly monitoring, checking or evaluating other (e.g. eliciting knowledge base or competence) or promoting demonstration of proficiency (behavioural skill); data collection or analysis. Inc. checking that other knows how to complete forms (such as the 'daily diary').
18. Feeding Back	(FN) or (FP): Giving negative (FN) or positive (FP) verbal or written information that is intended to weaken or strengthen specific aspects of the other's behaviour, thoughts and feelings. Seeking/ inviting feedback from the other (i.e. leader / learner). For example: 'What did you think of that?', 'Your approach was clear and effective'.
19. Other	(O): Cannot decide on suitable category from above; not observable; other behaviours (e.g. social chat, paperwork); off- task behaviour. Case information – giving the trainee information about a case that is shared (e.g. one seeing parent, one seeing child) Use this coding when uncertain of behaviour due to close balance between 2 (that cannot be separated by counting seconds) or when use of context does not offer clarity

Trainee Behaviour	Description
1. Experiencing	<p>(EX): Functions are: grasping of sensory/affective experience; Dialectic with ‘conceptualisation’- ‘prehension’ tension.</p> <p>Code if: subject indicates being aware of current sensations; recognises feelings; demonstrates intuition; is in the ‘here and now’ moment; is aware of emotional or sensory accompaniments to activity) indicated by non-verbal behaviour (e.g. places head in hands)</p> <p>May occur in relation to:</p> <p>Full and open engagement in ‘experimentation’. Expressing an emotion or an awareness of a situation (e.g. laughter; insight). Recognising the tangible, ‘felt’ experience (‘Here and now’ apprehension). Intuition. Discriminating amongst sensations. Regulating or managing emotions (positive or negative ones).</p>
2. Reflecting	<p>(REF): Functions are: drawing on ‘experience and other modes to perceive things; dialectic with ‘experimentation’. Knowledgs transformed by ‘intention’</p> <p>Code if: subject indicates shows signs of integrating material; assimilating things into a reasoned understanding; grounding ‘experience’ in their own understanding, particularly through ‘iconic’ learning. Encompasses going back over clinical material and actively thinking about the material, thinking about process rather than just information giving</p> <p>May occur I relation to: considering one’s own perspective. Free expression of own information and ideas (e.g. story telling, recalling). Forming own meaning from experiencing.</p>
3. Conceptualising	<p>(CON): Functions are: to grasp things in contrast to/in tension with ‘experience’ (‘head over heart’); using language and public knowledge to comprehend; seeking insight; related to inductive learning.</p> <p>Code if: subject indicates signs of assimilating information; reasoning something through; integrating material to make sense.</p> <p>May occur in relation to: summarising; defining; offering / demonstrating an understanding; integrating material; inc. theories, data, literature, drawing on knowledge-base; analysis; logical comprehension of material.</p>
4. Planning	<p>(P): Functions are: problem solving and decision making; tension with “reflection” and “conceptualisation” Hypothetico-deductive learning.</p> <p>Code if: Subject shows ability to draw on understanding to converge down on action plans. Actively managing client case load,</p> <p>May Occur in relation to: Making predictions; analysis;logical comprehension of material. Planning next step; action statements; goal setting; “homework” assignments; deciding/summarising what to do next.</p>

5. Experimenting	<p>(E): Functions are: to foster hypothetico-deductive learning, based on engaging in action to verify/falsify understanding; problem-solving efforts to develop knowledge through 'trial and error' activities; in tension with 'observation' (action as opposed to perception). Knowledge transformed via 'extension'. Most likely to lead to 'accommodative' learning (e.g. substituting old skills or understanding with newer, 'better' view/skill; new/much modified schema/competence). Practicing new therapeutic technique</p> <p>Code if: subject engages in observable actions designed to try things out; to act on world so as to address puzzle/concern/worry/goal/etc. To rehearse a new skill (e.g. in order to see what happens, gain competence, or to get feedback)</p> <p>May occur in relation to: role play; learning exercises; assigned tasks (like an 'experiment')</p>
6. Other	<p>(O): Cannot decide on suitable category from above; not observable; other behaviours (e.g. social chat, paperwork); off task behaviour.</p> <p>(OI): Informing supervisor – trainee is telling the supervisor factual information</p> <p>(OL): Listening to supervisor – trainee is actively listening to the supervisor</p> <p>(OA): Asking supervisor to take an action – trainee makes a request of the supervisor</p>

Note. Text in red indicates an amendment made by the author.

Appendix O: Inter-rater Reliability for Teacher's PET Codings

Behaviour	Intraclass correlation	95% Confidence Interval	
		Lower	Upper
Listening/Observing	.997	.955	1.00
Supporting	.178	-.836	.965
Questioning	-.080	-.899	.942
Needs Assessing	-.250	-.928	.918
Goal Setting	-.250	-.928	.918
Restating	.000	-.883	.950
Reflecting	.043	-.873	.954
Interpreting	.574	-.625	.986
Formulating	.969	.592	.999
Managing	.910	.142	.998
Informing	.953	.445	.999
Guided Experiential Learning	.800	-.281	.994
Self-disclosing	.000	-.883	.950
Challenging	.928	-.248	.998
Disagreeing	-	-	-
Evaluating	-	-	-
Feedback	.750	-.392	.993
Other – not otherwise specified	.000	-.883	.950
Other – case information	.951	.429	.999

Table 4 Intraclass correlations for Supervisor Teacher's PET behaviour codings

Behaviour	Intraclass correlation	95% Confidence Interval	
		Lower	Upper
Experiencing	-.125	-.908	.936
Reflecting	.710	-.665	.993
Conceptualising	.915	.167	.998
Planning	.600	-.601	.987
Experimenting	.500	-.685	.983
Other – not otherwise specified	.817	-.235	.995
Other – informing	-.265	-.930	.916
Other – listening	.870	-.056	.996
Other – asking for supervisor action	1.0	1.00	1.00

Table 5 Intraclass correlations for Trainee Teacher's PET behaviour codes

Note. Text in bold indicates behaviours that were analysed in the study.