Supervisors' experiences of delivering supervision in trauma settings

By

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Volume I

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ACADEMIC DOSSIER
ESSAYS
Year I

Essay Title: What is the evidence base for formulation as a core clinical skill?

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Introduction

Throughout my pre-training clinical experience, I grappled with understanding the concept of psychological formulation. It seemed to me, to be an elusive and almost magical skill that only psychologists possessed. Seeing it as a psychological framework for understanding someone's problems was an appealing but somehow lacking explanation. If it is that easy, then why does it feel so complicated, and why can only psychologists do it, I wondered. I chose this essay in order to further my learning about this skill and demystify its components, with the view to beginning on the road to becoming more adept in its use.

Formulation is seen as a 'core skill of the clinical psychologist' (Division of Clinical Psychology, 2001, p.2). This is a view that is echoed almost unanimously in the literature (e.g. Butler, 1998, Kendejelic & Eells, 2007). Following Beck's (as cited in Chadwick et al, 2003) identification of it as 'the first principle of cognitive therapy' in 1995, endeavours to provide empirical support for formulation in cognitive therapy have begun to emerge. Some research into formulation in other approaches, for example psychotherapy, has been conducted prior to its appearance in 2001 as core skill (e.g. Luborsky & Diguer 1998 in Bieling & Kuyken, 2003). A review of the literature highlights however, that there is a definite paucity of empirical support for this concept.

The central argument of this essay is that formulation is a core skill, but one that does not carry a strong underpinning of empirical support. In exploring these ideas I have chosen to borrow some elements of a social constructionist perspective. I support the view that clinical psychology does not operate in a socio-cultural vacuum and underpin my review with critical psychology perspectives. I take the stance that it is imperative to consider what it is clinical psychologists are trying to do with these 'core skills', for example, improve psychological well being and secondly, are we succeeding? Finally, I propose that formulation is a core skill for the reflective practitioner.

The topic will be considered in following sections. Initially, I will provide a definition of the concept of formulation and a brief overview of the BPS document that outlines it as a core clinical skill. I provide a brief overview of the current consensus of
formulation. I investigate the historical origins of such a firmly 'taken for granted' concept. I then appraise the current evidence based culture and how this may influence the dominant discourses in contemporary psychological practice. A review of a sample of the studies that endeavour to place formulation in the context of the scientist-practitioner is presented. Within this review I also consider service user perspectives, to address the question of the usefulness of formulation. I argue that formulation is a core clinical skill for the reflective practitioner, and needs to incorporate more fully, the importance of socio-economic and cultural factors in the identification of mental health problems and intervention planning. I will use literature and reflection from my own clinical experience to explore the ideas outlined.

Formulation and the Core Clinical Skills

An immediate challenge in defining formulation is that multiple definitions abound in the literature. I have chosen the definition provided by the Core Purpose and Philosophy of the Profession (CPPP) document, as it is this document that is the springboard for the essay question.

'Formulation is the summation and integration of the knowledge that is acquired by the assessment process (which may involve a number of different procedures). This will draw on psychological theory and data to provide a framework for describing a problem, how it developed and is being maintained' (Division of Clinical Psychology, 2001, p.3).

This document outlines the aims for the profession as the following; 'to enable service users to...maximise their psychological and physical well-being... maximise their independence and autonomy, to have a sense of self understanding, self respect and self worth; to be able to enjoy good social and personal relationships; and to share commonly valued social and environmental facilities' (p.2). The paper also aims to provide 'psychologically informed ways of thinking' (p.2) to other professionals for the benefit of their clients. Psychologists will achieve these aims by 'assessment, formulation, intervention and evaluation' (p.2).

It is interesting to note that a cursory glance at the documents that support the paper do not appear to have any evident titles, or indeed titles that suggest, an empirical
basis for the core skills. This seems to concur with Crellin’s (1998) perspective, that by the early nineteen nineties, formulation had been cemented into the literature as an absolute and unquestioned concept.

Even a brief overview of the literature in the area, shows that praise for the skill of formulation is wholehearted and ubiquitous. Endorsements along the lines of formulation being ‘the lynch pin that holds theory and practice together’ (Butler, 1998), to ‘the cornerstone of cognitive therapy’ (Evans & Midence, 2005), and a ‘core psychotherapy skill’ (Kendjelic & Eells, 2007, p.66) are often repeated descriptions and undoubtedly familiar to the reader.

In 1995, Persons et al consider it unfortunate that there is little empirical support for the idea that ‘a good case formulation is essential for effective treatment’ (p.21). Conversely, other researchers (e.g. Eeells et al, 1998 and Bieling & Kuyken, 2003), consider it surprising that as the concept of formulation is so firmly embedded into our collective professional conscious, there is a striking lack of evidence that supports its usefulness and value. There is also a significant gap in the literature that allows for service user perspectives on its importance. This absence seems even more marked when one considers formulation in many approaches (Johnstone & Dallos, 2006) is seen to be a collaborative process that is often reliant on the client for verification.

As I began to review the literature, I found myself growing less clear on what formulation was, and how something that was so established had not seemed to warrant extensive research. This led to two queries, firstly where and how had such a firmly entrenched concept originated in light of this empirical gap. Secondly, if formulation has been carried out for more than 50 years, what was driving the current quest for evidence in recent years?

Past and Present, the Construction of Formulation

Crellin (1998) posits that the concept of ‘formulation’ began to emerge in the psychology literature during the 1950s. She aligns this emergence with clinical psychology’s burgeoning attempts to distinguish itself as a discipline as distinct from psychiatry.
Crellin (1998, p.20) notes that 'In response to the need to establish credibility on the basis of a body of expert and specialised knowledge, belonging exclusively to psychologists, the first set of Regulations (for clinical training) was published in 1967'. In 1969, formulation appears in the revised Regulations for training document (Crellin, 1998). This document states that 'there is no general agreement about how clinical problems should be presented, but that the psychologist has to identify and elucidate the psychological aspects of a patient's problem by making a provisional formulation...using relevant data, and reformulating the problems in light of test results' (BPS, 1969 in Crellin, 1998). The idea that 'reformulation' should be undertaken 'in the light of test results' highlights the long-standing scientific paradigm in which psychology resides.

As psychology evolved from being defined by assessment, to incorporating formulation and treatment, Crellin (1998) suggests that that 'the emphasis on formulating problems within a psychological framework was crucial in defining what competencies could be successfully circumscribed and closed off to others, and for deciding which aspects of a problem belonged to the domain of psychology' (emphasis added) (p. 21). This assumption seems to ring true when reading the CPPP document that states 'What makes this skill unique to clinical psychologists is the information on which they draw' (BPS, 2001 p.3). I would argue that similarly, what might make the skill unique to sociologists would be the information on which they would draw, and the same for psychiatrists, occupational therapists etc.

Butler (1998) also refers to this idea of determining the domain of psychology when she states 'the attempt to formulate a case, so as to apply an appropriately chosen method of intervention in the light of a particular theory, is one of the activities that makes therapists, as opposed to friends, accountable for their practice' (p.2)

While this type of reasoning lends itself both directly and indirectly to imbuing the psychologist with value, and more importantly a raison d'être, its flipside is what Kitzinger and Perkins (1993) argue is the method of 'privatising pain' (p.77). It is their view that psychology and psychiatry have appropriated normal human difficulty and pain into the realm of diagnosable pathology. The social consequences of this are a deskilling of community members in the managing of low mood, anxiety and so on, resulting in a breakdown in community support, as 'experts' (or in this case,
accountable professionals) are more frequently called upon to manage these sequestered problems.

In the early 1970's psychological testing was beginning to lose its central role in psychological practice. As Crellin (1998) notes 'this raised the question of whether psychologists were offering anything distinctive or were simply one of many professions offering to alleviate suffering from mental distress' (p.22). It is interesting that this question is still being asked some thirty to forty years later (some years later, Smail (2006) rather cynically suggests that 'a relatively inflated salary' is the sole basis for psychology's distinctiveness). Crellin (1998) suggests that this is the first of several attempts to identify the unique contribution of psychology, and that this uniqueness is thought to be rooted in 'scientific enquiry and empirical basis' (p. 22).

The Manpower Planning Advisory Group 1990 (cited in Crellin, 1998) aimed to settle this question about the unique skills and contribution of psychology to the alleviation of mental health problems. This report stated that 'only psychologists could formulate and respond to complex problems in terms of broad based psychological knowledge. It was this ability that differentiated and elevated them from other professions who might use psychological techniques. 'Psychologists' competence as therapists was simply assumed and not reviewed' (Crellin, 1998 p.24).

This historical review suggests that psychology's first challenge as a discipline was to differentiate itself from psychiatry. This struggle then evolved into justifying its distinctiveness and unique contribution to mental health. The notion of the scientist-practitioner is at the heart of psychological practice, and perhaps its unique value. In one respect it could be viewed as ironic that formulation as the essence of clinical psychology is a concept that does not appear to have been rigorously subjected to scientific investigation. Conversely, I think it may be useful to consider how the scientific paradigm has evolved and is playing out in the current climate of psychological practice. It is possible that the defining empirical characteristics of psychology may form part of its dethroning as evidence and justification is currently sought for almost every psychological endeavour.

Formulation and the culture of the 'evidence base'
Priebe & Slade (2002) posit that the deinstitutionalisation of mental health services that began in the 1960's and their subsequent evolution, sparked an interest in research in service provision. 'The creation of an internal market at the beginning of the 1990's meant that providers of healthcare had to render evidence of the effectiveness and efficiency of services' (Priebe & Slade 2002 p.29). This requirement then went to reach government level with the publication of The National Service Framework for Mental health in 1999. This highlighted the necessity for an evidence based culture in mental health and in some respects paved the way for a future culture that is now beginning to emerge, of the commission of services based on performance. This sanctification of the 'evidence base' began to permeate individual clinical psychology interventions, via the establishment of the National Institute for Clinical Excellence (NICE) in 1999 which provides 'guidance' on the most appropriate treatment for the different disorders in mental health.

It would appear that clinical psychology is embedded into an evidence based culture, and embedded into clinical psychology is an underpinning of research based practice. Whilst superficially these two frameworks seem to complement each other, a difficulty arises if research does not support the clinical intervention. Smail (2006) rather scathingly opines that 'since we cannot afford to discover that such treatment (e.g. cognitive behavioural therapy) doesn't work, critical thought, genuine empirical enquiry and (in the best sense) scientific detachment have become encumbrances to the smooth advance of professional influence and no longer figure seriously in our discourse' (p.17). I consider this to be a somewhat extreme view, and, in this case, think it important to attempt a critical review of the empirical basis of formulation, as a core clinical skill.

What the Research Says

An initial challenge in reviewing the vast amount of literature in the area was in locating articles that seek out the empirical basis of formulation and do not simply repeat assumed, taken for granted acceptance for it.

Bieling & Kuyken (2003) describe two approaches to the research in cognitive behavioural therapy. The first being a top down approach, i.e. if the theories that underpin cognitive case formulation have an evidence base then by default, the
formulation that integrates these theories will also be empirically supported. The second approach is that of a bottom up perspective. The authors describe this as questioning if the formulation is ‘reliable, valid and positively related to outcome’ (p.59). I chose to review the research that addresses this ‘bottom up’ perspective. Although they describe this in relation to CBT, I consider it to be a pertinent model for analysis, when looking at other approaches. It is also amenable to alignment with the core thrust of this essay, which is looking at what formulation as a core clinical skill is trying to achieve.

Reliability

Although, Johnstone (2002) urges caution when exploring the question of reliability and validity, I think this component of the empirical process does merit some attention. I see it as invaluable when looking at how research has tackled the question, the inevitable difficulties in measurement and how it then influenced the direction of future research.

A review of the literature suggests the common consensus is that, the bulk of the evidence shows moderate to good reliability for descriptive aspects but poor for inferential aspects (Bieling & Kuyken, 2003) of formulation. One of the first key studies examining cognitive case formulation was carried out by Persons et al (1995). This study investigated inter-rater reliability with regard to overt problems and underlying cognitive mechanisms. When reviewing this paper I was surprised at how the authors own interpretations of their findings differed from future interpretation, and also how one clear limitation that is to my mind, not adequately addressed.

This limitation relates to the development of the problem criterion list. The first hurdle in the study was to ensure that the two expert judges agreed on the problems. In terms of firstly identifying overt problems for one client, the two judges initially did not appear to show strong reliability (the judges needed to consult over the absence of one problem and the addition of another one). Perhaps predictably (but without irony), Persons et al (1995) subsequently find clinicians’ ability to identify overt problem as ‘moderate’ and even go so far as to express disappointment that two problems were missed by ‘one fourth to one third on the second case’ (p.29). Interpretation of the reliability for the underlying cognitive
mechanisms is described as 'promising but needs improvement' (Persons et al., 1995, p.30). Inter-rater reliabilities were good when averaged over five clinicians but poor for individual clinicians.

There interpretations seem at odds with future reviews that cite this article (amongst others) as providing, for instance 'generally good agreement among judges in identifying manifest presenting problems'. (Bieling & Kuyken, 2003, p.59, Kukyen, 2005). Or indeed, reviews that reference this paper, as providing evidence that there is good agreement for the descriptive element of formulation (e.g. Evans and Midence, 2005, Butler, 2006).

I think this type of referencing of the 'evidence base' highlights quite nicely, the question of whether the emperor is indeed clothed, as Kukyen (2006), so eloquently put it. It also raises the question of how and where 'the consensus' originates, and on how much evidence, it is based on in reality.

The difficulties in measuring accuracy and reliability are similar in the psychodynamic field. A review of eight studies examining the Core Conflictual Relationship Theme (CCRT) case formulation method, (Lubrorsky & Crits-Christophe, 1998 in Bieling & Kuyken 2003) and clinicians' agreements on it, showed moderate to good reliability. Bieling & Kuyken do however, draw attention to the fact that the CCRT group has completed the majority of this research, and their results remain to be replicated by independent researchers.

What I see as a somewhat disabling limitation of the studies mentioned above is the absence of the real world component. Kukyen et al (2005) also highlight this issue and suggest that these studies and others do not use data that is available in the real world. This data might include 'comprehensive intake interview, standardised assessment instruments, downward hour technique' materials (p.1190). The inclusion of these may permit increased external validity.

However, the hunt for reliability generates some challenging questions that include some of the following; can clinicians even identify presenting problems? Is one formulation more right than another and thus is one therapeutic approach more right than another? And fundamentally, does the difficulty in matching the real world to
the experimental condition highlight the overarching flaw in a logical positivism paradigm?

Deftly sidestepping these challenges, the thrust of research has surged forward into scrutinising the utility of formulation. An arguably valid point proposed by Bieling & Kuyken (2003) however, is that a reliable formulation does not automatically equal a correct one, or indeed one that is useful to the client. Butler (2006) continues in this vein and suggests that ‘there is no one right way of doing formulation’ (p.8) and also ‘an incomplete or incorrect formulation can still be useful’ (p.11).

The Usefulness of Formulation

On a somewhat bleak note for cognitive behavioural therapy, Bieling & Kuyken (2003) conclude that ‘there is no evidence to confirm or falsify the validity of cognitive case formulation’ and that ‘there is limited evidence linking case formulation with outcome’ (p.60). Butler (2006) however, offers alternative assumptions in measuring the usefulness and value of formulation. One of these being that the formulation is a hypothesis. Another being the ‘meta message’ that the formulation sends to the client. This refers to the information they have shared with the therapist, has been heard, acknowledged and makes sense. In order to seek confirmation or disconfirmation on this assumption of utility, it seems intuitive to look at the perspectives of those at the receiving end of our formulations.

Spotlight on the Service User

'Tread carefully because you tread on my dreams'

William Butler Yeats

I chose to include this quote from the poet Yeats, because after the overview of formulation I have presented, I had to some degree, lost sight of what the information in a formulation actually pertains to. I would speculate that in considering this vast area of research I am not alone in doing this. Indeed the previously noted scarcity of research that focuses on what the recipients of our formulations have to say about the matter, lends some credence to this speculation.
Evans and Parry (1996) investigated the impact of reformulation in a Cognitive Analytical Therapy (CAT) approach. Whilst participants in this study did rate the formulation as useful, emotive and important to the therapy, analysis failed to show an improvement in symptoms. There was no change in the perceived helpfulness of the sessions, pre and post reformulation and no change in the helping alliance. It is possible that the measures used, did not tap into the clients true value attributions of the reformulation. The authors also argue that it is the process of working toward the formulation that is of most importance and not just the presentation of it. These concerns raise the difficulty of how to measure formulation if it is so closely interwoven into the fabric of the intervention.

Chadwick et al (2003) encounter similar difficulties when exploring the impact of case formulation psychosis on the service user. Their findings are somewhat mixed with nine service users (out of eleven) reporting that they had found the formulation useful, six reporting positive feelings towards it and six reporting negative feelings toward it (although four of these six had also recorded positive comments). Three service users reported no emotional impact due to the formulation. On the other hand, therapists generally reported positive feelings toward it, with the view being that it was helpful to the therapeutic alliance, helped them adhere to the model, and increased confidence that CBT was an appropriate intervention for the client.

This last point is especially interesting as it highlights somewhat circular reasoning; the formulation supports the intervention, which supports the formulation. It also highlights reality of what Butler (2006) raises as one of the objections to formulations, i.e. that formulation can suffer from a risk of 'fitting someone to a formula' (p.10).

Although this study did not support its hypotheses that the formulation would reduce distress and improve alliance, its authors are emphatic that this does not mean case formulation does not have value. It is likely that a personalised formulation may be a difficult thing to take in, and it might be the first time a service user sees this summary of the projected factors that precipitate and maintain their difficulties, written on paper. This may be tapping into painful emotions. Again this underlines the difficulty in apportioning formulation out of a (hopefully) useful intervention. It might be helpful to gather qualitative longitudinal data to construct alternative inroads into this problem.
On a positive note, P.S. (2006), offers their (it is an anonymous personal account) own perspective of how useful the formulation was in their personal experience of schema focused therapy. P.S. describes it as tool that was 'enormously helpful' (p.13). Also recounted is a 'sense of ownership, because I had contributed data towards the formulation'. In addressing the question of accuracy, P.S. states that 'it cannot be completely accurate at the beginning. As therapy progresses it can be refined' and 'it should be allowed to grow organically as therapy continues' (p.13).

I particularly like this last description of the process, as to me it underscores the importance of the usefulness of the formulation to the person who lies at its centre. It also alludes to what Harper & Moss (2003) refer to as 'collaborative sense making' (p.8) as opposed to 'an objective or semi-objective formulation of a problem “out there”'. It is this idea then that clinicians operate as people in the world, just as clients do. As Harper & Moss suggest, we are 'sharing our expertise of various kinds and learning from clients expertise on themselves and their experience' (p.8). Reflexive and reflective practice would logically be a fundamental component of this process.

**Formulation and the Future. Will the reflective practitioner lead the way?**

'So, just like that, we all became reflective practitioners' (Newnes, 2006 p.38)

Newnes (2006) somewhat irreverently, states that 'claiming to be a scientist-practitioner profession and not living up to the mark, just didn't work; (p.38). I would propose (albeit tentatively), that it just didn't fit.

Harper and Moss (2003) propose another understanding of formulation (as distinct from a scientifically based one), an understanding akin to the generation of peace agreements. They suggest that this is almost alchemistic in nature. It can be 'fluid, messy, subjective and passionate yet those involved are still admirably engaged in the task of trying to build a structure, a reasonably clear way to go forward' (p.8).

To enter into this sense making with another person it is necessary to attempt to take a reflexive and reflective approach. Harper and Moss do not suggest that theoretical underpinnings of human behaviours are jettisoned in this approach, only
that 'those theories are servants of a larger engagement' (pp8). Additionally, caution is advised against 'co-creating any reality where anything goes' (p.9), which Smail identifies as naïve social constructionism (Smail, 2002, in Harper & Moss, 2003). They put forth the idea that 'in systemic terms, a formulation is a map rather than the territory' (p.8).

Within this map building, it is imperative for the clinician to be aware of their position in the world as well as their clients'. In my limited experience as a co-author of formulations, I have struggled to balance my own basic understanding of theory, preferences for certain parts of a theory, and the gradual unveiling of blind spots in my perception of the world, with the story that the client is sharing with me. A lot can go into a formulation, but equally a lot can be left out.

Presumably the strength of the reflective practitioner resides in their perpetual endeavours to be aware of what is happening in the therapeutic relationship and what each individual is bringing to it. Ideally this should result in what Harper & Moss (2003) suggest are the elements of a good formulation, that is, 'sensitivity to context, show commitment and rigour, and be transparent and coherent'. (p.9). They also include the positioning of the clients concerns in a social milieu, as a measure of value.

I believe that in order to help maximise the usefulness of formulation, acknowledgement of the social context in which someone lives is of paramount importance. Psychodynamic approaches have been accused of being reductionist and lacking context (e.g. Pilgrim 1992). Or as Boyle (2006) more diplomatically describes 'in spite of strong evidence about the importance of ... social circumstances in the development, maintenance and expression of emotional and behavioural problems, we continue to privilege theories which locate problems inside people’s heads' (p.5). Although a full review of this perceived failing is beyond the scope of this essay, I think it is important to note that the reflective practitioner has a valid role in formulation within approaches that seek to redress this imbalance (for example, systemic models, a social constructionist model, and social inequalities models).

Kendjelic and Eells (2007) note that there is a paucity of research on the multicultural facets of formulation, and currently there is no agreement on how best
to incorporate this information into a formulation. While this state of uncertainty is hardly shocking in a westernised framework of mental health, it does exemplify the need for the reflective practitioner to resist a reducing and individualising approach to formulation. In order to contribute to a meaningful and useful formulation for the client, it is imperative to be aware of one’s own culture, class, background etc and how this may influence the way in which theory is bridged to practice.

Conclusion
In this essay I have sought to elucidate the question of whether or not there is an evidence base for formulation as a core clinical skill. It seems that there are no easy answers to this question, and if anything, the question begets more questions and ad infinitum.

As a clinical psychology trainee with an arguably superficial understanding of formulation and its constituents, I opted to borrow from social constructionist and critical psychology schools of thought, to make sense of the proposed answers. This mode of interpretation is most meaningful to me, and I think allows for a broader understanding of the question.

A historical perspective contributed to the clarification of how this ‘taken for granted’ idea originated and the paradigm in which it blossomed. An overview of the current culture of evidence based practice, and its influence on psychological endeavour was co-opted to shed more light on the driving forces that are currently driving evidence finding.

In reviewing the literature, I made the decision to include the references that I felt best addressed the relation of formulation to improving wellbeing and making sense of an individual’s difficulties. Or more specifically, what formulation as one of four core clinical skills is aiming to achieve. This research did not seem to sing the same praises that were to be found in the literature more generally. The difficulty in selecting out formulation from the intervention more generally is in my mind, a rather significant hurdle to developing its evidence base. Also of note are the methodological limitations inherent in this type of research.
It could be argued that substituting the scientist practitioner model for a reflective practitioner model, is a shrewd side-stepping of the apparent difficulties in accruing evidence for formulation. I do not consider this to be the most useful perspective to take however.

The assumption of a reflective model of practice that aims to incorporate the social context in which the person is located, has to go some way to producing a useful formulation, that helps a person make sense of their difficulties (Hagan & Smail 1997 in Harper & Moss, 2003). The difficulties in 'proving' this usefulness should not preclude its inclusion from the therapeutic encounter. Johnstone (2002) advocates the use of different types of research (e.g. qualitative studies with service users) in order to contribute to a more sound basis). In the meantime, the usefulness and quality of the formulation could be assessed in collaboration with the client on a case by case basis.

The implications of reflective practice, and a social inequalities model, on service provision, would hopefully be less individualising and reductionist for the client. Ideally the acknowledgment and inclusion of cultural, class, and gender differences would offer a more meaningful formulation to the clients that we see. The development of this reflective and inclusive approach is something I seek to further in my own practice, both through supervision and critical review of the evidence and opinions that abound in the literature.
References


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Year II

Essay Title: Emancipation versus empowerment (Stickley, 2006). Is the involvement of service users and carers in the development and planning of services perpetuating existing power imbalances?

Word Count: 4944
Introduction

I chose this essay title due to my interest in the area of service user and carer involvement theory and practice. In my clinical experience, I have found a range of differing opinions on involvement and diverse practices in clinical settings. An issue that I feel often resurfaces is that of 'tokenism' and more specifically, how to involve users and carers in a meaningful way.

I have interpreted the part of essay question that refers to 'emancipation versus empowerment' as providing the backdrop to the question of whether involvement is perpetuating power imbalances. I plan to deconstruct the terms used, i.e., service user, power imbalance, emancipation and empowerment. The purpose of this deconstruction is to begin to question the use of language in this area and how language itself can perpetuate difference and imbalance. I will briefly set out Stickley's (2006) argument for emancipation versus empowerment. This will be followed by a history of involvement. Subsequently I will present the argument that service user and carer involvement in its current form does perpetuate power imbalances.

This argument is supported by an exploration of the empirical investigation into how user and carer involvement is implemented and its outcomes. This will be underpinned by theories of power (Foucault, 1971 & Lukes, 1974, in Masterson & Owen, 2006) and proposed models of user and carer involvement.

Although efforts have been made to include the perspective of carer involvement, the majority of the research and policy in the field relates to that of the service user. However, I feel that for the most part, the arguments put forward here also relate also to carers.

Terms

The term 'service user' will be used to describe people whom currently or have previously, receive (d) input from mental health services. The term carer will be used to describe individuals that care for those with mental health difficulties.
I am aware however, of the myriad of labels (both self generated and not) that are used to describe members of this unarguably diverse group, e.g. survivors, clients and consumers. And as with most categorising terms, each of these carries with it, its own implicit ethos or construction of what it is representing, for example, the word survivor carries a considerably different meaning to consumer.

I would argue that the term ‘service user’ itself, suggests a rather false premise of service choice, with the implicit notion that services are there to be availed of and can be discontinued or changed at any time, based solely on the users’ prerogative. I believe that this use of language infuses the issue with a false sense of freedom and personal choice that is plainly at odds with the current medical model of mental distress and the risk aversive NHS culture.

However, as much of the literature in this area concedes, these terms will have to suffice for now, with the acknowledgement that service users and carers are not homogenous groups and that the arguments set out here will not, and could not represent all facets of the involvement movement.

**Power, empowerment and emancipation**

Lukes (1974, cited in Masterson & Owen, 2006) posits three faces of power. These faces of power refer to how governments exercise control over people. The first of these is open decision making, i.e. the public involvement in decision making. The second refers to non decision making, i.e. the power to control what is discussed (i.e. the dominant discourse). The third refers to ideological power or ‘the manipulation of roles and identities, so that social groups can be persuaded to accept certain situations without conflict (Masterson & Owen, 2006, p. 21). It is at these three faces of power that we can consider the question of the maintaing of power imbalances and empowerment in service user involvement.

Empowerment, Stickley (2006) suggests is is an act that is done to recipients, that is, it implies the giving of power which ultimately maintains the status quo, as those in charge determine how and when users can be empowered. This idea of power as something that is a finite resource that exists between people is consistent with Weber’s (cited in Lloyd, 2007) theory of the constant sum of power, in which for power to be gained, it is lost from somewhere else. This conceptualisation is at
odds with the psychological or feminist theorising of power as something that can be self generated and shared, that is, 'power with rather than power over/power for' (Masterson & Owen, 2006, p. 21).

'Empowerment'
It has to be noted that Stickley, although strongly advocating for the theme of empowerment, does not offer much explanation of what the term means. It is described as the 'potential for individuals to take power, rather than have it given' (p. 571). Furthermore, Stickley draws from Campbell's (2002) description which states that emancipation is the ability to take action, perhaps outside the prevailing institution of power.

Emancipation versus empowerment (Stickley, 2006)

In summary, Stickley uses the theory of critical realism to advance the idea that service user involvement serves only maintain existing power imbalances. Critical realism refers to the idea that there is an objective reality 'out there' that is separate to our descriptions of it. It also posits that knowledge is bound to culture and time and seeks to understand how things are the way they are (p. 571). He suggests that emancipation refers to action rather than involvement, and concludes that user owned, designed and implemented action is 'indeed better than empowerment' (p. 575). Although perhaps intuitive, there is no consensus offered in support of this value judgement.

Background to the service user movement

Service user agency, action and protest are not new concepts. The renewed dominance of a biological and neurological model of mental illness in the 1980's combined with the emergence of a consumerist market in health services in the 1990's has led to a shift from radical survivor action to what some would argue as the more muted service user or consumerist involvement (Campbell, 2005).

The NHS and Community Care Act in 1990\(^1\) was the first policy document to formalise a requirement for user involvement in service planning (Tait & Lester,

\(^1\) This act created an internal market in the NHS and stimulated local authorities to encourage private and voluntary provision of services (Hickey & Kipping, 1998)
This was followed by several more policy documents emphasising the requirement for service user input (e.g. DoH, 2000, 2001). It would seem that the demand for service user input continues to grow. Pilgrim and Waldron (1998) suggest however, that these additions to policy may be more to do with consumerism\(^2\) rather than the inherent right of individuals to have their voices heard.

Perhaps not so publicly advertised, are changes in policy focusing on risk and what some authors would describe as coercive care. This begs the question of how much of the governmental conception of involvement is rhetoric, due to a notable absence of involvement or consultation when it comes to the business of minimising perceived risk to the public and the burgeoning culture of defensive clinical practice.

Whilst undoubtedly much has been achieved, there have been considerable difficulties with the actual implementation of the somewhat intangible theoretical construct of ‘service user and carer involvement’. The slur of the ‘professional user’ has been bandied about in the context of representativeness and user involvement has been seen as tokenism and/or as a means of legitimating governmental policy.

A review of the research carried out in this area underlines the contentious issue of ‘representativeness’ of the involved user or carer. It seems that those who get involved might often deemed to be ‘too articulate’ (Lindow, 1994 cited in Tait p.172) and do not accurately represent the ‘typical patient’ (p.172) who may be seen as passive or compliant. Lindow points out that: ‘as they [managers], are selected for their expertise and experience so are we. We ask, would workers send their least articulate colleague to represent their views or the least confident nurse to negotiate for change in conditions’ (p. 172)?

This is an interesting point and serves to underscore the potentially opposing aims of involvement for users and staff. That is, users may be getting involved to effect change at an organisational level as opposed to the service who want to record that they acquired ‘the typical patient’ or even better, a ‘hard to reach patient’ to legitimise policy changes.

\(^2\) Simpson & House (2003) describe consumerism as ‘an approach based on the assumption that users have a choice of services and through existing choice can influence service provision’ (p: 89).
Bearing the above in mind, it is important however to note that a more valid criticism with regard to representativeness is the predominantly white male face of user and carer involvement (Campbell, 2005). Although this has been highlighted as something that needs rectifying in the wider rhetoric, to my knowledge, there is limited practical guidance on how to go about doing this.

It is accepted that there are varying models of involving users in different services. Several different frameworks of user involvement have been proposed in addition to multiple theories of power and empowerment. For me, this has contributed to a somewhat confusing field of theory to wade through.

The conceptualisation of empowerment as operating at two levels, the individual and the social, or in other terms, the personal and the political is, I believe, a useful framework in which to theorise the issue and so I will underpin the following discussion with reference to these levels. As so many frameworks abound for considering involvement I will interweave Lukes' (1974, cited in Masterson & Owen, 2006) three faces of power with different levels of involvement. I have chosen this approach because it provides the best fit to my understanding and own thinking on the area. I am aware however that in focusing primarily on this approach, other conceptualisations of involvement may be omitted.

Decision-making

Lukes's first face of power is that of decision-making, that is, power can be located in the ability to make decisions. Here, I broaden the understanding of this power face to consider users' ability to make decisions. This is a somewhat contentious area in user involvement in planning and delivery of services and can operate both on a personal and collective level. A study exploring clinical psychologist views' of service user involvement (Soffe, 2004) offers the following quote from one of its participants (p. 4):

'What's left for user involvement is that bit about, well you (service users) get to decide what colour the curtains are then. And that's actually all we're going to ask you about. So thank you very much for all those proposals about safe houses in the community, and not wanting to go to hospital or have twenty four hour access, but actually we're going to build this and you (service users) can tell us what colour it should be'.
This quote highlights the question of how to meaningfully involve service users and more specifically in which decision making processes are they 1) involved in and 2) influential in. It would seem from the research that much of the decision-making or policy making remains in the hands of the professionals.

It becomes clear when reviewing the research, that questions about the process of involvement and its personal effects on participants form the dominant discourse. There is comparatively less research (at least in formal peer reviewed journals) about the concrete, structural changes that involvement has resulted in. This begs the question of how can authentic joint working really occur when there are so many varying and possibly conflicting agendas and aims for involvement. This is an issue that will be returned to when consultation and partnership are considered.

Campbell (2005) highlights the following advances in decision-making: 'independent advocacy, consultation and monitoring in connection with existing services and input into the development of new services; provision of training and education to all groups of mental health workers and involvement in selection of employees; undertaking service user led research, creating and running service user controlled services' (p. 77).

Whilst by no means seeking to deny these achievements, the difficulty here is with their formal recording and review, that is, to what extent do users get to make decisions about recruitment, how much input is there in monitoring services etc. It is important that these changes are centrally collated and reviewed in order to uncover the picture of user involvement.

Due to space constrictions the following explores how power imbalances are maintained in decision-making, focusing on the Care Plan Approach (CPA (DoH, 1999) and the management of risk. This incorporates both personal and social empowerment.

The CPA
This is perhaps an example of increased user involvement around decision making and influencing the planning of services directly related to them. This approach was designed to ensure that the needs of individuals with mental health problems are
met, and to ensure interagency working for the individual. This seminal piece of policy is believed to emphasise users as being at the centre of their care. A more lacklustre description is offered from the DOH (2008):

*The CPA is a way of describing what you need in order to get all your needs met. You have a right to a reasonable amount of choice about when and how you wish to be treated, whenever possible.*

It is hardly the discourse of emancipation. Research carried out by Perkins and Fisher, (1996) suggests that care plans do not always fully represent the users' contribution. Rose (2003) explored users' knowledge and understanding of the CPA and found that awareness of the CPA in the sample was below 50%.

I would argue that involvement at this personal level can perpetuate power imbalances and can be seen as little more than rhetoric and a paper exercise for those involved. This leads to important considerations for clinical practice and working to ensure a culture of transparency and encouraging user and carer autonomy around these procedures.

**Risk**

In marked contrast to increasing users and carers' autonomy in services there has been a parallel contrasting emergence of legislation that relates to managing risk to the general public (DoH, 2007). Laurence (2003) describes this idea of risk as the 'fear that drives the mental health system'.

The area of risk assessment and management has become more and more crucial in recent years. It is interesting to note the level of user and carer involvement in this arena of service planning and delivery. While policy dictates that users should be involved in risk assessment and management, there is limited guidance on how to achieve this.

Perhaps unsurprisingly, there is little research in the area. A study carried out by Langham and Linard (2004) highlights that the majority of service users asked had not seen copies of risk assessments carried out on them, and often were not aware that they had even been carried out. Indeed some clients were prohibited from participating in this research (by the psychiatrists consulted), as they were unaware
that they were the subjects of risk management plans. Langham and Lindow conclude that user involvement in this area is variable at best, and in part, depends on the individual professional involved.

It is interesting that as risk assessment and management is seen as a lynchpin of current services, yet users and carers have both at an individual and collective level, been left outside this decision making process.

The exclusion of users at the pivotal point of decision-making is evident in the recent change to the Mental Health Act. Although 'concessions' have been made, for example allowing people rights to advocacy if they believed they are detained unfairly, the amendments to the Act focusing on increasing coercive powers went ahead against strong opposition from several user and carer groups. It would seem that although governmental rhetoric is calling for involvement, actual policy decisions will proceed as planned, with or without user agreement. In this case it seems that involvement serves only to maintain or perhaps even give more credibility to the status quo.

This is an area that clinical psychology as a profession can take heed of imbalances and work to influence teams thinking and challenge the dominant discourse of risk, to effect change.

Carers and decision-making

Although carers form a large group, Arksey (2003) suggests there are 1.3 million people caring for a relative with mental health problems or dementia in the UK, (a number which is likely to have increased in the last five years), there appears to be limited research into carers' involvement in services.

Studies that explore inpatient settings (e.g. O'Brien et al, 2004) have found that the carers interviewed reported often being excluded from the formal process of care. They reported little to no involvement.

Wilson and McAndrew (2008) explored carers' perception of involvement. The authors interviewed carers in an inpatient setting and found evidence to back up other reports. They suggest that in some cases carers are not even being involved
at the most basic level of involvement, i.e. information/explanation (Hickey & Kipping, 1998). In addition the carers interviewed stated that they would like to work in partnership with staff, but this partnership was perhaps reliant on a change in staff attitudes and relinquishing their 'expert' positioning. This is a useful message to take to clinical practice and where I see I could work on remaining open and curious about the expertise by experience that users offer.

Non-decision making and consultation

Luke's (1974), second face of power is that of non-decision making, or what can also be understood as agenda setting, that is, determining what is discussed and what is not suitable for discussion. This theorising of power has parallels to what Foucault (1971) describes as the 'dominant discourse'. These dominant discourses will shape socially acceptable ways to view constructs, such as the medical model of mental illness (Boyle, 2000 cited in Masterson & Owen, 2006). It would seem that it is these agendas or discourses that users are sought to consult upon.

When applying the idea of consultation to the practice of user and carer involvement, it has been suggested that consultation would lie on the consumerist end of an involvement continuum (Hickey & Kippin, 1998). The authors propose a continuum-based understanding of user and carer involvement. This incorporates a consumerist and a democratisation approach. The consumerist approach includes 'information /explanation and consultation'. The democratising approach incorporates partnership and user control. Although this model is I believe, an over simplification of a very complex issue, omitting differentiation of personal and social empowerment, it is a helpful framework to break down involvement. Consultation also falls under what Peck et al, (2002) describe as one of three constructs of user, that is: recipients, subjects of consultation and agents of control. It is at the level of consultation that the maintenance of a power imbalance is most marked.

Consultation with users and carers seems to form a large bulk of the research in this area. Recent legislation (DoH, 2006) has emphasised the legal requirement for patient and carer involvement in the NHS, an initiative that is underpinned with the vaguely menacing tagline: 'You will be involved'. This legislation sets out more

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2 In practice there is considerable overlap between decision-making and consultation in user and carer involvement, but for the purposes of discussion I have separated them here.
specific mechanisms of consultation although the language and the theme of this legislation adheres firmly to a consumerist approach and appears to do little to promote the idea of users and carers as equals but more as boxes to be ticked before changes in services can be made. There is little to suggest that users might propose changes that would then require consultation or discussion with professionals. That is, the agenda has already been set.

This concurs with a discourse analysis of government publications carried out by Hui and Stickley (2007). They suggest that for the most part the agenda has already been set in regard to policy and ‘opinions of users are unlikely to have any impact on what has already been decided’ (p. 421). They also suggest that there is a propensity to anticipate what users want, or as one participant in the Rutter et al (2004) study states: ‘The art of psychiatry is getting users to want what they need’ (p. 1975).

Maguire (2005 cited in Hui & Stickley, 2007), asserts that ‘users were sold a solution, instead of being involved in creating one’ (p18). This leads to the question of whether consultation is a construct of the past that furthers the argument that empowering users and carers is something that we as professionals can do through consultation.

Rutter et al (2004) highlight this difficulty with opposing objectives for user and carer. Following case studies carried out across two London Mental Health trusts (seeking staff and user feedback) they determined that the users in this sample sought greater influence and more concrete outcomes to involvement, whereas managerial staff were content with consultation of existing user groups. They describe involvement as remaining ‘the gift’ (p 1981) of management staff, with users getting little opportunity to influence the agenda with issues they felt were of importance e.g. compulsory detention.

Findings from research carried out by Connor and Wilson (2006) suggests that another area where users and carers are less involved in setting the agenda for are that of medication and ‘talking therapies’. The authors posit that although users frequently emphasise their desire for increased access to talking therapies, a large proportion of research money is allocated to medication.
Whilst taking into account the current Improving Access to Psychological Therapies drive, it seems that the landscape of care for those with what are described, as 'severe and enduring mental health problems' remains medication focused. Connor & Wilson conclude that their study adds to the research base of users as 'subjects of consultation' (Peck, 2002 italics added) but not as agenda setters or 'agents in control'.

In order to determine how this question of agenda setting might act at a local level, Hodge (2005) carried out a discourse analytic study to explore how 'power is used to exclude certain voices... to give legitimacy to the status quo' (p. 65) in a service user forum. Here, Hodge found that topics that were of pressing importance to some users were deigned as 'no go' areas, such as the use of electroconvulsive therapy (ECT) or alternative approaches to mental illness. It seemed that in this instance the agenda for the mental health professionals present heavily influenced this 'user led' forum, and issues that might challenge the status quo were off limits. Although this study focused only on one forum, and is limited in generalisability, it points to a helpful means of deconstructing the rhetoric in this area and applying a microscope to the practice of user involvement (Ul) and its inherent power dynamics.

Here it is important to reflect on and try to be aware of how the linguistic devices we employ in a clinical setting may also serve to perpetuate power imbalances, and how covert disempowering through agenda setting can be a frequent occurrence.

**Partnership and agents in control**

Partnership and user control are at the democratisation continuum of involvement as outlined by Hickey & Kipping (1998). Peck (2002) also posits 'agents in control' as the more involved end of Ul. I have combined these two as I think the notion of control implies a necessary level of partnership or equality in the relationship in order to be in the position to effect change. That is, one cannot exert power over an institution if one is not perceived to have at least an equal standing in knowledge, responsibility or authority.

Campbell (2006) explains the difficulties with the rhetoric of partnership, for example that it 'implies a degree of equality between partners that more often than not, does
not exist. Partnership also suggests that there are common goals to working together and that the process, the aims and objectives and the possible outcomes are being openly discussed from the outset' (p. 578).

The Involving patients and the public, NHS document (2006) uses the word partnership to describe much of the mechanism of involvement. On reading this document it seems that this is a linguistic device used to imply the ideas of shared goals and equality that Campbell describes, without really considering what this proposed partnership would look like at a national level. The power imbalance remains, yet is perhaps more covert than explicit in the more recent policy documents such as this.

A cross sectional review of user groups and psychiatry providers across London (Crawford et al, 2003) found that none of the trusts had models of involvement that met national standards and that involvement was heavily based on information sharing rather than partnership. Interestingly, Honey (1999) found in a qualitative exploration of 'consumers' views, that many were content with their consultative role, and were not seeking anything else. This raises the question of whether the concept of partnership or increased control can be universally assumed that users want. Perhaps this is an assumption of those holding the power, and the reality may be that users who do want more autonomy/control do not think it is feasible or desirable to partner up with services and may act outside them.

**Manipulation of roles and identity**

Lukes's third face of power is that of manipulation of role and identity. Masterson & Owen (2006) suggest that user and carer groups 'that challenge social-wide negative ideologies of mental illness represent empowerment at this third face' (p. 28). I would argue that these groups, including Survivors Speak Out (SSO), the Hearing Voices Network (HVN), Mad Pride and the World Network of Users and Survivors of Psychiatry move beyond empowerment and fit into what Stickley (2006) describes as emancipatory approaches. These groups generally work outside the confines of the NHS and have contributed to challenging the dominant discourse on mental distress as wholly negative (e.g. Mad Pride), contributed a non-medical approach to managing the hearing of voices (Hearing Voices Network) and have organised collectively and supportively to challenge the prevailing paternal and
coercive psychiatric driven model of service provision (SSO) and WNUSP. A practical example of an initiative that appears to surpass the limitations of empowerment is that of the Recovery model.

Former service users and others have championed the recovery model, as an alternative and critique to the medical model of pathology. This is a distinct and concrete outcome of user involvement in mental health services, and effects both personal and political change. This model has been described as 'a far reaching critique of current prevailing mental health policies and practices' and is 'both a pathway for empowered action and a strategic necessity to legitimise expanded service user rights, autonomy and self direction' (Masterson & Owen, 2006. p29).

Ultimately it moves away from a symptom reduction notion of recovery to one more user led and identified. This change signifies a shift in the focus of traditional ideas of recovery, and puts users at the centre of their care.

Bridging the personal and political

Anderson (1996) argues that consumerist or individual empowerment is detrimental to social empowerment or working at Lukes's third face of power. Ryles (1999) suggests that 'because of inequality and oppression, peoples' disempowerment cannot be summed up as result of personal disability. Therefore the only impactual response must be through group action that is socio-political'. (p. 25). However, I feel that this is something of the proverbial baby going out with the bathwater and disregards the significant cultural changes that have been achieved by involvement at all levels. It would more reasonable to perhaps step out of academically constructed concepts of power and consider change that is happening at both the personal and political level in a complementary rather than opposing framework (Kendall, 1998).

Social inclusion and recovery approaches are perhaps areas where the personal overlaps with the political and where meaningful changes regarding employment and relationships (what users would define as priorities, Perkins, 2001) are in the making. Perhaps the issue is more of influence rather than power (Campbell, 2001) and the acknowledgement that change is a process and will not happen overnight. But the physical presence of users and carers in NHS structures, the growing
critique of the medical coercive model and the legal requirements for involvement are all advances that have changed the culture of mental health services globally.

Conclusions
The service user and carer movement is not a new phenomenon and has been around in various guises for several decades at least. Changes have occurred at both the micro level and the macro level for people including recovery and social inclusion approaches, and the Hearing Voices network. These advances combined with legal requirements for consultation and efforts at partnership have influenced a broader and more critical understanding of current models of mental distress and service development and planning.

However, against this backdrop of change, user and carer involvement in their current forms do seem to continue to maintain existing power imbalances and at a macro level, reinforce the status quo. This is done through: limited power in decision making, both at a personal and social level, the continued absence of compulsory detention from the involvement agenda, limited power in consultation and agenda setting more generally, including covert mechanisms to maintain the status quo and restricted control over personal services and the wider development and planning of services nationally.

However, it is possible for personal and social methods of power sharing/generating to work together to make a difference and it is these that need to continue to be built upon. Perhaps some useful directions would be to continue to find new ways of challenging the dominant discourse, try to assuage the fear of risk that drives the NHS and keep chipping away at the coercive and compulsory nature of this apparently democratic and consumer led service. What might be a fundamental component of this, is the expansion of initiatives to include those from more different and diverse backgrounds as these are the people who seem to be over represented in services but under represented in involvement.
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Problem Based Learning Accounts
Problem Based Learning Reflective Account

'The relationship to change'

Year I

February 2008

Word Count: 2000
The ‘problem’ and the presentation:

‘The relationship to change’ was the title that was given in this Problem Based Learning (PBL) task. Our group explored the media’s relationship to the change in public opinion towards the family of a missing child in the news at the time. We chose this approach through discussion on what the title could be applied to and where our interests lay. We generated areas of interest to research and bring back to the group. This strand of working separately at home and then together in the sessions led to a feeling of cohesion within the group where it felt that everybody contributed equally. We made the decision to have a rolling chair and scribe, in order to have equality amongst all group members.

We discussed the relationship to change under a postmodernist umbrella of ‘truth’ searching and using cognitive theories to explain how people process information and make decisions (e.g. heuristic and accessibility principles, Shrum, 2002). We also explored the role of fear in relation to change (e.g. Klein, 2007).

In the presentation we acted out a current affairs programme to discuss our interpretation of the title. I thought a key strength in this approach was our use of role-play, music and humour.

Self in the process:

On rereading the first reflective notes I had kept during this task, I was struck by how constrained the writing seemed to be. My thoughts and feelings about the task read back as confined by an awkward imposition of an unfamiliar structure. It reads as if I had written it entirely with this account in mind, without fully allowing myself to slip into a stream of consciousness about my initial reactions to the task. Although at this point, I was yet to encounter what Newnes (2006) describes as the trainees’ need to include the right elements in a reflective diary to succeed in the Doctorate, it seems to highlight my position and therefore outlook at that initial starting point. This position was very much one of unsafe uncertainty (Mason, 1993, in Harper, in press).

On being allocated the title of the PBL, I felt unsure of what the task might entail. I did not understand the title and remember feeling slightly anxious about not ‘getting
it right'. I wanted clarification and explanation of the title, in language that I could understand. This led to feelings of being disempowered and frustrated at the beginning of this task. As our work on the task progressed I began to understand that the title could be appropriated in any way that our group decided. Subsequently I began to enjoy working on the title more as my sense of ownership of it increased.

**Power and language:**

The agent of disempowerment at that first session was for me, our group's complete lack of understanding of the title. It felt that as trainees, we were located in unfamiliar terrain faced with an initially inaccessible construct.

For me, this experience has clear ethical implications for clinical practice. It has given me a sense of what it might feel like to be given a task that I don't understand and therefore may not immediately engage with. It has underscored for me the importance of a collaborative approach with clients. An obvious example of this is the use of homework in clinical work. Schwartz and Flowers (2006) suggest that either allocating homework without agreeing it with the client or agreeing a homework task that the client does not fully understand is likely to result in the homework not being completed. This may ultimately predict a poor outcome for the intervention. Engaging in a discussion that allows the clients to devise their own tasks for outside the session is something I have considered when trying to increase the clients' sense of ownership of the work.

Language is also something that I see as an agent of disempowerment. The title 'the relationship to change' was comprised of words that made sense but that together I could not make sense of! I have experienced a similar situation in clinical practice when working with a client, who said she did not understand some of the words in the formulation. In this situation I have reflected on how the language we use can imbue us with power in the face of other professionals but can also serve to act as a barrier to working with people who may not have a university education or whose first language is not English. The learning point here for me is to try to engage in self-reflexivity when choosing means of communication with people.

**Self and the 'problem':**
When I acted as ‘scribe’ in one of the sessions I felt as if I had a more clearly delineated role in the process. Reflecting back over the process has highlighted for me how I tend to work in a group context. Considering the process as a whole I can see how I was somewhat reserved in the beginning but as the group grew more cohesive and as I focused on ideas that appealed to me, I became more vocal. I have seen this continuing evolution of myself as trainee at university, mirrored on placement. In my first experience of working in a CMHT I have found that I have a tendency to wait until I am on ‘safe’ or knowledgeable ground with regard to psychological issues before offering my voice to a discussion. I have reflected on how this may influence others’ view of me personally and also me as an ambassador for clinical psychology, e.g. psychology might be seen as having little to offer. Challenging myself to speak out even if I feel I may have little to offer is a learning point to consider both now and for the future.

The continual uncovering/discovering/constructing (depending on one’s perspective) of myself as a practitioner, is one challenge that clinical training brings. (John, 1990 in Lane & Marlow) uses the metaphor of dance to support the idea that the self is constructed through discursive action, i.e. dance is a social action. The idea being that the ‘dance consists of dancers conducting individual actions, when their actions stop only they remain. The experience of the dance remains not as an entity but as an abstract reflection. The ‘self’ is the explanation we apply to the embodied experience’ (Lane & Marlow, 1999, p361). To hijack this metaphor slightly, I have reflected on the PBL task (or the dance) as enabling one of several strands of the construction of my professional identity (or self) through a group process. Whilst it was difficult to engage in a task about change against a background of actual change, I have since thought about how useful this task was, in a way that I could not see at the time.

This view of self as autonomous and continuous is an essentially Western view as many point out however (e.g. Barglow, 1994 in Lane and & Marlow, 1999). This has led me to reflect on how even in the process of developing my sense of professional identity and the very process of reflecting on it, situates me very firmly in a Western framework of understanding the world. This has the potential to perpetuate the differences between the clients I see and myself. So far, trying to be aware of difference and trying to see from another vantage point has gone some way to beginning to address this.
The group process:

My initial overall reflections on the group process were that we started off as slightly nervous and unsure of each other and the task and then became more comfortable and familiar with each other as time passed. We became cohesive as a group by the time we presented. Further reflections on the group lead me to consider how we achieved this cohesion, the process of 'othering' and how reflective in action we were.

Group cohesion and ideas of 'the other'

When examining the media's relationship to the change in public opinion to the news story we explored, ideas of difference and 'the other' (Cahoone, 1996) emerged in our thinking. The idea of 'the other' was considered as a means to understand how the family could remain appealing as a news story but also be distanced, in order to reconcile the idea that the disappearance of a child could happen to anyone. To a certain extent if felt that we as a group, unwittingly, replicated this process and experienced the group facilitator as 'the other', as he appeared to be in the safe certain area as opposed to our unsafe uncertainty. Papadopoulos (2002) states that 'the other regardless of its inherent marginality or complementarity to a this, somehow belongs together with the this, and together they are part of a larger unity' (p: 165). I like this description; as to me it brings the task back to John's (1990) metaphor, of the dance, and what I would see as the discovery/construction of the self as facilitated through group processes and the experiencing of experience.

Reflecting on this I see how crucial it is to be aware of our own reactions when working with clients who we may feel intimidated by or uncomfortable around, or just very different to. It can be appealing to hide behind the persona of the professional when feeling vulnerable and construct them as the other. Again working with someone to access a different perspective to one's own and reflecting on feelings in supervision may go some way to begin to redress this.

Many theories of group workings include conflict and its resolution, as key ingredients in group development (e.g. McGrath, 1991). My reflection on our group is that we did not experience conflict. I am unsure whether this indicates that we did
not reach our full potential or that this conflict is lurking on the horizon or that we
transferred it to the facilitator. We were told that we had tackled emotive and
challenging discourses early on. This is something that we have reflected on and
agreed with, noting how open to differing opinions, we were and remain, as a group.

The group, myself and reflection:

The approach we took was fundamentally task focused. Although our approach
suited me at the time, on reflection, I believe we could have been enriched as a
group had we allowed some time for reflection in action. This makes me appreciate
the value of a reflective account several months later to allow a forum to consider
these issues. At the same time I have contemplated how difficult this reflective
account has been to write, however. Mainly that its purpose is evaluative as well as
reflective. I am aware that different readers will bring different feedback and
interpretations to the account (e.g. Fiske and Fogg, 1990 & Newnes, 2006), which
takes it somewhat out of the domain of my reflections.

Reflecting on the process since, I have considered Padesky's (1993) discussion on
guided discovery versus changing minds. It has helped me to understand how
potentially deflating it can be for a client when a therapist has an agenda they want
to get to, via questions, rather than an open and curious stance where questions
help to bring about a shared understanding.

Similar to the case we explored in our PBL, there is a human desire for the 'truth' of
the situation, or in the case of the clinical trainee, a need to find the correct way to
do, for fear of negative evaluation. Reassuringly, this need for the truth of the
situation is not the sole preserve of the trainee. Yalom (1989) yearns for 'an umpire
of reality' and concludes that it is 'disquieting to realise that reality is an illusion, at
best a democratisation of perception based on participant consensus'. (p.172).
Carrying out this PBL exercise, and now this reflective account, feels like a
reconnaissance mission into the alternating safe and unsafe, uncertain and certain
territories of being a trainee clinical psychologist and learning how to manage these.
References


Papadopoulos, R.K. (2002). The other other: when the exotic other subjugates the familiar other. *Journal of Analytical Psychology,* 47, 163-188


Problem Based Learning Reflective Account II

Working with People in Later Life, their Families, and the Professional Network

Year 2 – February 2009

Word count: 2000
The problem presented

For this task, the Personal and Professional Learning Development Groups (PPD) from years two and three were combined which facilitated cross cohort group work. The title of the presentation was ‘Working with People in Later Life, their Families, and the Professional Network’. The task was presented as a vignette focusing on ‘Mr Nicholas’, an older adult who had been referred to a psychology service to assess his care needs and short-term memory. The main questions posed of the task were; what is the problem? Who has the problem? What might happen?

Our group explored this task by looking into the different ways to make sense of the information given. We decided to try to generate several formulations of the problem drawing from a range of theoretical models. These included a cognitive behavioural therapy (CBT) framework, a neuropsychological approach, a psychodynamic perspective and a systemic approach (e.g. Johnstone & Dallos, 2006). It felt that we came to this approach by discussion and mutual agreement about this being an interesting and innovative approach to take.

At the time, this seemed to me, to be a task that could only be achieved by combined effort. That is, to present a meaningful representation of each theory driven formulation was beyond the scope of my own knowledge base and confidence at the time. On completion of the work, and from my current vantage point I wondered if there was an element of the ‘showcase’ about our approach. That is, in trying to demonstrate how clever and creative we were, we did not fully engage with the difficulties presented, or indeed really come together as group to work through the task. I wonder if we had chosen one formulation or even two, would we have gained something different or more substantial from the task.

I think that the idea of something only feeling achievable through joint working can be applicable to clinical work as well as of course, to team working. Finding ways in my communication with clients to externalise difficulties (White & Epston, 1990) and describe how we are going to tackle them, has helped create a culture of a combined effort where the overcoming of obstacles seems more like a reality. Similarly to this PBL task however, I have found it crucial to be aware of the inclination towards inflated ambitions when thinking about change. Whilst at the
overt therapy level, work is driven by the clients' own aims and goals for how they want things to be, I have come to realise through reflection, that I have sometimes held different or bigger hopes for how the person might improve and have their 'miracle' (de Shazer, 1988 in O'Connell, 2005).

Reflection on this in supervision and an exploration of my beliefs about change has helped facilitate my continuing growth in this area. Interestingly research carried out by Lloyd & Dallos (2008) found that clients they interviewed who had undergone solution focused therapy found the 'miracle question' baffling and irrelevant. I think this highlights the need to adhere very closely to the service users hopes for change and be mindful of the language that we use.

Self in the process

Initially, I felt intimidated by the knowledge base that seemed to be held by the third year trainees in the group. It seemed to me that they were at a very advanced level of competency and knowledge than I. We had several discussions about formulating within the different models and sometimes I was unsure of how much I was contributing to the group and I realised that I still had much to learn about psychodynamic and systemic understandings of psychological difficulties.

I felt less knowledgeable and creative than other group members and as a result less confident in the group. Indeed Jetten et al (1995) suggest that if group members' perceived prototypicality (how much the in-group members match the descriptive norms of the group) is low then they are more likely to be less confident and more anxious than other group members. In some respects our group identity seemed to be characterised by 'wackiness' and 'creativity', which was underpinned by a deep knowledge base. This was not an identity that I felt I represented at an individual level, that is, I was not prototypical.

However writing this account now, I am able to view these learning needs as a normal part of clinical training as opposed to the sense at the time that this knowledge gap was a personal failing. I have since reflected on the process of learning and how it is necessary to 'not know' in order to learn. To me, this makes the inevitability of not knowing and making what are often perceived as mistakes, more comfortable. This is an important reflection to consider when working
clinically with groups and raising my own awareness of whether group members feel peripheral or marginal in the process.

I have considered the feeling of being intimidated when working with children and young people and I have reflected a great deal on how I may come across to clients, focusing especially on building a non-terrifying environment for a young child to enter. I believe it has been a fundamental and ongoing component of both my personal and professional development to become more comfortable with the incongruence of how I see myself and how a nine-year-old boy or sixteen-year-old girl may view me. For example, while I may see myself as a young, warm and empathic clinician, clients may see me solely as an ‘ancient’ authority figure. I have considered ways to create a ‘playful environment’ (Winnicott, 1971 in Wilson, 2003) and exploring different mediums through which to communicate about complex and emotive topics, e.g. the use of drawing, clay sculpture and role-play (Wilson, 2003), in order to work toward creating a safe and fun therapeutic space.

This has led me to reflect on the same process working in reverse, that is, that clients may also struggle with incongruency between how they see themselves and how they are seen in a clinical setting. The learning point for me here is to continue to be mindful of becoming complacent about having understood another person’s experience and to use supervision and case discussion forums to explore whether I am making any assumptions about the client.

The group process and presentation

Our group met for all the timetabled slots for this work. After an initial group discussion about the use of formulation from different standpoints, we split into dyads to each work on a formulation from a certain theoretical standpoint. We subsequently came together to discuss our work as a group. Interestingly, we all paired with another person from our original PPD, that is, there were no year-two/year-three mixed dyads. As discussions we went on over the course of the task, we decided to present the formulations modelled on a popular television programme, where business ideas are pitched to interested bidders. For me, this was a very useful way in which to consider the formulation and how to ‘sell’ it. This drive to ‘sell’ psychological approaches is particularly pertinent in the current climate of Improving Access to Psychological Therapies (Department of Health, 2008) and
supplemented my own understanding of how these approaches compare and contrast.

Our group was composed of predominantly white British members with the exception of myself and one other group member (ethnic identity was discussed within the group) with five women and two men. In terms of difference and diversity, it felt to me that the gender difference was more marked than ethnicity. Working with two men in this small group setting was somewhat unusual for me as in this cohort and most other training programmes, women generally tend to predominate and often there is either one or no men in smaller groups.

Although some thinking suggests that men tend to step back or withdraw in female dominated groups (e.g. Currat & Michel, 2002), converse thinking suggests that men are more likely to strive for dominance in groups (Rose, 2002). In our group, it felt to me that whilst generally, we all had a fairly equal voice, the men in the group presented as somewhat more vocal and confident in the process. I am unsure however of whether this perceived difference could be ascribed to gender or personality, or neither.

Reflections on gender have been pertinent in clinical practice. Working in a CAMHS service has led me to consider how best to build a therapeutic relationship with boys and young men. As I differ from these clients in terms of age and gender, I have reflected on how best to meet them in their world, with the awareness that most women of my age and above will assume a maternal or teacher role for these young people. Finding ways to negotiate a new relationship that is neither of these roles has been a challenge when working with this client group. For example, it can be difficult to build a collaborative therapeutic relationship when clients I have worked with often take a deferential role by default.

A learning point for now and the future is to continue to nurture my awareness of this diversity and use supervision to discuss it in more depth as appropriate. I have found also that whilst all people are different, gaining experience in this area has increased my confidence and comfort in finding ways to connect with clients with whom before I had little to no experience of interacting with, either in a personal or professional capacity.
Group development and feelings of fragmentation

Even though to a certain extent it seemed that our group appeared to function as a cluster of small groups, as a whole I think the process was similar to Tubbs' (1995) Systems Approach to group development. Here he describes development as consisting of orientation, conflict, consensus and closure.

I felt we began in the stage of orientation to each other and the task. Conflict in the group was limited, that is, including some minor differences of opinion about the content of the presentations. Although several theories posit that conflict is the crucial ingredient of group process (e.g. Tuckman, 1965) this did not seem to be the case in our group. It seemed that we moved fairly easy through to consensus and closure. This may be perhaps because we never fully came together as a group and kept our development at something of a superficial level.

This degree of separate units was characterised by our use of three separate formulations presented by each dyad. Although we had sought to include an integrative formulation, there did not seem to be the time or scope to do this. This seemed to match what happened physically to the group in that although we had sought to unify our work, I feel we presented three stand-alone presentations (although they were linked by the seventh member of the group, who acted as presenter).

Although it is usual to break a group task into components, I felt that the way in which we did this served to act as barrier to truly working together. Although our work was commended for its originality and creativity, qualities that we also saw as strengths, I felt that going perhaps deeper or creating a space where it conflict could have occurred, been resolved and led to a stronger group, could have enriched the experience for me personally.

I have considered this idea of depth of relationship and interaction in clinical work. Sometimes work can operate on what feels like a surface level, at certain stages and sometimes there can be a conflict or rupture. Although a therapeutic rupture can feel catastrophic at the time; it can often strengthen the therapeutic relationship creating a more open and safe space for both the therapist and the client (e.g.
Safran & Murran, 2000). Perhaps creating a safe space in which taking risks are possible is a both a personal and group learning point from this exercise.
References


Problem Based Learning Reflective Account III

Evaluating the effectiveness of the improving access to psychological therapies initiative

Year 3 – February 2010

Word count: 1938
The Problem

This task focused on evaluating the effectiveness of the Improving Access to Psychological Therapies (IAPT) initiative. The personal and professional learning and development (PPD) groups were split across years two and three to facilitate cross year group work. Our remit was to prepare a consultancy report on how the effectiveness of IAPT can be evaluated.

Our group began with exploring the concept of 'effectiveness' and what that might mean to different people. I think this was a strength of our approach as it afforded a detailed discussion about IAPT from our perceived perspectives of multiple parties. For the presentation we opted to look at the question of effectiveness from the perspective of commissioners and of service users. We created a polarised split between these positions in order to emphasise the issues. We adopted a television programme format and created two teams; Money Matters and People Matters, which presented the case for either side and included reflections upon closing. I wondered however, if creating such polarity between the views was the best approach as in some ways it might have served to caricature the commissioners, which then acted as a barrier to a fuller understanding of their perspectives.

Self in the process

At the beginning of the process, although I was keen to learn more about IAPT I was somewhat disengaged with the task itself. Although I have gained much from doing these exercises in the past, when the task was introduced, I was focused on working on my research project. This brief lack of engagement was soon replaced with enthusiasm for the task and I was curious about how it would feel to fit into the 'experienced' role of the third year trainee in the task.

I have considered how this type of situation may play out in therapy. When working with clients, I have thought about the dynamic that arises when somebody has been referred to psychology but may not necessarily want to be there. Working with older adults I have had the experience where the individual may have difficulty locating their difficulties in a psychological framework, and would prefer to be seen by a medical doctor. This might link to the stage of change, or motivation to change that the person is at (Proschaska and Diclemente, 1992). For example unawareness of
a problem (i.e. being in the precontemplation stage), or understanding the problem in a very different way, they will reasonably see little point in meeting with a psychologist. I have considered that while on one level, one sees the activity offered as potentially useful (either doing a PBL task or starting therapy), this does not mean that one will automatically want to engage in it. In the context of older adults, much of the pre therapy work I have done focused on exploring individuals’ beliefs about old age (e.g. ‘it is too late, things won’t change now’) or about therapy which may be cohort related (e.g. ‘talking doesn’t help’) and how to shift these (Gallagher-Thompson et al, 2008).

**Becoming a leader and assuming a ‘knowing’ position**

At the end of the process, some reflected that no one had emerged as leader. I was curious about this and thought that others and I had at times, guided the process to a certain degree. In the previous year’s PBL task, I had felt quite intimidated by the knowledge held by trainees in the then year above. In this task, I had some knowledge about IAPT, which with the exception of two other who had written an essay on IAPT, seemed to be the case for the rest of the group. This led me to wonder if my understanding of leadership relates to the amount of knowledge or information one holds about a topic.

I feel that at this stage of training, my comfort and confidence in the ‘expert’ or knowing position has evolved considerably. Previously, I would have felt compelled to tell all I knew about a topic, if I was in a situation where I thought I held a lot of knowledge. In this task, I enjoyed a role, where I shared what I thought might be relevant but was curious about what others knew in a more authentic way, perhaps than in the past. This idea of wanting to share everything that is known on a topic has arisen in the course of my research work on delivering supervision. Some participants have mentioned the realisation that they may have spoken a great deal on a topic, but on the close of session wondered about how much the supervisee may have taken in, and what they might have taken from the session if the process had been one of guided discovery (Padesky, 1993).

I have reflected on the idea that for me, some of this wanting to ‘teach’ comes from a place of uncertainty or insecurity about my ability to facilitate change or how others perceive me. Whilst one of the tasks for me in the early part of training was to
monitor this with client work, I have now begun to consider how this might play out when I begin to supervise, or when I'm consulting with other team members. Supervision and adopting a reflexive approach are helping to keep this in the fore of my mind.

At this point in my career, I can understand leadership as not solely relying on the amount of expert information that one has, but may also incorporate confidence, enthusiasm, and strong interpersonal skills, for instance. Based on this I reflected on how group members experienced me in the group, and wondered if they found me somewhat quiet. We had some group discussions about our experiences of being in the group and it seemed that everybody felt it was a relaxed and pleasant space in which to explore the topic. I feel that assuming the approach that I did, combined with my interpersonal manner, contributed to this atmosphere. A potential disadvantage of this atmosphere might have been that it inhibited some members from raising points that strayed far from the general consensus on the topic, for fear of disrupting the pleasant nature of the group.

The group process

It was agreed that the two members who had written their essay on IAPT would work in separate groups, as this seemed a sensible delineation. Membership of either group was then decided on personal interest and knowledge. The two groups were split between both year groups, which was different to my experience of this last year, when we remained within our PPD groups within the task. I opted to be part of the service user perspective group.

I was pleased with this split and saw it as a strength of our approach, as it allowed us to work with the trainees from the other year group, rather than working alongside them. This reminded me of multi-disciplinary teams that I have been part of, where on some occasions members from different disciplines work alongside each other, whereas others work integratively and together as one team. It is likely that interdisciplinary working will pose certain challenges for different disciplines (Atwal & Caldwell, 2005) and perhaps psychology can play a role in mediating this.

Our group was comprised of two men, and six women. With the exception of three of us, group members identified as white British. We were interested to consider the
aspects of difference and diversity both in respect to our own group but also in the context of IAPT. We reflected on how our different diversities impacted upon the choices we made within the group, for example opting to be part of either subgroup.

It seemed that within the IAPT agenda as a whole, there is relatively little deep consideration of how to improve access for clients from a diverse background. This is similar to the provision of psychology services as a whole, in which minority ethnic groups are not accessing mainstream psychological services (Williams, et al. 2006). We discussed this and saw its omission as a major weakness of the evaluation process in IAPT.

The question

A key task for the group was to remain focused on the question that was being asked. It seemed that several times during the process, the question was interpreted as; 'is IAPT effective?' rather than 'how IAPT can be evaluated to determine if is effective'. This caused some confusion in our group on occasion. This experience has links with therapy. For example, it seems intuitive that shared goals and a shared plan on how to achieve these goals will contribute to successful therapy. In the beginning of our work, I felt that we did not strictly have a shared understanding of the task, which then led to some inter-group difficulties. In working with clients, I have learnt just how important it is to obtain a real understanding of how an individual understands their difficulties before introducing a psychological understanding. This then leads onto a rich discussion on what the person's goals are for change and how likely they believe change to be and what role they think therapy will play in this (George et al., 1999).

I have reflected a great deal on the idea that how somebody understands a problem is very much influenced by their age, gender, ethnicity, past experiences etc. While one task of my professional development has been to negotiate discussing this in a way that is comfortable and accessible for clients and myself, I have also considered how to reflect on how my own background, beliefs, ethnicity, gender and spirituality for example, impact on my practice. While this has been long running developmental task, I feel that it has gotten somewhat easier for me to be more open about these contributions to my current practice, as time has gone on. More recently I have considered how my own cultural background and family scripts have
impacted on this journey of reflecting on personal diversity. Burman et al. (1998), suggest that cultural norms can be a liability when operating unacknowledged, but conversely can be valuable resource when made more explicit. For this reason, it is important to negotiate their discussion in supervision as well as personal reflection.

The use of humour

I think the use of humour was a pivotal aspect in our development as a group. Some research suggests that humour makes an important contribution to group productivity in terms of cohesiveness (Duncan, 1982 in Romero and Pescosolido, 2008). Romero (2005 in Romero & Pescosolido, 2008) suggests that when humour is used in a group, 'people experience positive effect, which facilitates more efficient and effective social processes' (p, 396). I believe that the use of humour in our group facilitated the deepening of relationships and helped create an atmosphere of creativity. These factors led us to have a positive experience in the group and carry out a presentation that we were proud of.

The use of humour in personal and professional work is something that I've considered in varying degrees throughout training. I see myself as someone who uses humour in my personal life, yet not as much in my professional role. I have considered this as one aspect of integrating the personal into the professional, in supervision discussions and personal reflections. As I have grown confident about technique and content in therapeutic work, I have begun to focus more on how to work on the process issues with clients. I see a key developmental learning point for now and the future as integrating more personal and idiosyncratic elements into the professional in a considered and thoughtful manner in order to develop as more of an authentic practitioner.
References


PERSONAL AND PROFESSIONAL LEARNING

DEVELOPMENT GROUP (PPLDG) PROCESS ACCOUNTS:

SUMMARIES
Personal and Professional Learning Development Group Process Account I

Summary

September 2008

Year II
The account begins with reflections on my personal and professional development. In this context, themes that emerged related to beginning feelings of anxiety, and finding my voice to speak both about neutral content and processes I did not find useful. I found this experience had its parallels in my clinical practice. For example, striving to maintain awareness of the potential power differentials in therapy and from the outset, striving to set up a collaborative space, which allows the client to tell their story, but also allows for the introduction of alternative perspectives in a respectful and collaborative manner.

In terms of group development, I began with reflections on how we experienced the group facilitator as 'the other', and our group over time disengaged with the process due to dissatisfaction with the content of the session combined with a perceived inability to change it. Again, this had its parallels in clinical work, when thinking about how the therapist's goals and objective may influence the work.

I believe that reflection on the various facets of our diversity in the group (through use of a cultural genogram) facilitated the group's development and cohesion. It also added something of a three-dimensional quality to the group members. Equally, humour helped in this process. This experience of group development led me to consider how humour can be useful therapeutically, and also how it is important to strive to maintain a holistic understanding of clients.

Word count: 238
Personal and Professional Learning Development Group Process Account II

Summary

September 2009

Year II
Themes that emerged from the group process and writing this account include: the impact of past experience and cultural background on the therapeutic process, the development of multi-layered selves and conflict and group process.

I believe that the group this year began with some residual negative feeling from the preceding year. In the first year we disengaged somewhat from the structure of the PPD. This disengagement was due to feeling disempowered and unheard in the group, by the facilitator. This linked to clinical practice when considering the choices or opportunities clients have to give feedback on intervention, especially in child and learning disability settings.

The initial PPD sessions were spent debriefing about the previous year and reflecting on what we had learnt through a process that we found challenging. This was linked to clinical practice when considering the impact of past experiences of therapy and health professionals on current work.

After initial sessions working on the Problem Based Learning exercise we decided to each take a turn at facilitating the group for the remaining sessions. When it was my turn, I chose to use this experience as a behavioural experiment and discussed this with the group after.

Our group appeared to be characterised by a lack of conflict. We discussed potential reasons for this and a learning point that emerged was to work together in the upcoming year to consider this in more detail and reflect on what we each want from the group and how to achieve our goals.

Word count: 250
Overview of Clinical Placements
Core: Adult Mental Health Placement  
Date: September 2007 - September 2008  
Setting: Community Mental Health Team (CMHT), Family Therapy Clinic, Psychological Therapies In Primary Care Team (PTiPC)

This placement was mainly based in the CMHT, although in the second part of the year, I worked in the PTiPC service for one session per week. I also worked as part of the reflecting team for two families in the family therapy service.

In the CMHT, I assessed clients from a wide range of backgrounds and ages, who presented with difficulties including generalised anxiety, social anxiety, obsessive-compulsive disorder, depression, bi-polar disorder, auditory hallucinations and psychosis. I carried out formulations and interventions in a predominantly cognitive behavioural therapy framework, although also drew from solution focused and schema focused approaches in this work. I took on a consulting role to provide indirect input to two clients in the team. Participation in the family therapy service provided an opportunity to act as part of the reflecting team and work within a systemic approach.

In the PTiPC, I co-facilitated a stress management group for clients with anxiety and low mood. I also had the opportunity to work with clients on an individual basis presenting with depression, phobia and bereavement.

I also carried out neuropsychological assessments to investigate memory difficulties in two clients.

Core: Child and Adolescent Mental Health (CAMHS) Placement  
Date: October 2008 – March 2009  
Setting: CAMHS Team

I worked with children, young people, families and associated professionals in this setting. I carried out individual work with clients (and their families or carers), ranging from four to 17 years of age, presenting with difficulties including behavioural difficulties, anxiety, low mood, ADHD and Autism Spectrum Disorder. I drew from, and built upon my knowledge and skills in CBT, behaviour therapy and systemic therapy to work with clients. I also received supervision in a
psychodynamic framework to inform my work with one client and incorporated narrative approaches into work with younger clients. Regular participation in family therapy sessions in the service allowed me to expand my understanding of systemic approaches with this client group.

I gained experience in liaising with associated professionals, e.g. teachers, Special Education Needs Coordinators (SENCO's) as well as working in a multi disciplinary team. This facilitated further learning in organisational and professional issues, and the role of the clinical psychologist in this kind of setting. Furthermore, I gained experience in conducting school observations, systemic information gathering and carrying out detailed developmental histories, as well as neuropsychological assessments.

Core: People with Learning Disabilities (PLD) Placement
Date April 2009 – September 2009
Setting Community Learning Disabilities Team (CLDT)

In this placement I worked with adults both on a direct and indirect basis. I worked with clients with a diagnosis of autism spectrum disorder, and Down’s syndrome. Direct work with clients focused on difficulties with low mood, bereavement and identity, sexuality and self esteem issues. I drew from behavioural, psychodynamic and CBT approaches to inform this work, and also worked within a psychodynamic orientation with one client. Work with one client on sexuality issues, broadened my understanding on how society can pathologise and exclude based on diversity in relation to people with learning disabilities. I carried out an extended assessment with one client, focusing on sexual risk, which expanded my skills in comprehensive information gathering and collating from multiple source.

Indirect work consolidated these skills in information gathering as well as liaising with a wide range of allied staff and carrying out behavioural observations. Indirect work, focused on challenging behaviour and sexuality issues. This work took place in clients' homes, day centres and supported living settings.

In addition to cognitive assessments, I gained experience in carrying out a neuropsychological assessment through an interpreter. This facilitated further
learning on cultural issues related to psychometric assessment with non-minority groups.

Core: Older Adults Placement  
Date October 2009 – March 2010  
Setting Community Mental Health Team for Older People

I worked with clients across this age group (e.g. 66-84), with complex and long-term mental health difficulties, including low mood, anxiety and long-standing psychiatric conditions. Work was carried out in clients home and in inpatient settings. CBT, psychodynamic, behavioural and Acceptance and Commitment (ACT) approaches informed my work, and I gained further experience of working therapeutically with clients who had concurrent cognitive impairment, e.g. Dementia.

I drew from systemic thinking when working with family members and carers and gained experience in addressing difficult ethical issues, e.g. a client’s relative not wishing them to be told of a diagnosis of dementia. I co facilitated an information and support group for clients with dementia and through this learnt about the lived experience of this condition as well as the challenges in providing a safe therapeutic frame for clients to discuss their experiences. I carried out a pilot information and support event for carers of clients in the service.

Advanced Competencies Placement: Traumatic Stress Service  
Date March 2010 – September 2010  
Setting Tertiary care, Traumatic Stress Service

I worked with clients between the ages of 24 and 65 who were presenting with posttraumatic stress disorder and in some cases co-morbid psychological or substance misuse difficulties. I carried out individual and group work. I offered a cognitive behavioural trauma focused intervention as the main treatment. Work in this service incorporated a large element of risk assessment and management and liaison with other services. I carried out several joint diagnostic assessments, often through the use of an interpreter. Cognitive based therapy was supplemented with the use of psychodynamic theory and metacognitive therapy approaches, in addition to the detailed consideration of cross cultural issues with the use of the PTSD diagnosis.
Clinical Case Report Summaries and Summary of Oral Presentation of Clinical Activity
Adult Mental Health Case Report | Summary

Cognitive Behavioural therapy with a man in his mid-twenties presenting with Obsessive Compulsive Disorder

Mr Patel was referred to the Community Mental Health Team and subsequently to psychology for support with what he described as OCD, as he felt his difficulties had become unmanageable. My supervisor and I jointly assessed Mr Patel over two assessment sessions after which he did not get back in contact with the service until several months later. Following this reengagement I considered relationship building and stage of change models in determining how best to support Mr Patel.

Mr Patel's concerns related to fears about dirt and contamination, specifically that he would contract HIV and so carried out cleaning rituals and avoidance behaviours to avoid this. He held a strong belief in 'new starts' and cleaning to a 'perfect' level.

I drew from Salkovskis's (1995) cognitive appraisal model to formulate Mr Patel's difficulties. This model formulates the problem as that of excessive worry, rather than excessive risk. Mr Patel generated goals and we agreed on an intervention that would include exposure and response prevention (of compulsive behaviours) and exploration of beliefs related to contamination. The Obsessive Compulsive Inventory (OCI) was used as an outcome measure.

We met for 9 sessions (at the time of writing), after which Mr Patel reported a shift in his thinking about the likelihood of risk, which reduced his washing compulsions. This change was supported by a reduction in the OCI.

Critical evaluation of the work focused on the delay of the use of behavioural strategies, limitations of the model and diversity in the therapeutic relationship.

Word count: 250
Adult Mental Health Case Report II Summary

Assessment and relapse management plan with a woman in her mid thirties presenting with a history of psychosis

This report details the assessment and relapse management plan that was carried out with Kate Fisher, an Australian woman in the Community Mental Health Team. Mrs Fisher had experienced three periods of distress related to persecutory and paranoid beliefs and was subsequently referred to psychology. At the time our work, she was not experiencing distressing beliefs, although reported some low mood and anxiety.

Assessment was carried out over two sessions, and I formulated Kate’s difficulties using a cognitive understanding of distressing beliefs, specifically drawing from Chadwick (2006), and Morison’s integrative cognitive model of psychosis (2004). The BDI and BAI were administered to assess mood and anxiety. Idiosyncratic continuums were developed to measure where Mrs Fisher felt she lay with regard to goals for the work (e.g. how much she understood why she became ‘ill’). The intervention was based on Birchwood’s (2003) ‘Back in the Saddle’ approach to managing relapse in psychosis. This consists of identifying triggers to a psychotic episode and developing accompanying management strategies.

Work with Mrs Fisher was ongoing at the time of the report so outcome information was not available, however themes around ‘why me’, distress tolerance and her feeling of disconnection from her emotional world, emerged during the work. Mrs Fisher reported some positive shifts in her coping style with regard to accessing and managing her distress.

Learning points centred on the need to develop a useful and explanatory formulation with the position of not knowing, both for Mrs Fisher and myself as the therapist.

Word count: 242
Child and Adolescent Case Report Summary

Cognitive Behaviour Therapy, informed by psychodynamic and systemic theory, with a young woman presenting with panic attacks and vomit phobia

Carol Jenkins, a White British, young woman in her teens, was referred to psychology for support with panic attacks and vomit phobia, prior to moving to adult services. At assessment, Carol was self-harming (cutting her arms) although had no thoughts of suicide. Her scores on The Beck Depression Inventory- Youth 2nd Edition (BDI-Y II) and the Beck Anxiety Inventory – Y 2nd Edition (BAI-Y II) lay in the 'extremely elevated' range. It was not possible to find a vomit phobia specific measure for outcome purposes.

The formulation drew from Clark’s (1986) model of panic, in addition to psychodynamic theory on ‘core pain’ or fear (Lemma, 2003), i.e. hypothesizing that vomiting fears might relate to fears of abandonment. The reformulation focused explicitly on the vomit cycle (Borschen, 2007) as panic attacks substantially decreased during the work, in addition to including Carol’s mother for a systemic focus. Content included cognitive and behavioural management strategies, and circular interviewing with Carol and her mother. Issues related to eating and self-harm challenged the therapeutic relationship and shifted the focus of the work to risk management in later stages. Management of these issues as well as the ending was informed by psychodynamic thinking.

On completion of the agreed six sessions, Carol had achieved four of five of her goals and her scores on the BDI-Y II and BAI- Y II had decreased to the normal range although she felt there was still more to do though in terms of overcoming her difficulties.

Word count: 245
Summary

Sexual Education Within a Systemic Informed Intervention, with a 36-year-old woman with a Learning Disability

This presentation focused on the complexity of supporting Claire, a 36-year-old woman with Down's syndrome – in the expression of her sexuality. This was in the context of her current system, which was a supported living unit (formerly part of a Catholic order), sharing with eleven other people.

Claire was referred to the service because staff were concerned about her behaviour around male staff and male members of the public and had requested input to help Claire to develop her understanding of intimacy, relationships and to develop boundaries.

Assessment with Claire and staff identified problem maintaining factors and feedback loops within the system. For example, there was much inconsistency related to boundaries of physical contact with Claire, within staff members with responding to Claire in different ways, for example, it being acceptable to kiss some staff on the cheek and unacceptable to show similar affection to others. A genogram was constructed and elaborated upon to reflect on how gender, religion, sexuality and discourses about sexuality were involved in the problems reported. Difficulties and inconsistency around expressing sexuality lead to much distress for Claire.

Reflections were offered on the intervention and outcome (sex education and assertiveness training for Claire in conjunction with discussion with the staff team about sexuality and disability), with a specific focus on discourses of sexuality and disability. Therapist diversity was considered in the context of shared religious and cultural background with the staff system.

Word count: 236
Older Adults Placement – Psychometric Assessment

Neuropsychological assessment of a man in his early 70's presenting with memory problems

Mr Wilson (a 70 year old, white British retired civil service worker) was referred to the Community Mental Health Team for Older People by his GP following reported memory loss. The psychiatrist reported Mr Wilson's scores on the MMSE, to be on the cusp for suspecting dementia and verbally referred to psychology for neuropsychological testing. Mr Wilson explained that although he had become more forgetful, he attributed this to the normal ageing process. His wife noticed a gradual deterioration beginning 3 years previously.

Mr Wilson had no recent or past medical history. His CT scan was 'normal'. Differential causes were considered and a literature review suggested that Mr Wilson was potentially experiencing dementia, which informed the hypothesis. The Weschler Test of Adult Reading (WTAR) was used to provide an estimate of premorbid intellectual ability, which is relatively resistant to the effects of neurological illness. The WAIS-III was used to obtain a measure of current intellectual functioning. Memory was assessed using the partial WMS, the RAVLT and the RCFT. Executive function was measured with the Hayling and Brixton and other tests, with good reliability and validity. Language was assessed using the GNT, and mood, using the HADS.

Assessment results showed deterioration in general intellectual functioning, specifically processing speed, and impairments in executive function, memory, learning abilities and attention and semantic language. The pattern of impairment indicated the likelihood of probable AD. Results and recommendations (including memory strategies, anti-dementia medication and emotional support) were discussed and agreed with Mr and Mrs Wilson.

Word count: 250
Research Dossier
<table>
<thead>
<tr>
<th></th>
<th>Research Log</th>
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<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
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<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
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<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
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<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
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<td>9</td>
<td>Obtaining appropriate supervision for research</td>
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<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
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<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
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<td>13</td>
<td>Writing patient information and consent forms</td>
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<td>14</td>
<td>Devising and administering questionnaires</td>
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<td>Negotiating access to study participants in applied NHS settings</td>
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<td>16</td>
<td>Setting up a data file</td>
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<td>Conducting statistical analyses</td>
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<td>21</td>
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<td>Conducting semi-structured interviews</td>
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<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
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<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
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<td>26</td>
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<td>Producing a written report on a research project</td>
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<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
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<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
</tr>
</tbody>
</table>
A qualitative approach was employed in this study to explore the understandings that parents have of differences in their children’s characteristics, with a particular focus on exploring the impact of birth order on these differences. Four semi-structured interviews were carried out with four parents with at least two children between the ages of two and twelve. Interviews were recorded and transcribed verbatim.

Transcripts were then analysed using an Interpretative Phenomenological Approach (IPA). Four master themes emerged: differences in personality, differences in birth order, differences in nature and nurture and stages in development. Results were considered with respect to other exploration in this field and the study was critically evaluated.
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Acknowledgements

I would like to express my gratitude to both my field and university supervisors for their support and helpful feedback during this evaluation. I would also like to thank my buddy for the provision of some very useful references and details on the format of the group. Thanks also to the psychology team who devised the staff group, for their reflections on the process and feedback on the questionnaire. I am immensely grateful to the ward manager and the nursing staff for their participation in this evaluation.
Abstract

Objective:
This evaluation aimed to gather feedback on a staff group that was devised to support staff deal with emotions generated from work with clients, on an acute inpatient ward. It also aimed to determine if participation in the group impacted on the staff's management of work related stress and their relationships with service users.

Design: Data was collected from a questionnaire designed by the author. An information sheet about the study, and copies of the questionnaire were left in an envelope in the staff office on the ward. A semi-structured interview was conducted with the ward manager.

Participants:
Eleven nursing staff participated in the evaluation.

Analysis:
Quantitative data was analysed with descriptive measures. Content analysis (Flick, 2002) was used to interpret qualitative data.

Results:
Staff reported that sharing emotions was helpful. Conflict, in addition to practical constraints, appeared to hinder the implementation of the group. Staff did not see participation as impacting on their relationships with clients. The majority of respondents said they would recommend the group to other acute wards.

Conclusions:
The mixed feedback may be linked to the limited evidence for staff support groups generally. Alternatively, it may be connected to the limited input from staff in this initiative, and the occasionally negative experiences of participation. Considering the limitations of the evaluation however, further exploration is required to determine how best to support this staff team.
Introduction

The relationship between working in an inpatient psychiatric setting and emotional strain caused to staff has been extensively reported in the literature (e.g. Edwards and Burnard, 2003). Interactions with highly distressed service users can generate strong emotions in staff (Haigh, 2000). Additionally, high levels of stress and burnout have been observed in acute inpatient settings (e.g. Jenkins & Elliot, 2004).

O'Brien (2006) describes burnout as a 'state of physical, emotional and mental exhaustion caused by long term involvement in an emotionally demanding situation' (p: 17). He suggests that a lack of supervision and support are two of several factors that can contribute to burnout in staff. Haigh (2000) posits that interactions with clients in an acute setting can sometimes leave staff feeling 'frustrated', 'angry' or 'inadequate' (p: 312). Feelings that have been 'denied conscious relevance' (p: 312) can lead to a potential bias in clinical decision-making or could have a negative impact on relationships with other staff and service users.

Similarly, Holmes (2002) suggests that 'inpatient wards run the risk of not being so much un-therapeutic as anti-therapeutic' (p: 383). Challenges to establishing and maintaining a therapeutic ward might include high levels of staff stress and burnout. For example, stress or burnout in staff may compromise the therapeutic alliance with clients, which is correlated with improved outcomes, (Roth and Fonagy, 1996). Or at a more basic level, it might lead to a decline in the care provided (Dennis & Leach, 2007).

Setting and Rationale

This evaluation was based on an acute inpatient psychiatric ward. Its clients come from the area's Assertive Outreach Team and two Community Mental Health Teams. The psychology service in the borough was asked for assistance to establish a supportive space for nursing staff to discuss and process emotions generated through direct work with clients on the ward. In response to this, two clinical psychologists and one trainee clinical psychologist devised the staff group that is the subject of this evaluation.

Although staff groups are widely seen as beneficial to staff to reduce workplace stress they have limited empirical support (Griffin & Christie, 2004). There is
however, some support for the management of emotions within a contained and supervised group format (Milton & Davison, 1997).

It was proposed that the provision of this staff group to discuss emotions generated through direct clinical work, would contribute to a reduction in staff burnout and workplace stress. It was hoped that this support might impact on the nurses' relationships with service users. Novakovic (2002) asserts that 'only staff that are supported and contained can provide the interpersonal medium through which patients can achieve therapeutic change', (p: 572).

The Staff Group

The group was roughly based on the 'staff sensitivity group' model (Haigh, 2000). The remit of the group evaluated here was solely to discuss and reflect upon emotions that had been generated through clinical work with service users. In order to accomplish this, the group drew from systems centred theory *(Agazarian, 1997).

One staff member acted as group facilitator. Staff were asked to share any emotions they experienced during the shift. Group members were asked if they shared the emotion identified. The facilitator would then pose a series of questions to guide participants from experiencing the emotions to reflecting on them (see Appendix 2 for the format of the group).

All permanent staff members on the ward (16) participated in a three-hour training session prior to participating in the group. See Appendix 3. Following the training session, staff were provided with regular live supervision by the psychology team for a period of two months.

Aims and objectives of the evaluation

The primary aim of this evaluation was to gain feedback on the group from the nursing staff and the ward manager. As the ward manager also participated in the group, it was hoped that his feedback might add a perspective from management to the feedback. The secondary aims were to explore if participation in the group

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4 See Appendix 1 for definitions of the terms used
supported the management of work-generated emotions and perceived staff relationships with service users.

Objectives:

1) To obtain feedback on the group from the nursing staff

2) To obtain feedback from the ward manager

3) To determine the group's usefulness in managing emotions and stress generated through clinical work with service users in an acute ward setting, as rated by group participants.

4) To make recommendations for any alterations needed to maintain the group.

5) To determine if participants thought involvement in the group had impacted on their relationships with service users.
Methods

Participants
All nursing staff (16) on the ward that had participated in the training for the group and the group itself, were offered the opportunity to take part in the evaluation. Participation was voluntary. Ten staff members took part in the evaluation. The ward manager participated in a semi-structured interview detailing his experience of the group.

Ethics
Ethical approval was not required for this evaluation as this was a service evaluation and no personal data was collected. This was confirmed with the service.

Measures
Informal feedback from staff indicated low morale on the ward and general dissatisfaction with the group at the point of evaluation. As a consequence of this, all participants excluding the ward manager opted to give feedback via a questionnaire\(^5\). Questions were based on the stated objectives of the evaluation. These questions were checked with a member of the psychology training team before distribution. This questionnaire contained six closed questions that asked respondents to rate different aspects of the group on a five point Likert scale. The scale ranged from 1 (not at all) to 5 (very much so). There was one closed question (that is, that required a yes or no response) that asked if respondents would recommend the group. Three open-ended questions asked participants about the strengths and weaknesses of the group and any changes they would recommend.

Prompts used in the interview schedule were based on those from the questionnaire, with minor adjustments, to explore the ward manager's perspective (see Appendix 5).

Procedures
The evaluation was carried out four months after the group began. It was hypothesised that if the group had been occurring daily (as laid out in the training) then all members of staff would have had several experiences of participating in it. Information about the study was provided (see Appendix 6), and copies of the

\(^5\) See Appendix 4
questionnaire were left in the staff office for staff to complete. Completed questionnaires were returned to an envelope addressed to the lead supervisor of the project, which was placed in the office. This envelope was left in the office for one month, with one email reminder to staff about the evaluation during this timeframe.

In addition to the information sheet given, the ward manager was advised that his would not be reported separately in any feedback to the service. He was aware that it would be reported separately in this report, and that all identifying features would be anonymous to maintain confidentiality.

Analysis
Closed questions on the questionnaire were analysed using frequencies. Open-ended questions and the interview transcript with the ward manager were analysed using Content Analysis (Flick, 2002). Analysis focused on the manifest content of the data (Graneheim & Lundman, 2004). Answers were aggregated into themes. Within these themes, responses were collated into categories. Graneheim & Lundman, propose that 'since all data have multiple meanings, themes are not necessarily mutually exclusive; (p: 107). And indeed there is overlap in the themes and categories reported here.
Results

Responses to Questionnaire

The majority of responses to 6 of the closed-ended questions were 'Neutral'. See figures 1 to 6 for staff responses to all Likert scale based questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
<th>Figure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has taking part in the group helped you feel more able to discuss your feelings about work, with colleagues?</td>
<td>Not at all, Not very much, Neutral, Somewhat, Very much so, No response</td>
<td>Figure 1: Responses to question 1</td>
</tr>
<tr>
<td>Has taking part helped you manage strong feelings that come from direct work with service users?</td>
<td>Not at all, Not very much, Neutral, Somewhat, Very much so, No response</td>
<td>Figure 2: Responses to question 2</td>
</tr>
<tr>
<td>Has the existence of the group contributed to a positive change on the ward?</td>
<td>Not at all, Not very much, Neutral, Somewhat, Very much so, No response</td>
<td>Figure 3: Responses to question 3</td>
</tr>
<tr>
<td>Has taking part helped you manage work related stress?</td>
<td>Not at all, Not very much, Neutral, Somewhat, Very much so, No response</td>
<td>Figure 4: Responses to question 4</td>
</tr>
<tr>
<td>Has taking part helped improve your professional relationship with service users?</td>
<td>Not at all, Not very much, Neutral, Somewhat, Very much so, No response</td>
<td>Figure 5: Responses to question 5</td>
</tr>
<tr>
<td>Have the training session helped prepare you to discuss feelings in the group?</td>
<td>Not at all, Not very much, Neutral, Somewhat, Very much so, No response</td>
<td>Figure 6: Responses to question 6</td>
</tr>
</tbody>
</table>
When asked if respondents would recommend this group to staff on other inpatient acute wards, eight said yes, one said no and one did not answer.

**Open-ended questions**

Three major themes were identified from the data. These were 1) Benefits of the group, 2) Staff responses to group content, and 3) Changes to future 'emotional handovers'. See Table 1. The majority of respondents stated that a forum to express feelings had been the main benefit of the group. A second theme that emerged strongly was staff responses to the content of the group. Several staff mentioned that comments had been taken personally and one mentioned that sometimes people used the group to discuss conflicts with other staff. Barriers to carrying out the group emerged as another theme including difficulties with time and staff. The final theme that emerged was that of changes to future groups. Some participants requested further input on how to manage feelings and develop skills on how to manage difficult situations or clients.

Table 1: Themes and subthemes from open-ended questions (the numbers in parentheses refer to the frequency of occurrence of the response from group members)

<table>
<thead>
<tr>
<th>Theme: Benefits of the group</th>
<th>Subthemes⁶:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Support:</td>
<td></td>
</tr>
<tr>
<td>Express feelings in the group (7)</td>
<td></td>
</tr>
<tr>
<td>Hear about feelings of others (3)</td>
<td></td>
</tr>
<tr>
<td>Support each other (2)</td>
<td></td>
</tr>
<tr>
<td>Coming together as a team (1)</td>
<td></td>
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<table>
<thead>
<tr>
<th>Time Out:</th>
<th></th>
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<tbody>
<tr>
<td>Time out from busy ward (3)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Absence of management:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Express feelings without manager present (1)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff responses to group content</th>
<th>Negative Reactions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff take comments personally (4)</td>
<td></td>
</tr>
</tbody>
</table>

⁶ See Appendix 7 for illustrative quotes of the subthemes
Discussion of staff conflicts:
Staff discuss problems with other staff (1)

<table>
<thead>
<tr>
<th>Barriers to carrying out the group</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No time to do the group (1)</td>
</tr>
<tr>
<td>Staff Difficulties:</td>
<td>Staff difficult to gather for the group (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations for future groups</th>
<th>Instructional Advice:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>How to manage emotions (3)</td>
</tr>
<tr>
<td></td>
<td>How to manage difficult situations (2)</td>
</tr>
<tr>
<td></td>
<td>How to manage difficult clients (1)</td>
</tr>
<tr>
<td></td>
<td>Evaluate the shift and derive an action plan for future similar shifts (1)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th></th>
<th>External support:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Ward manager to attend (1)</td>
</tr>
<tr>
<td></td>
<td>Member of psychology as part of group (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Revisit training:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Run the group as taught in the training (1)</td>
</tr>
</tbody>
</table>

**Interview with the ward manager**

Six themes emerged from this semi-structured interview (see Appendix 8). These included: 1) Objectives of the group, 2) Content of the group, 3) The impact of the group, 4) Obstacles to carrying out the group and 5) Changes for future groups. See Table 2.

**Table 2: Themes and categories from open-ended questions with the ward manager**

<table>
<thead>
<tr>
<th>Themes:</th>
<th>Subthemes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived objectives of the group</td>
<td>Emotional Support</td>
</tr>
<tr>
<td></td>
<td>Acknowledgement of the work</td>
</tr>
<tr>
<td>Content of the group</td>
<td>Perceived positive reactions to the content</td>
</tr>
<tr>
<td></td>
<td>Perceived negative reactions to the content</td>
</tr>
<tr>
<td></td>
<td>Change in content</td>
</tr>
<tr>
<td>Perceived impact of the group</td>
<td>Relationships between nursing staff</td>
</tr>
<tr>
<td></td>
<td>Service user feedback</td>
</tr>
<tr>
<td>Obstacles to carrying out the group</td>
<td>Practical Difficulties</td>
</tr>
<tr>
<td></td>
<td>Staff perceptions of usefulness of the group</td>
</tr>
<tr>
<td>Changes to future groups</td>
<td>Shift Evaluation</td>
</tr>
<tr>
<td></td>
<td>Reflect on Positives</td>
</tr>
</tbody>
</table>
The theme 'content of the group' has been selected for further discussion as it provides further information on the difficulties that were encountered in the group that emerged from the questionnaires. In addition, the 'perceived impact of the group' has been selected as it adds information from a managerial perspective in line with the objectives of the evaluation. It is hoped that the inclusion of this feedback adds more detail to some of the themes that emerged from the questionnaire and includes the manager's perspective.

**Content of the group**

The first subtheme relates to the perceived positive reactions to the content of the group.

"I picked up from them mixed feelings about the group, whether it was helpful or not helpful. Some of them thought it was. I think in general, most of them did found it beneficial".

The second subtheme relates to the perceived negative reactions of staff to the content.

"It was becoming a bit personal really, and so they were not very keen to just talking about their emotions. How do you feel? How do you feel? To me some of them said it was becoming a bit irritating”. And: "Over and over the same thing”.

The third subtheme refers to how the content of the group began to include other topics in addition to discussing emotion

"Is about the shift, is about what we did well, what we could have done better, who was aggressive and what needed to be done. A kind of shift evaluation, as well together with not forgetting the purpose of that group”.

**Perceived impact of the group**

The ward manager was unsure of whether participation in the group had helped staff manage work related emotions or stress. He believed that at times going to the
group served only to exacerbate staff stress levels as staff often felt criticised in the group.

"I heard one of them walked out; angry at being told he had done the wrong thing. Often it was about what had been done wrong, criticising. None of them said to me it helped manage emotions, often just caused problems between the em, nurses".

He did however state that he was receiving fewer informal complaints about staff from clients, since the group had begun but was unsure if this was due to participation in the group or other factors.
Discussion

Feedback from the nursing team and the ward manager highlight relatively mixed views about the contribution of the group to the management of work related emotions and stress. This replicates much of the research in the area (Reid, 1999). Although sharing emotions was rated as helpful, conflict in addition to practical constraints appeared to impede its implementation. Staff did not see it as impacting on their relationships with clients. Although, the majority of respondents said they would recommend the handover for use in other settings.

The majority of participants stated that the most helpful aspect of the group was the discussion and sharing of emotions. Most participants saw the group as somewhat helpful in allowing for more open discussions of feelings generated from the work. The majority did not believe that participation in the group had any impact on the management of work related emotions or stress. Thornycraft & McCabe (2008), suggest that staff groups can encounter difficulties when there is inadequate consideration of the motivation behind the request for them. Whilst in this case, both management and staff requested a forum for support, the qualitative feedback seems to support the notion that instruction on how to manage emotions and situations would have been helpful. For future groups, the psychology team could work more closely with the nursing team to incorporate their ideas of how they would like to use the space.

The majority of respondents said that the group had little to no impact on the ward atmosphere or relationships with service users. This may be because participants experienced conflict in the group. That is, the group might have been viewed as a challenging or negative space that had little relevance to clinical practice. Haigh (2000) suggests that boundaries are crucial to a group's success. It is likely that staff taking comments personally in the group could have led to an unboundaried and unsafe space for participants. This conflict seemed linked to a reluctance to carry out the group and possibly why it moved away from solely discussing emotions.

Whilst many theories of group process (e.g. McGrath, 1991) contend that conflict within a group is instrumental to its development, this can be difficult to endure at the time. Haigh (2000) suggests that: 'the team with a well functioning support group is the team that least needs one' (p: 316). Delineating the boundaries in
additional training sessions and ensuring that other support structures are in place (for example supervision) may go some to supporting staff in resolving conflicts that emerge in the group.

Limitations
A key limitation is that the measure used did not tap into why the majority of staff would recommend the group to other wards. Although staff reported the most helpful aspect of the group as the sharing of emotions, it is unclear exactly how this was helpful to them. It did not appear to link to hypothesised benefits of the initiative. A further limitation of the measure was that its reliability and validity were not assessed. Additionally, terms such as 'emotions', 'stress' and professional relationships were not clarified for participants. This may have contributed the lack of clarity. Future evaluations might use a focus group or individual interviews to obtain more detailed feedback and deconstruct terms that are used.

A further limitation was the interview schedule used with the ward manager. It did not yield sufficient first hand information about his experience of the group. Future research might reconsider this schedule in addition to following up his comments from on the reduction of client complaints about staff in this time frame. Client feedback could be explored, perhaps via a service user feedback group. A Ward Atmosphere Scale (Moos, 1996), or a review of critical incidents at different time points may provide additional insights into relationships on the ward. The omission of these measures is noted as a further limitation of this evaluation.

Service Implications:
The feedback obtained has identified the developmental needs of the group and can be used to guide what additional support and training is needed (e.g. additional training on how to manage difficult emotions and how to maintain boundaries). It can also be used to develop and pilot the group for use on other wards. Feedback indicates that staff found sharing emotions most helpful about the group. Further discussion with staff may be helpful to explore how this group can be used to manage workplace stress and burnout.

Conclusions
The mixed feedback may be linked to the limited evidence for staff support groups generally. Alternatively, it may be connected to the limited input from staff in this
initiative, and the occasionally negative experiences of participation. Considering the limitations of the evaluation however, further exploration is required to determine how best to support this staff team.

Feedback to the service

Results were presented to a nurses' forum meeting that is open to all staff in the trust and summarised in a report for the psychology services (Appendix 9). Due to the placement ending, the lead supervisor has presented the results to the nursing team.
References


Appendix 1: Concepts taken from Systems Centred Therapy (Agazarian, 1997)
Staff Sensitivity Group:

This is a staff group where the 'feelings discussed are related to the task of work, about patient care and how relationships between staff impinge on it; (Haigh, 2000, p: 314). It is not a case discussion group, business meeting or social group.

Systems Centred Theory:

This theory posits that all human systems survive and develop through an ability to recognise and integrate differences in order to achieve their goals. The primary goal is postulated to be survival and development and the secondary goal is postulated to be environmental mastery. Through the use of functional subgrouping and boundarying, systems can identify and integrate difference (Agazarian, 1997)

Functional Subgrouping:

The idea that 'all human systems, survive, develop and transform from simple to complex, from an ongoing process of recognising differences and integrating them. All groups naturally come together around similarities and separate on differences. Systems Centred Therapy (SCT) introduces the technique of functional subgrouping to resolve the conflict that difference causes in groups. Instead of automatically splitting around difference SCT groups deliberately subgroup around differences and explore them (Agazarian, 1997, p: 41). 'Functional subgrouping provides a structure within which the splits can be contained in a way that encourages groups to work toward integrating these splits' (p: 43).

Boundarying:

'Boundaries are seen as the containers of energy that give system life. The structure of a system is defined by its boundaries (p: 62'). Boundarying draws the map of the boundaries of the system in space and time; (p 64). This can be used to help resolve conflict and assist a group in reaching its goals.
Appendix 2:

Format of the staff group
Fifteen minutes of each nursing handover would be allocated for the group. Any staff member who had attended a training session could act as facilitator. After selection of the facilitator, staff would be invited to share any feelings aroused by the work on that day. The information would be shared in a structured way:

- What happened? (The facts of the situation or the incident)
- What feelings were aroused in the staff members?
- Did other members of the group share the feelings identified?

The process would be repeated for as many participants as required. The facilitator would then facilitate a closure exercise. This would involve a series of standard questions intended to move participants from experiencing the emotions to reflecting on them:

- Were there any surprises from today’s discussion
- Have we learned anything?
- Any satisfactions from today?
- Any next steps we need to take?

The role of the group is not to provide solutions to issues identified, but to listen to and validate the emotions described. If issues were raised that did need to be addressed, the facilitator would refer these for managerial action or to appropriate forums.
Appendix 3

Format of the Training session
The training session ran on three occasions in order to accommodate staff members' shift patterns. Each session lasted up to three hours. A minimum of two clinical psychologists and one trainee clinical psychologist facilitated each session. The training session focused on the following:

Exploring the difference between thoughts, emotions and behaviours. Exercises to support this were taken from Mind over Mood (Greenberger and Padesky, 2004).

Considering techniques to use descriptive reflection and boundarying (for example the 'earn the pen' exercise (Agazarian, 1997). This exercise asks the first participant to speak about a topic, for example a film they had seen and how it had made them feel. The second participant must then paraphrase what has been said in order to earn the pen. The pen is only to be passed on if the content of what has been said has been paraphrased sufficiently. The first speaker will determine the accuracy of the paraphrased summary.

Considering techniques to join on similarities when discussing emotions (functional subgrouping). For example if a participant identified a feeling of anxiety, other participants would be asked if they shared this feeling. If a participant said they had felt anger and not anxiety, anger would be identified as the next emotion to discuss. The discussion would move to the next emotion after it was determined if anyone else had experienced anxiety also.
Appendix 4

Questionnaire
Questionnaire

Evaluation of the staff group

All information on this questionnaire is strictly anonymous and confidential

1) Do you think that taking part in the emotions handover group has helped you to feel more able to discuss your feelings about work, with colleagues?

Not at all ________ 2 ________ 3 ________ 4 ________ 5

2) Do you think that taking part in the emotions handover group has helped you manage strong feelings that can come from direct work with service users in an acute ward setting?

Not at all ________ 2 ________ 3 ________ 4 ________ 5

3) Do you think the existence of the emotions handover group has contributed to a positive change in the ward atmosphere?

Not at all ________ 2 ________ 3 ________ 4 ________ 5

4) Do you think that taking part in the group has helped you manage any work related stress you may experience?

Not at all ________ 2 ________ 3 ________ 4 ________ 5

5) Do you think that taking part in the group has helped you manage any work related stress you may experience?

Not at all ________ 2 ________ 3 ________ 4 ________ 5

6) Do you think that taking part in the emotions handover group has helped improve your professional relationship with service users?

Not at all ________ 2 ________ 3 ________ 4 ________ 5
7) Do you think the training session prepared you to discuss your feelings in the group?
   Not at all 1 2 3 4 5 Very much so

8) Would you recommend this staff group to staff on other inpatient acute wards? Please circle one.
   Yes  No

9) What do you think has been most helpful about the group

10) What do you think has been least helpful about the group?

11) If you were responsible for running the group, what if anything, would you change?

Thank you
Appendix 5

Semi-structured interview prompts
Prompts for interview with ward manager

What is your understanding of how the group came about?

What did you as a manager; understand the objectives of the group to be?

Did you observe/ or hear anything from staff about whether it helped manage emotions or stress? Did it have any impact on staff comfort/desire to discuss emotions?

Did you see the group as having any impact on the ward generally?

To what extent, if any, did you see the group as impacting on staff-client relationships? Was there any feedback about this?

What do you as the manager on the ward see as the strengths/weakness of the group?
Appendix 6

Information for participants
This evaluation aims to gather feedback about the staff group that has been carried out on the ward. It will be carried out by (clinical psychology trainee). The aim is to identify the strengths and weaknesses of the group in order to make any necessary changes for improvement. This is to ensure it is a useful and relevant resource for staff. Participation in the evaluation is voluntary and all responses will be anonymous. The findings of the evaluation will be fed back to the service. A confidential report will also be submitted to the university as part of the trainee’s research requirements for fulfilment of their qualification.
Appendix 7

Illustrative themes from the questionnaire
Qualitative themes that emerged from the questionnaire

Benefits of the group:

‘Sharing your feelings with members of the team in a group in a positive way’
‘Taking time out to discuss your feelings’.

It’s better when the ward manager don’t attend. It gives staff the chance to express emotions without being seen as weak’

Staff responses to group content:

‘Members of the group often took things personally and got angry’

Barriers to carrying out the group:

‘The pressure of getting staff together made it hard to do the group’

Recommendations for future groups:

‘Have staff trained on how to deal with negative emotions and give some answers on how to overcome these emotions’

‘Stick to how the group was meant to be run as was led out in the training session’
Appendix 8

Transcript from interview conducted with the ward manager
Transcript of interview with ward manager

I – interviewer

WM – Ward Manager

Interview carried out on the ward on 26/03/08

1 I Could you tell me how you understand the group came about?

2 WM Em, how the group came about was like, that was instigated by (psychologists). We all, all of us had training on how to run that group and that after the training we started it on the ward. We had a set of questions, what we were supposed to be asking, about emotions and feelings, on the ward. If they didn't find anything, how they feel about that and you know, it was just to explore the emotions and feelings about staff working on that particular shift, and it was led by one person. And they did it religiously for awhile, and it seems to have, some people find it beneficial, find benefit.

10 I What do you think prompted the psychologists to instigate it?

11 WM Well, I'm not, um, exactly sure. I think it was because em, some had been asking for help with working on the ward. They (psychologists) thought this, eh, feelings group could help. They came and talked with some staff about what they eh, wanted, yes.

15 I As the ward manager, what had been your objectives for the group?

16 WM Well, the objectives from my point of view was, is part of the team building process, really. You have a forum where a group of people is meeting up discussion going on around, or discussing how the shift had been and all the difficulties and what could they have done better. You know, how did you feel about this, what could we do to prevent this? It was about learning, one the objectives was learning, teambuilding, sharing information, basically bringing togetherness really. What I thought, and basically feeling better a
Do you think the group impacted on how the staff managed workplace stress or emotions?

WM

Well, some of them did find it a bit difficult, because they thought it was personal. And it became a bit, well things are not changing so why am I going to talk about my feelings. Some saying to me they didn't want to go anymore, I heard one of them walked out, angry at being told he had done the wrong thing. Often it was about what had been done wrong, criticising. None of them said to me it helped manage emotions, often just caused problems between the nurses. So this is how other bits came into it. Because they are the people who work here everyday, and know what things they need to discuss, in order to make it a bit more, productive, and so that's what they did.

What kinds of things did they end up discussing?

WM

Well, is about the shift, is about what we did well, what we could have done better, who was aggressive and what needed to be done. A kind of shift evaluation, as well together with not forgetting the purpose of that group.

Did you attend the group?

WM

I did go, two of them where I was just listening to them, and em, two that I attended I did find it quite useful. It appears that the nurses were able to talk freely, openly, at the same time it was becoming a bit personal, and so they were not very keen to just talking about emotions. How do you feel? How you feel? To me some of them said it was becoming a bit irritating. Over and over the same thing.

What do you think could have helped avoid that?

WM

Eh, one thing was that to explore the emotions and feelings that were there, which was one of their aspects and the other one was to say what we did
Because the nurses, I feel and I think, not always get praised or what a good job they do. So is like praising each other, acknowledging that it was a difficult shift, and we managed it. We did this. We achieved that. I've heard better about it. It doesn't have to just be negative, it has to be positive as well. So that's what I think we could add up in that, and I guess with the questions we have at the moment, you can always explore the positive aspects of it. But the positive aspects can only be explored, by you know, if we have achieved something, and it was very much discussing all the time about what was wrong.

Do think the group had any impact on the ward atmosphere?

If all the time discussing the negative, then it seemed to make a bad feeling on the ward. But on days after a good shift, it was a better atmosphere, fun even.

Do you think participating in the group influenced staff-client relationships?

To me, I can't say if it did or not. Staff had not mentioning they thought it had. Although, recently, eh, clients don't make as many complaints about staff like they, eh, there was a few before. Reflecting on the positive aspects and thinking what needed to be done might have helped.

Is the group still taking place?

I would recommend that, I would want them to carry on doing it. Some staff does it, it isn't something that is done routinely.

What has got in the way of it happening on a regular basis?

Timing, but that is the only time it can be done. It became a bit like, for few of them it became a bit tedious, repetitive. Some of them probably forgot to do it. We are having a bit of a problem with staffing level. At times it is just taking two nurses, so organising this and that, only one person ends up
doing it. While you are organising for ward round or a meeting, sometimes it gets overlooked.

**What do you see as a manager could be done to make the group more useful?**

Reflecting on the positive aspects, saying what we've done well and how we could have done things better. If for example, an incident happened, they down and they talking. Who did what and things like that. Can also talk, how well we can prevent this? Was this incident avoidable, and things like that. And I guess all of the nurses on the ward are quite experienced. They have been here a pretty long time. I am pretty sure they can explore these kinds of things.

**Did the staff ever come back to you with specific feedback?**

Just general talk, I picked up from them really. Mixed feelings about the group, whether it was helpful or not helpful. Some of them thought it was some of them thought they should have discussed these things, so there a bit of mixed feeling. But in general, I think most of them did find it beneficial. Most of them. You would have the odd one here and there that don't see the purpose of that, which is human nature.

**That completes the interview, thank you for your participation.**
Appendix 9: Feedback to the service
Dear Susan

Re: Feedback to nursing staff on service evaluation

Thank you for presenting the feedback on the Emotions Handover service evaluation project that you carried out (see attached flyer). Associate Director of Nursing, emailed to thank us and said it had been well received. They are now hoping to extend the project to other wards.

Yours sincerely

Clinical Psychologist
Abstract

Introduction:
This study aimed to explore the experiences of supervisors (clinical and counselling psychologists) who deliver clinical supervision to qualified therapists within trauma services, and/or in other services with a special interest in trauma. Trauma work and its supervision are considered within the context of the following challenges; diversity, complex therapeutic interactions and the personal impact of the work on the therapist. The available literature on supervision in trauma, in addition to general research on supervisor development and the supervisory relationship are reviewed. In light of limited research in the area, the following research is posed: ‘how do clinical supervisors think about their supervision with qualified staff in trauma work?’

Methods:
Interviews with 7 supervisors were conducted, transcribed and analysed using Interpretative Phenomenological Analysis (IPA).

Results:
Four master themes emerged from the IPA analysis: 1) ‘The kind of stuff of your worst nightmares’: Managing the impact of the trauma content in the therapeutic and supervisory relationship, 2) The importance of openness and transparency in the supervisory relationship, 3) Supervision as not operating in a vacuum: the role of wider context and a multiplicity of viewpoints, 4) The learning experience: the interplay between experience, knowledge, confidence and expertise.

Discussion:
Participants describe difficulties in negotiating boundaries around self-care for supervisees in addition to addressing sensitive topics in supervision. Openness and transparency in supervision were deemed important and were facilitated through joint work, supervisor self-disclosure and modelling. The wider context was deemed important, specifically culture, and supervisee contexts. Challenges in facilitating the learning process were described in relation to supervising peers. Limitations are considered and future research is indicated. Clinical implications refer to the use of supervision of supervision, the use of supervision contracts and continuing training in the area.
Acknowledgements

Thanks to all the participants for taking the time to share their experiences with me and also for useful feedback on themes that emerged from the results. I am grateful to my research supervisor Arlene Vetere and also Renos Papadopoulos for advice and support throughout the process.
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Introduction
This study aims to explore the experiences of supervisors (clinical and counselling psychologists) who deliver clinical supervision to qualified therapists within tertiary NHS trauma services, and/or in other services with a special interest in trauma. Experiences in this context refer to participants' beliefs, views and knowledge of the supervision of trauma-focused work.

In this study I firstly offer a definition of trauma services, elaborate current understandings of traumatic experience with respect to diagnostic categories and review trauma-focused therapy. Current theory and research will be presented to consider particular complexities of trauma work, and the role of clinical supervision to address these. A review of supervision research specific to trauma focused work will then be presented.

Given the somewhat limited literature on supervision specific to trauma work, I offer an overview of clinical supervision more generally, focusing on the definition and purpose of supervision and current theoretical conceptualisations of supervisor development and the supervisory relationship. The aim of this review is to identify how more generic thinking and research in clinical supervision can inform supervision of trauma-focused work. The introduction will conclude with the rationale for the current study.

Trauma services, diagnostic criteria and interventions
In the context of this study, trauma services are understood to be specialist services that work with individuals who have experienced a traumatising event, which has led to difficulties in coping or adjustment. These events might include accidents, military action and deliberate acts of sexual or physical violence including torture. In addition to difficulties related to trauma, individuals can also present with suicidal ideation, self harm, personality disorders, substance misuse and psychiatric histories prior to the trauma (Lab et al, 2008). Some services restrict inclusion to adult trauma, others include trauma experienced in childhood. Services with a special interest in trauma, refers to more generic (possibly secondary care) services that offer trauma focused work as a specialty.

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7 Supervision in this study is designated as the clinical supervision of a therapist's work and not managerial supervision. Issues of definition are addressed later in the study.
8 This research project will be written in the first person in order to allow reflection on my position in regard to the research and how this may influence the research process.
Papadopoulos (2007) outlined three categories of the negative effects of trauma. These include: ordinary human suffering, distressful psychological reaction and psychiatric disorder. The latter will be focused on in this study. Within psychiatric disorder, Post Traumatic Stress Disorder (PTSD) is believed to have the highest prevalence, (i.e. more frequent than post traumatic depression for instance, National Institute of Clinical Excellence, NICE 2005). This diagnosis focuses on the distress caused as a result of experiencing or witnessing a traumatising experience. Complex PTSD (Herman, 1992) or Disorders of Extreme Stress not Otherwise Specified (Van der Kolk et al, 2005), include psychological sequelae related to prolonged trauma (e.g. torture or domestic violence) as distinct from one index trauma. Complex PTSD adds relationship difficulties, somatisation, dissociation, retraumatisation, disruption to identity, and affect regulation, to the difficulties typically seen in PTSD (Herman, 1992). Most commonly, although not always, trauma services work with individuals whose difficulties are thought to come within the diagnosis of PTSD, complex PTSD or Disorders of Extreme Stress not Otherwise Specified.

Trauma focused therapy is understood as a specialist psychological intervention for people who are experiencing psychological distress following a trauma. This might occur within specialist or generic services. NICE, (2005) propose a package of Cognitive Behavioural Therapy (CBT) or Eye Movement Desensitisation Reprogramming (EMDR) as first line treatments for PTSD, based on a meta review of studies in the field. This review however, did not include work with individuals with co-morbid difficulties and only one study on trauma work with refugees, so it is likely that trauma work in clinical settings will complement NICE directives with a wider range of theoretical models of distress (e.g. Lab et al, 2008).

Specific complexities in trauma focused work, and the role of clinical supervision

- Diversity

Trauma focused work can involve working with large numbers of clients from diverse ethnic backgrounds, and in particular, working with refugee and asylum seeker clients. Whilst the challenges of working in a culturally sensitive way are certainly

9 A threat to one's own life or the life of another is the main criterion (Criterion A) for diagnosis.
10 While it is acknowledged that medication comes under the umbrella of treatment in the NICE guidelines, this will not be the focus of the current study.
not unique to trauma specific interventions (e.g. Patel et al, 2000), it is possible that these types of challenges will be encountered more frequently than in generic services. A review of 17 specialised trauma services in the UK (Gavrilovic et al, 2005) indicated that the proportion of refugee clients ranged from 10% (four services) to more than 50% (6 services) of clients. Given that these statistics are now five years old, it is highly likely that this number has since increased in the context of inclusion of further member states to the EU and continuing worldwide political conflicts.

There have been several challenges to the use of PTSD as a diagnosis with ethnically diverse clients. Zur (1996) reviews the need to consider diverging views about what constitutes 'normal' emotional expression across cultures and the positive connotations to the experience of nightmares about the dead for instance. Similarly, Kirmayer (1996) reflects on how intrusions and avoidance may have different values across cultures. While most work suggests that although PTSD can be considered as somewhat universal, it is imperative to explore individual aspects of diversity in trauma-focused work (e.g. Brown, 2008).

Clinical supervision has been recognised as an important component of developing skills in working with ethnically and culturally diverse clients in clinical psychology (e.g. Williams et al, 2006). However, as will be considered later in the review of the supervision literature, there has been limited elaboration (exceptions include Tribe, 2009 & Yabusaki, 2010) of how this cultural competence might be developed in supervision.

The need for interpreting services is another facet of diversity. The need to work through an interpreter is observed across most services and psychological interventions in this country. Again I contend that due to the high proportion of refugee clients in addition to non-refugee, non-English speaking clients, it is likely that the use of interpreters in trauma services could be a frequent occurrence.

It has been observed (e.g. Skelton, Kai & Loudon, 2001) that most pre-qualification practitioner courses offer limited training on working with interpreters or consideration of multicultural frameworks. Across general mental health settings, practitioners report difficulties when with working through interpreters, such as difficulties developing a therapeutic alliance with the client and the simplifying of
interventions (e.g. Raval & Smith, 2003). d'Ardenne and Farmer (2009) offer some practice points on carrying out trauma focused CBT with interpreters, focusing on building rapport and working with alternative realities for example. To date however, there appears to be limited empirical elaboration of whether supervision is used to support work through interpreters.

- Complex therapeutic interactions

Woodcock (2002) draws from experience as a family therapist to reflect on the complex relationship dynamics that can play out between therapists and survivors of war or torture. He explains that at times 'the fear of the horror of war can confound my thinking' (p143). For example this may lead to idealising or distorting the clients' identity. He concludes that this experience can be related to the denial of painful realities of the trauma experience and supervision is essential for identifying and managing these reactions. Woodcock elaborates on the necessity of supervision to explore complex transference issues for therapists, such as clients feeling persecuted by the therapist or the therapy. He advocates 'careful unpacking' (p.146) of these issues in supervision to maintain clinical effectiveness.

Century et al (2007) found some counsellor-identified challenges in maintaining appropriate boundaries in the therapeutic relationship with traumatised refugee clients and the need for flexibility or more education on boundaries when considering this. Participants reported bringing these difficulties to supervision, which was described as supportive. Century and colleagues conclude that specialist supervision might be highly useful for counsellors who work with this client group, although do not elaborate on what this specialist supervision might entail.

Complex relationship dynamics are not confined solely to work with refugees. For example in the field of domestic violence (DV) Illife & Steed (2000) found that therapists reported taking too much responsibility for their clients. Clinicians in this study reported difficulties in managing the reality of the objective risks to clients. Similarly clinicians in this study reported a loss of confidence in initial work with the propensity to become overwhelmed and hopeless in the absence of change. I

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11 A process in which the client's current (and past) emotions, as well as parts of the self are externalised into the current relationship with the therapist. (Lemma, 2003, p233)

12 This kind of therapy can increase risk, as for some, therapy may lead to leaving abusive relationships, which can result in further violence (Vetere & Cooper, 2008).
would contend that similar issues are likely to be at play in therapy with other traumatised groups and could potentially impact upon the therapeutic relationship. For example, some refugee clients may be more at risk in the UK rather than country of origin (e.g. women who have been trafficked), and equally clients with limited memories of a traumatising attack may face increased objective risk due to limited memory of danger areas/triggers.

It is not my intention to suggest that issues of diversity and complex therapeutic relationships are the sole preserve of trauma-focused therapy. However, it seems likely that the frequency of work with refugees, the often extreme nature of clients' traumatising experiences and the objective safety concerns inherent in the work, may require an explicit or additional focus in supervision. Below, I consider the personal impact on the therapist when working with trauma material.

- The personal impact of trauma focused work on the therapist and the role of supervision

The personal or emotional impact of trauma work on the therapist has been conceptualised using terms such as Vicarious Trauma (VT), Secondary Traumatic Stress (STS) and burnout. These terms refer to the ascribed negative effects for professionals of working with trauma content. VT refers to a gradual and long-term change in therapist beliefs with associated affect disruption, while STS is characterised by a sudden adverse reaction to working with a traumatised person. Burnout is the considered to be the consequence of prolonged work (not necessarily in trauma) and is related to emotional exhaustion (Figley, 1995). As VT is a phenomenon that is considered prevalent in long-term trauma therapy (that is, time focused therapeutic interactions rather than emergency response work), it is the more relevant of the concepts to the current study and will be considered in more detail below. However, STS is also included, as the terms are so frequently used interchangeably (Jenkins & Baird, 2002).

McCann and Pearlman (1990) first used the term 'vicarious traumatisation' to describe the long-term effects on practitioners of working with traumatic material. VT is thought to occur through empathic engagement with the client's material which can result in negatively shifting the therapists' beliefs about themselves and the world, particularly focusing on intimacy, esteem, safety and control (Saakvitne &
Pearlman, 1995). Counter-transference is the theoretical framework most frequently invoked as an explanatory mechanism of VT (e.g. Pearlman & Saakvitne, 1995).

Whilst VT and STS have been widely adopted in the field, with corresponding guidelines for clinicians, including the proposal to expand the definition of PTSD in the DSM-V to include 'learning about traumatic events that have occurred to a close relative or friend and repeated or extreme exposure to details of traumatic events through work practices', (e.g. police officers repeatedly exposed to child abuse details), (American Psychiatric Association 2010), empirical support for their existence is mixed. See Sabin-Farrell and Turpin, (2003) for a full review.

Although much of the research on VT and STS is carried out in the area of sexual violence, of note to the current study is Birck's (2002) study of STS in work with torture victims. Birck found some contradictory results suggesting that longer duration (years) working in trauma settings correlated with higher rates of STS, but also correlated negatively with disruptions in self-intimacy. The latter might indicate a protective role of experience in disruption of this belief. Contrary to the notion of VT, there was no evidence of cognitive shift in workers. The threat of client deportation seemed to be a high risk factor for STS in workers, which parallels with qualitative findings from Iliffe and Steed (2000); indicating therapist stress is related to objective safety concerns for clients.

In contrast to mixed results from quantitative research, findings from qualitative exploration appear to provide more conclusive reports of the impact on practitioners of working in trauma settings (e.g. Steed & Downing, 1998, Benatar, 2000, Iliffe & Steed, 2000), including negative emotional, cognitive and physiological effects, and altered views on safety and relationships for instance.

In terms of the relationship between supervision and VT or STS, Kassam-Adams (1995) found no connection between supervision and PTSD symptoms in staff. However, Pearlman & Mclan (1995) found that workers who had no supervision (as well as being new to the work) had high TSI Scale scores.

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13 Counter-transference is thought to have two meanings. One refers to something that the therapist feels the client is non-verbally, non consciously communicating, but which belongs to the client. The other refers to the something that is felt by the therapist, which may be triggered by the client but essentially belongs to the therapist. (Walker, 2004, p 176)

14 This is an item on the Traumatic Stress Institute Belief Scale (TSI), which refers to connection to the self.
Harrison and Westwood (2009) explored how ‘master therapists’ manage the challenges of working with traumatised clients. The first narrative theme that emerged related to the importance of supervision (‘supervision as relational healing’, p. 208) as a means of helping to overcome shame about experiencing VT in addition to reinforcing ideas of the need to maintain good self care and management in this work. Supervision was also cited as helping therapists to maintain boundaries, and to manage therapist resonance with trauma content.

In summary, it appears that quantitative support for the concepts of VT and STS is somewhat mixed and often inconsistent. Qualitative research appears to provide more support for the idea that this type of work impacts upon the worker personally. Equally, the protective role of supervision against these effects is inconsistent, and further exploration of its role has been advocated (e.g. Sabin-Farrell & Turpin, 2003). The available literature that explicitly explores supervision in this context is reviewed below.

**Supervision of trauma work**

Pearlman & Mclan (1995) recommend that trauma supervision should comprise of four components; a firm grasp of trauma theory, attention to the conscious and unconscious aspects of treatment, a mutually respectful supervision climate and education on VT (p. 360). It is unclear however how much practical use these inclusions may be, as there is limited elaboration of how supervisors might navigate the introduction of concepts of VT, such as where and when it might be appropriate to do so. These guidelines have been elaborated upon, mainly in sexual abuse work.

Etherington (2000) considers work with child sex abuse survivors in the context of more general services. As well as the ‘normative, formative and support functions of supervision’ (p. 377) Etherington also argues for the need of supervisors to hold a good understanding of trauma theory, i.e. understanding experiences like disassociation, flashbacks, and an open and non-judgemental approach to survivor coping strategies. She sees a role for the supervisor in drawing attention to the potential dynamics that can play out in therapy, e.g. therapists identifying in the rescuer or abuser role. She suggests that supervisors maintain awareness of the
material that is not brought to supervision, as well as being vigilant to patterns in the material that is brought, and the need to initiate discussion on what the troubling aspects of this material might be for the supervisee. Additionally she suggests that the supervisor maintains awareness of their own reactions to material and the occurrence of parallel process, such as feeling like they are being intrusive in supervision by questioning. She positions the need for this level of supervisory awareness in the context of maintaining vigilance for VT and STS in supervisees. This appears to be underpinned by her personal experience of VT (p. 380), which arguably holds its own advantages and disadvantages.

Azar (2000) suggests that trauma work can affect supervisors as well as supervisees and advocates the need for supervisors to accept that they are as equally vulnerable to becoming 'dysregulated', (p. 651) as supervisees. In contrast to much of the theorising in the area, she acknowledges the importance of the evaluative function of supervision and how this might affect supervisees' comfort with disclosing personal reactions to the work. The overall premise of her paper lies in the use of CBT techniques in supervision to identify supervisees 'violated assumptions' (p. 649) about how clients 'should react', which she posits as underpinning therapist burnout. It is unclear how this might be negotiated with the supervisee however, as the 'slow shifting of individuals' deeply held and cherished belief systems, expectancies, and assumptions' (p. 644) would arguably require explicit discussion with, and consent from the supervisee as well as presumably taking time away from other tasks of supervision, something that Azar does not discuss.

Walker (2004) similarly sees the role of the supervisor as crucial in managing transference and counter-transference, especially with regard to talking about very difficult topics or experiences, for example sexual feelings in the transference. Walker also suggests that an 'incompetent supervisor' may add to the likelihood that counter-transference could become traumatising, i.e. if the supervisee does not get the support they need.

Walker suggests that supervisors need to be aware of their own strengths and limitations, not attribute all difficulties to parallel process16, and to be able to hold

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16The unconscious replication of relationship dynamics in another relationship, in this case the therapy relationship replicating in the supervisory relationship
and contain the despair and the horror of what the supervisee is bringing. She also advocates that a supervisor have a good awareness of organisational and institutional dynamics, e.g. being able to reflect on organisational dynamics in addition to therapeutic ones. In reflecting on the creation of a safe and containing space however, it is interesting that Walker does not consider the evaluative component of supervision and how it might play out in supervision between experienced, qualified staff. It may also be of use to explore emotional reactions and responses of the supervisor in navigating these difficult areas.

With regard to work with refugee clients, Papadopoulos (2001) offers some reflections on supervising therapeutic work with refugees in a family therapy service. He suggests that one of the core purposes of supervision is to enable the supervisee to develop their skills in obtaining appropriate information from clients and also discriminate between information and background noise (Bateson, 1971). Relevant information will be guided by the therapeutic approach and therapists will endeavour to minimise interference from background noise. In this setting Papadopoulos includes the wider societal discourse about 'traumatised refugees as constituting background noise and suggests that it is this identification of this background noise and its impact on the therapy, which, may be the focus of supervision, rather than refugee therapy specific techniques.

In the field of DV, Vetere & Cooper (2008) suggest that working in this area requires supervisors to be more directive and active in their supervision than in other supervision (p. 348). They outline the importance of safety and the need to challenge supervisees' theoretical ideas to develop safety in practice. They explicate their beliefs on the responsibilities of the supervisor, which include: supervisor sharing of their style and how this may be altered when supervising in DV and their efforts to create safety in the supervisory relationship in which it is permissible to articulate indecision and uncertainty. They discuss the importance of being aware of the emotional impact of the work on the supervisee and state their stance in being supportive in such circumstances.

They note the potential stressors for supervisees, which include: the repeated exposure to accounts of extreme cruelty or violence, powerful feelings that were evoked for them and feelings of inflated responsibility. I would contend that similar processes might be at play in trauma-focused work. The authors posit the
supervisory relationship as a means in which difficult feelings can be held and tolerated. Equally, coping strategies and resources can be identified here.

Wells, Trad and Alves (2003) offer a relational model of supervision in trauma therapy (focusing on novice supervisors and supervisees), which supports supervisor development in the following areas; skill building and specialised knowledge, self-care, self-awareness, use of self as instrument, ability to work with parallel processes and integration of multicultural and individualized perspectives into their work (p.19). Although this model addresses some of the complexities in this work, it has limited theoretical underpinnings and empirical support.

Whilst the above papers offer many helpful insights into the complexity of supervising in trauma settings, it is important to note that they are theory papers, often based on one practitioner's reflections on working in the field. The only published study (to my knowledge) of the experience of supervision in a trauma setting was published by Sommer and Cox in 2005, who investigated sexual violence counsellors' experiences of clinical supervision.

Sommer and Cox identified four themes including counsellor feelings, vicarious traumatisation, helpful qualities of supervision and organisational considerations. Participants reported valuing supervision to discuss their feelings in relation to the work, multiple perspectives, collaborative guidance, a calming presence and attention to self care (p, 127). This study creates a useful starting point to consider how supervision is used and thought of in this work, and demonstrates good methodological rigour, e.g. the use of owning one's perspective and member checking to establish trustworthiness of the results (e.g. Elliot et al, 1999). However, results also need to be viewed with some caution, as the sample comprised of American unqualified practitioners, which may have limited transferability to a qualified UK sample.

**Summary**

Research in the area highlights that trauma focused work can include a heightened focus on diversity, result in complex therapeutic relationship dynamics and trauma content can have a direct impact on the therapists' well being. While clinical supervision is cited as a necessary tool in addressing these difficulties there is a
marked paucity of empirical exploration of clinical supervision in trauma services, or in trauma focused work, although there are several practitioner reflective accounts. Given this empirical gap, this introduction will consider generic supervision practices and research in order to determine what current theorising and research in the area of clinical supervision can offer trauma specific work.

Clinical Supervision

Supervision – definition and purpose
Clinical supervision can be a complex endeavour, encompassing many roles, responsibilities and multi-layered relationship dynamics for supervisees and supervisors. This is evident even in the task of definition, which is contentious and without consensus across professional groups (e.g. Milne 2007). Most research in the area uses the following definition from Barnard & Goodyear (2004): ‘an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients, she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession’ (p. 1).

Consideration of problems in defining supervision is important for the current study, as this lack of consensus has inevitable implications both for clinical practice and also when reviewing empirical investigation of supervision. That is, it raises two issues. The first relates to what practitioners consider supervision to mean, in every day clinical practice. And secondly, if the term itself is not defined, then this impacts upon construct validity in empirical research (e.g. Ellis et al, 1996).

Supervision and clinical psychology
The Division of Clinical Psychology (DCP) stipulates that: 'It is expected that all clinical psychologists, at all stages of their career and in all work contexts, will engage in regular supervision of their own work.' And ‘Such supervision is regarded as a core clinical activity to ensure the delivery of effective and high quality services’. (DCP, 2003, p. 2)
It is interesting that whilst supervision has been accorded such importance in clinical psychology, it is vastly under researched with most of the literature originating in the USA, predominantly with pre-qualified staff. Research in the UK has for the most part, been conducted in nursing and counselling psychology.

Theoretical frameworks of supervision

A plethora of supervision models abound in the literature, (a review of which is beyond the scope of this study), which have been subjected to much criticism, e.g. Feltham (2000) described the field as comprising predominantly 'emotional rhetoric'. Meta reviews carried out in the area (e.g. Ellis et al, 1996, Wheeler & Richards, 2007) indicate poor methodological rigour of empirical studies with limited validity and reliability. The theoretical conceptualisation of supervisor development and the supervisory relationship are deemed to be the most relevant to this study and will be reviewed below.

Supervisor development

Watkins (1993) proposed a model of four stages of supervisor development. These include role shock, role recovery and transition, role consolidation and role mastery. These stages sit within one of six core elements of the model, i.e. the developmental stage. The other five elements include personality, environment supports, supervisor experience, supervisor supervision and developmental issues.

Watkins proposes that in order to ascend through developmental stages, it is necessary to confront any developmental issues that may be in place. Watkins acknowledges that the model is in the preliminary stages of conceptualisation and requires formal testing to explore its constructs. To date, extensive exploration does not seem to have taken place. The model can be criticised for reducing supervisor development to pure developmental theory and not including for instance the role of learning theory or other ways of acquiring knowledge. Also it is likely that this development will not occur sequentially and supervisors may feel competent in some areas and not others throughout their supervisory careers, regardless of developmental stage.

Stoltenberg, McNeil & Delworth (1998) draw from a slightly altered version of their Integrated Development Model to conceptualise supervisor development. They posit three overarching structures within which supervisor development can occur.
These include self-other awareness, motivation and autonomy. They propose that supervisors will proceed through three stages of development beginning with rigidity moving through to more flexibility in the role, to eventually integrating their role of supervisor into the wider context of their professional role. Similar to supervisee development, this model omits inclusion of the supervisory relationship and the limited research to date appears to contradict its basic assumptions. For example, Stevens et al (1997) found that increased training rather than experience was linked to improved scores of supervisory development.

In considering the potential risk management concerns, complex relationship issues and the need for a broad understanding of diversity, in addition to potential ceiling effects of development, it seems that these theories of supervisor development have a limited applicability to highly experienced practitioners supervising experienced colleagues on complex cases in trauma. Given the reported importance of the supervisory relationship in trauma work, it is possible that current theorising on the supervisory relationship may provide a more relevant theoretical context to this study.

The supervisory relationship
Bordin (1983) suggests that the supervisory relationship has three components, including; mutual agreements and understandings of the goals, the tasks of each of the partners and the bonds of the partners. Here supervisors’ tasks refer to coaching, promoting theoretical understanding and focusing on gaps in understanding, as well as giving feedback (Beinart, 2004, p. 44). However, this conceptualisation of the relationship is somewhat different to those used in studies, which measure the relationship (e.g. Effstation et al, 1990), which inevitably generates methodological issues in the research.

Nonetheless, there is much support for linking this relationship to supervisee self-efficacy (Effstation et al, 1990) and satisfaction with supervision (Ladany et al, 1999). More recently, research has explored attachment styles and the supervisory relationship and found that supervisors’ ability to make healthy adult attachments was predictive of supervisee and supervisor perspectives of the relationship (White & Queener, 2003). Overall, supervisees seem to view the relationship as the most crucial aspect of supervision (e.g. Webb & Wheeler, 1998). However, as theoretical
accounts in trauma suggest, it is possible that this relationship could be further complicated in trauma focused supervision.

**Supervisors' perspectives of supervision**

Exploration of clinical supervision is primarily dominated by supervisee accounts of the experience (e.g. Perris, 1997, Nelson & Friedlander, 2001). Supervisor accounts are not unknown (e.g. Carroll, 1994, King & Wheeler, 1999) although are comparatively less frequent. To my knowledge there do not appear to be any published empirical investigation of supervision in trauma from supervisors' perspective, and so general supervisor accounts in the literature will be examined here to determine how they can inform the current study.

Bang and Park (2009) explored supervisors' experiences (counselling psychologists) of supervision in a Korean setting and found that teaching and discussion of supervisees' personal issues (although brief) were considered key functions of supervision. Content was influenced by theoretical orientation of the supervisor and the developmental stage of the supervisee. Interestingly the supervisory relationship did not emerge in the accounts (interviewers used an unstructured interview format). This study provides a useful starting point to consider supervisor perspectives, although is somewhat limited in its transferability to a UK context given the acknowledged limitations of translating accounts in addition to the cultural and professional context the study is embedded in.

Townend (2008) explored 'expert supervisors' views of CBT based supervision in the UK, (participants comprised of eleven psychologists), and determined eight categories of supervisor experience. These included, moderating (external) factors, relationships and roles, beliefs and values, learning processes, cognitive processes, mechanisms, monitoring and assessment and outputs from supervision. This study is helpful as it contributes a supervisor-influenced framework of thinking into the practicalities of supervision. However, as the sample was that of cognitive behavioural psychotherapy course directors, and the study did not state what types of supervisees were referred to, it is unclear whether these experiences apply to supervisors of experienced supervisors or trainees and how the experience might differ in this regard.
Summary and rationale for the current study

Trauma focused work appears to generate certain challenges for therapist and supervision is deemed to be a crucial component in managing these issues. However, there appears to be limited research into supervision in trauma work. Given this gap in the literature, this study attempted to consider how more general thinking and research in clinical supervision might be relevant to trauma supervision.

Whilst clinical supervision is considered to be 'awash with theory' (Gonsalvez, 2008 p. 82) unequivocal empirical support for these theories as well as theories of supervisor development is lacking and much of the research has limited applicability to a UK context with experienced supervisory dyads. Research into the supervisory relationship appears somewhat more promising, although predominantly focuses on supervisees' (often pre-qualified) accounts of this relationship. Given the accounts of individual supervisors' reflections on the multiple complexities of this relationship in trauma work, it is argued that further exploration of it in a trauma specific context is merited.

At the current time, there is a striking lack of clarity about the processes and mechanisms of action in clinical supervision in trauma. There does appear to be however, a consensus on its necessity in this work with some reflective accounts of from supervisors, predominantly working in sexual trauma or with refugee clients. In order to continue to explore the area, consistent with evidence-based approaches to clinical work, I believe it is necessary to investigate supervision in trauma and begin to develop an elaborated account of it. In order to do this, bearing in mind the absence of current research, I contend that a phenomenological exploration is an appropriate starting point.

The choice of exploring supervisor experiences is underpinned by, 1) the need for an exploration of lived accounts of supervision in line with supervisors' reflective accounts presently in the literature, 2) as a response to the relative rarity of the supervisor voice in a UK context and 3) their length of experience in the field, what they have learned in their own development and thus extensive capacity to reflect on experience and think forward to potential challenges. As much of the supervision research focuses on pre qualified supervisees, which arguably will have a different focus to qualified experienced staff, qualified supervisees were chosen in order to again address this gap in the current literature base and to provide an insight into
the reality of life long supervision (for this sample) between qualified staff, in everyday practice.

Therefore, the primary research question in this study is identified as:

How do clinical supervisors' think about their supervision with qualified staff in trauma work?

The secondary questions are:

1) How do supervisors understand the purpose of supervision and their role in this context?
2) Do supervisors believe there are any particular or unique considerations in supervising this kind of therapeutic work?
3) How do supervisors think about the supervisory relationship in trauma focused work?
4) What do supervisors understand to be good or bad supervision in trauma focused work?
Methodology

Research Design

Rationale for qualitative methodology

My research objectives seek to obtain an insight into how participants perceive and make sense of the supervision they deliver in the context of trauma work. These objectives, in conjunction with the limited research in the area suggest that, a qualitative methodology is an appropriate fit, as qualitative methods tend to offer the opportunity to explore in depth, the details and complexity of individual experience and how this is understood. I contend that an initial exploration and illumination of the lived experiences of clinical supervisors is an essential first step to begin to understand this phenomenon for this sample, which further research can subsequently build upon.

Willig (2001) advocates the need to consider the epistemological assumptions that underpin qualitative research methods when selecting one for research. Willig describes three epistemological positions. The first refers to the realist position, which posits the existence of objective reality that can be measured. The second refers to a socially constructed approach of reality, i.e. that social reality is co-constructed through discourse and is a product of its historical context. The last designates a critical realist position, which proposes that individuals hold representations of external events that can be accessed through discussion. The critical realist position could be considered as being located between the first two positions and is deemed to be consistent with the current study.

Interpretative Phenomenological Analysis (IPA)

In order to conduct this exploration, IPA (Smith et al, 2009) was selected as the framework of the study design and method of analysis. This method is considered to be concordant with the epistemological position of the study, and will facilitate the development of an explanatory, interpretative, critical understanding of supervisors' experiences that are based in context. This method allows for an in depth exploration of the beliefs and perspectives that supervisors hold about their practice of supervision. It is assumed that this exploration will be achieved through interviews with participants about their experiences of delivering supervision.

IPA is concerned with participants' personal lived experiences, and how they understand these experiences (Smith, 2004). The phenomenological aspect refers
to how people make sense of their experiences. The interpretative aspect of the approach includes the researcher in this understanding. Here Smith, (2004) describes a double hermeneutic occurring, i.e. participants are trying to make sense of their experiences and also the researcher is seeking to make sense of participants’ process of understanding. This assumes that research is a dynamic process, in which the researcher will inevitably come to an understanding of the participants’ understanding, through the lens of their own experience. Therefore in concordance with the hermeneutic principles of IPA, it is assumed that my interpretation of these interviews will be influenced by my beliefs as a researcher and experiences of supervision and trauma work (Dallos & Vetere, 2005).

IPA can be considered to be idiographic, that is, it is concerned with specific individuals and a specific event in their lives (Smith, 2004). That is, how clinical supervisors understand the supervision they deliver in trauma services. It assumes that individuals' perceptions of their experiences are influenced by cognition, emotion and language, and thus research is aimed at accessing thoughts and feelings that give rise to individual understandings (Dallos & Vetere, 2005). Therefore, in agreement with the inductive, interpretative position of IPA, formulation of the primary research question in this study actively sought to 'avoid the imposition of an a priori theoretical construct on the phenomena' (Smith et al, 2009, p. 47). Equally, although secondary questions were identified to add a focus to the relatively wide area of clinical supervision, it was not the aim to treat them as hypotheses.

IPA was chosen over Grounded Theory (GT) (e.g. Glaser 1992), for several reasons. The first relates to the abundance of existing theory in the area of supervision, accompanied by relatively limited exploration of supervisor experience. The identification of individual and group themes, to be related in part, to existing theory was the aim of the study, as opposed to the development of a further theory of supervision. Also GT aims to develop middle range theories of social process, and the objective of this study was to obtain a phenomenological perspective first.

Procedure

*The interview schedule*
A semi structured interview approach was selected for data collection and to answer the primary research question. This was considered most appropriate to obtain a detailed, in depth, first person account of the participant experiences (Smith et al, 2009). Adopting a semi-structured approach allowed for flexibility in the participants description of their experiences and facilitated the exploration of new or unprompted in the interviewing process.

The schedule was constructed following guidelines from Willig (2001) and Smith et al (2009). The aim was to pose open questions in a logical sequence. The selection of questions was guided by the research questions and literature on supervision and trauma-focused work as outlined in the introduction. Additionally, selection of questions was discussed with the research supervisor who holds extensive experience as a clinical supervisor, working with survivors of domestic violence. Prompts were developed in accordance with the aforementioned guidelines.

Following these discussions, some questions were omitted as they were deemed to be too broad. Following the confirmation of a draft interview schedule, I carried out two pilot interviews with two systemic family therapist supervisors. Interviews were recorded and then transcribed verbatim. I examined and reflected upon the questioning style in addition to the questions posed, in order to determine the extent to which questions were sufficiently able to access participants' inner world in relation to clinical supervision and to what extent questions and prompts may have been leading or closed. Following this process, and discussion with the research supervisor, the interview schedule was completed with minor changes (Appendix 1).

Focus group

It was hoped to run a focus group with participants on completion of the interview process, in order to pose the emergent themes from the interviews to the group, and establish credibility of these themes. This was not feasible due to difficulties with recruitment. Validity checks will be discussed later in this section.

Sampling Method
Participants were identified through purposive sampling, i.e. with the intention that they could facilitate insights into the phenomenon under exploration. Initially the identified sample included clinical and counselling psychologists, systemic psychotherapists and psychodynamic psychotherapists, who acted as clinical supervisors. In the interests of recruiting a relatively homogenous theoretical sample however (Smith, 1999), I opted to exclude psychodynamic psychotherapists and systemic psychotherapists. Psychodynamic psychotherapists were excluded by nature of the theoretical orientation they worked within, and by consequence, the supervision they offer would be too divergent from the rest of the sample. Systemic psychotherapists were similarly excluded on the basis of divergent supervision model, that is, live supervision, which is in contrast to the one to one model of discussion of cases predominantly used in clinical and counselling psychology (Townend et al, 2002)

Therefore, clinical and counselling psychologists who offered supervision to qualified mental health professionals, who work with trauma, were identified as the target sample.

Inclusion criteria:

- Qualified clinical or counselling psychologists with at least one year’s experience of supervising qualified therapists (qualified therapists referred to a member of a mental health discipline [e.g. psychology, psychiatry], who were practising therapy, post qualification)
- Supervisors currently delivering supervision to this group, or within the last two years
- Supervisors working in specialist trauma services, or in generic services with a specialist interest in trauma (both in the NHS and privately)
- Supervisors who work within trauma services, that may hold a dual specialty with refugee or asylum seeker services

Exclusion criteria:

- Clinical supervisors who only supervise therapists pre-qualification

Smith et al, (2009), advocate between 6 and 10 interviews or participants as a reasonable sample size for a professional doctoral project. This number is thought
to give a relatively good insight into the particular phenomenon under exploration, but is also not so much data as to be unmanageable. Thus, the study aimed to recruit a sample of up to ten participants.

**Ethical Approval**

University Ethical approval and NHS ethical approval were applied for and obtained. The NHS Research Ethics Committee (REC) stipulated that it was necessary to apply for Research and Development (R&D) approval for each trust that potential participants may work within. Based on supervisory contacts, three trauma services were identified as potential recruitment centres. Following managerial approval from each of these services to recruit, each R&D application was completed and R&D approval given. Later in the recruitment phase, I approached a subsequent R&D department, which a potential participant worked within, and was, advised that NHS ethical approval withstanding, R&D approval would not be necessary (See Appendix 2 for Ethics documents).

**Recruitment**

**Recruitment through specific trauma services**

Following R&D approval, the service manager for each service was contacted again, and asked to circulate an invitation to participate in the study to relevant staff members. An information sheet was provided with this invitation. Interested parties were asked to contact the researcher directly. In this event, potential participants were sent an email detailing what involvement would involve with the opportunity to ask any questions. Interviews were scheduled for at least two weeks later in order to give participants time to consider their participation and withdraw interest during this time.

**Recruitment through specialist interest trauma groups**

Email contact was made with two specialist interest groups. Psychologists working for Refugee and Asylum Seekers, (PsyRAS) and an online (yahoo group) based trauma group. The administrator of the PsyRAS group circulated an invitation to participate in the study to all members. Interested parties were advised to contact the researcher directly. One participant was identified from this means of recruitment. Contact was made with the online trauma specialist interest group, and
an invitation to participate was circulated to members. This method of recruitment did not yield any participants.

The online information base- the UK trauma group was contacted and it was agreed with senior staff to circulate an invitation to participate to members. This method of recruitment yielded one participant who was working privately (i.e. outside of the NHS).

Recruitment through non-statutory trauma services
Contact was made with the service lead for two non-statutory trauma services and agreement was obtained from the service lead to recruit from the service. An invitation to participate in the study was circulated to supervisors in one organisation. This route of recruitment did not yield any participants. The clinical lead for the other service agreed in principle to participate but subsequently had to withdraw due to work commitments.

Recruitment through public advertisement
Advertisements were placed in the British Psychological Society magazine, ‘The Psychologist’ and the Counselling Psychologist forum. Neither of these avenues yielded any participants. See Appendix 3 for study invite and information sheet.

Participants
Consistent with qualitative research guidelines (e.g. Elliot et al, 1999), a limited amount of demographic information about participants will be presented here, in order to preserve anonymity. This is particularly pertinent to this group of participants as the field of trauma is a relatively small area, and within this, supervisors who supervise qualified staff are an even smaller representation of workers in the field.

Seven supervisors agreed to take part in this study and six agreed to share demographic information. See table 1 for a summary of demographic information for six participants.
Table 1: Demographic information for six participants

<table>
<thead>
<tr>
<th>Mean age of participants (std dev in brackets)</th>
<th>Range of ages</th>
<th>Participant identified Ethnicity</th>
<th>Gender</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>44.1 (9.3)</td>
<td>36 – 62</td>
<td>White European, White Irish, White British, British Mixed Race, Mixed White Asian</td>
<td>4 women 2 men</td>
<td>5 Clinical Psychologists, 1 Counselling Psychologist</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapeutic Orientation</th>
<th>Average years qualified (Average years supervising qualified staff in brackets)</th>
<th>Range of clinical supervision training</th>
<th>Range of services, supervisors worked within</th>
<th>Range of professions of supervisees</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT, Integrative, Narrative,</td>
<td>12.3 (6.1)</td>
<td>5 - Attendance at &gt;5 workshops (between 1 and 3 days duration), 1- post graduate course in clinical supervision</td>
<td>3 trauma specific services, 2 refugee and asylum seeker trauma services, 2 generic services with specialist interest in trauma</td>
<td>Clinical Psychologists, Counselling Psychologists, Psychiatrists</td>
</tr>
</tbody>
</table>

Data collection

All interviews, took place at the participants’ place of work. Each interview began with a description of the study, a review of the information sheet and an explanation about confidentiality within the study. Any further queries were addressed at this point and the consent form was signed. Demographic information was then obtained. After this process the interview commenced and discussion from this point was recorded (with prior consent) Interviews lasted between 49 minutes and 83 minutes. See Appendix 4 for data collection forms.

On completion of each interview, recording was stopped and a five minute debrief was conducted. Within this, participants were advised to contact their own
supervisors or an external body (e.g. the Samaritans) if any of the content had a distressing impact on them.

Analysis
All interview scripts were transcribed verbatim. See Appendix 5 for samples of transcript excerpts (whole transcripts are not included for anonymity purposes). Analysis of the data followed the guidelines outlined in Smith et al, (2009, p. 82 - 101). The steps were as follows:

1) Reading and re reading of the transcript.
   This is done to immerse the researcher in the text, and to put the focus on the participant as the centre of the research.

2) Initial noting
   This process involves exploring the semantic meaning within the text and the associated use of language. Noting was used to include, descriptive observation of the content of the transcript, linguistic observations, such as the type of language used and finally, conceptual comments. Conceptual comments referred to the move to a more interpretative approach to examining the text, with the use of researcher questions and reflections on the manifest content.

3) The development of emergent themes
   This step involves exploring the above notes, in addition to the text in order to produce a concise account of what the researcher sees as important in each segment of associated notes. These emergent themes should be grounded in the text but also contain a level of abstraction.

4) Connections between emergent themes
   This step involves exploring how the emergent themes may be both similar and different to each other. In line with guidelines, in the current study, the emergent themes for the text were printed onto paper and physically moved around to see how they related to each other. These connected emergent themes were categorised into super-ordinate themes

5) Moving to the next case
   Steps 1-4 were repeated for all transcripts
6) Patterns across cases

The emergent and superordinate themes were printed onto paper and physically moved around to explore patterns between each case. Resulting patterns were deemed master themes.

The researcher in the process

As stated, it is assumed that the researcher him/herself is the interpretative tool in IPA (e.g. Dallos & Vetere 2005). For this reason it is important to contextualise the researcher in this study. In order to develop and maintain a reflexive position in relation to this research, I participated in a small research group with two other colleagues who were carrying out research in similar areas. As part of this group, I participated in a self-reflexive interview about my reflections on the process at the beginning stages of the project. At the end of the interviewing stages, I participated in discussion about the process with members of this group. I also participated in a university led qualitative research methods group in order to guide thinking about the use of qualitative methods and the selection of IPA in particular.

Validity

Elliot et al (1999) offer guidelines to support appropriate and valid appraisal of qualitative research, as it is not appropriate to apply quantitative measures of evaluation to qualitative methodologies. Below, I outline how I have endeavoured to meet each of their criteria.

• Owning ones perspective

As a key component of the IPA approach requires interpretation of the researcher, it is crucial to be open about my own context and the experiences, beliefs and assumptions that will impact on my researcher lens. The inclusion of a reflective account, offers the reader an opportunity to understand my interpretative stance, concurrent with the acknowledgment that alternative interpretations are equally likely to have emerged from an alternative perspective (Appendix 6).

• Situating the sample

In order to situate the sample, I have provided details on basic demographics in addition to theoretical orientations and work contexts, as it is reasonable to assume
these factors will influence participants' experiences. However, in order to maintain confidentiality, I have not offered a break down of individual details.

- Grounding in examples

I have provided examples of themes with participant quotations. This allows the reader to appraise the data and my interpretations and understanding of the emergent themes. This transparency permits the reader to judge the coherence and trustworthiness of the interpretations.

- Credibility checks

Initially, a segment of one interview transcript was reviewed with the research supervisor in order to establish the means and rigour of data analysis in an IPA framework.

An independent audit was carried out with a colleague in the research group in order to check for coherence and meaningfulness of the results. In order to do this, a selection of quotes representing each of the major themes was shared and the colleague was asked to match the quote to the theme. This was done in order to establish the meaningfulness and trustworthiness of the findings, rather than to seek a shared reality or objectivity in the results (Henwood & Pidgeon, 1992). Five of seven quotes were matched directly. Following discussion and comments within the wider context of results, agreement was reached on the meaningfulness of the mismatched quotes.

Member checking was similarly utilized to establish the coherence and trustworthiness of the results. Four participants responded to this invitation, three offered reported perceived validity of, and satisfaction with themes. One offered feedback on sub themes, to which some slight changes were then made. See Appendix 7.
Results

The primary research question in this study was:

How do clinical supervisors' think about their supervision with qualified staff in trauma work?

The secondary questions were:

1. How do supervisors understand the purpose of supervision and their role in this context?
2. Do supervisors believe there are any particular or unique considerations in supervising this kind of therapeutic work?
3. How do supervisors think about the supervisory relationship in trauma focused work?
4. What do supervisors understand to be good or bad supervision in trauma focused work?

Four master themes emerged from the IPA analysis: 1) 'The kind of stuff of your worst nightmares': Managing the impact of the trauma content in the therapeutic and supervisory relationship, 2) The importance of openness and transparency in the supervisory relationship, 3) Supervision as not operating in a vacuum: the role of wider context and a multiplicity of viewpoints, 4) The learning experience: the interplay between experience, knowledge, confidence and expertise. See table 2. These will be considered in turn below.

Table 2: Overview of master and super-ordinate themes

<table>
<thead>
<tr>
<th>Master Theme</th>
<th>Super-ordinate theme</th>
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<tbody>
<tr>
<td>The kind of stuff of your worst nightmares': Managing the impact of the trauma content in the therapeutic and supervisory relationship (1)</td>
<td>Impact of the work on supervisee emotions and beliefs (1a)</td>
</tr>
<tr>
<td></td>
<td>A parallel between complex therapeutic relationships and the supervisory relationship (1b)</td>
</tr>
<tr>
<td></td>
<td>Supervisee self care and negotiating boundaries around support in this area (1c)</td>
</tr>
<tr>
<td>Section</td>
<td>Contents</td>
</tr>
<tr>
<td>---------</td>
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</tbody>
</table>
| The importance of transparency and openness in the supervisory relationship (2) | Establishing openness and promoting trust in the supervisory relationship (2a)  
Demystifying trauma work to build the supervisory relationship and increase supervisee confidence (2b)  
Supervisor modelling and normalising through self-disclosure (2c)  
Giving voice to the unmentioned or unmentionable (2d) |
| Supervision as not existing within a vacuum: the role of wider context and a multiplicity of views (3) | Reflection on clients' and therapists' social environments and past experiences in supervision (3a)  
The importance of considering clients' culture and language in supervision (3b)  
The interpreter as another person to consider in the therapeutic relationship (3c)  
Participants' dual roles as supervisors and gatekeepers of quality for the service (3d)  
The influence of past supervisors on participants' current supervision (3e)  
Influence of participants' therapeutic stance on their supervision style (3f) |
| The learning experience: the interplay between experience, knowledge, confidence and expertise (4) | The interplay between supervisor experience, knowledge and confidence (4a)  
Complexity in facilitating supervisee learning and assumptions of supervisor omniscience (4b)  
Invoking theory to address supervisee avoidance and facilitate learning (4c) |
1) 'The kind of stuff of your worst nightmares': Managing the impact of the trauma content in the therapeutic and supervisory relationship.

This theme explores how participants (speaking from their experiences as therapists, supervisees and supervisors) described the impact of the content of the work on the participants themselves and their supervisees at emotional and cognitive levels. Participants linked clients’ traumatising experiences with unusual or emotionally intense therapeutic relationships, which were mirrored to a certain degree in the supervisory relationship. Such intense relationships often led to supervisors feeling more vigilant or responsible for trainees, from an external perspective and participants described the difficulty in negotiating the impact of the work on the supervisee.

1 a) Impact of the work on supervisee emotions and beliefs

A strong theme that emerged across each supervision interview was that at the very least, the content of trauma-focused work would impact upon the therapist, and at worst, that it might be intolerable for the therapist to work with. Participants appeared to reflect on these both as supervisors and as therapists.

Their experiences are so awful and you kind of can't bear to hear them, or are very over involved, so you're bursting into tears with them. (Robin: 198)

For participant four the inexpressibility of the horror of clients’ traumatic histories is mirrored in difficulties expressing the phenomenon in the interview.

It's clear really from some patients whose kind of histories were just so horrendous, I never felt that it was either helpful, or to anybody, or to yeah, bearable for the therapist to have to listen to some of this material. (Morgan: 102)

16 Participant names are pseudonyms. The numbered line in the transcript is provided to locate the quote)
Trauma therapy was also described as challenging therapists’ less explicitly expressed beliefs about being a therapist and wanting to support people into feeling better.

‘God, I'm really worried I'm making them worse’, that’s a classic thing supervisees come up with when they first start interventions like reliving. (Drew: 222)

I think partly they’re scared of making things worse, of re-traumatising people. (Ash: 102)

1b) A parallel between complex therapeutic relationships and the supervisory relationship

Participants spoke from their vantage points as both therapists and supervisors about the links between peoples’ extreme or traumatising experiences and the therapeutic relationship. This in turn led to some complexity in the supervisory relationship, such as the supervisor assuming a more protective or more responsible role.

It can go more awry, because of the strong pulls that come from experience of having been persecuted or traumatised...And so the possibility that you can end up in this crazy rescuer role is really problematic and you need someone to take that to. (Robin: 179)

So if for example you're working with someone who was very violently abused you'll find I think that the dynamic between feeling that you're sort of rescuing them or that you're abusing them in the room through reliving or that you're being abused, for example by their threats to harm themselves. That dynamic can get very powerful because the fuel of the fire, which is the trauma, is very powerful. (Alex: 829)

Participants described similar pulls in supervision, as their supervisees were experiencing in therapy. Emotionally charged and complex therapeutic relationships evoked feelings of increased responsibility and a need to protect.

One participant conceptualises the risk as an external or objective quality of trauma work, which needs to be protected against.
I think it's also to protect colleagues from what is sometimes dangerous work, emotionally and psychologically risky, it's risk laden (Morgan: 159).

Two other participants explicate the potential risks as the reaction of the therapist to the content. They invoked their own experiences as therapists when considering why they offer this aspect of supervision as supervisors.

I can feel myself [] thinking about it too long, too much, too tearful, you know, all that kind of stuff so I hope with supervisees I can provide a safety that prevents them feeling that feeling. (Robin: 211)

I think I find myself feeling quite responsible for people I supervise, a bit more in the trauma service, than I do in other areas, because I know what they're listening to, I know what they're going through. (Drew: 197)

1c) Supervisee self care and negotiating boundaries around support in this area

Participants described the need to address supervisee reactions to the work, but also noted that there was some complexity in doing this within the boundaries of the supervisory relationship. However, there appeared to be a certain degree of ambivalence between the acceptability of this topic and the legitimacy of having these kinds of discussion in supervision.

Participants shared the belief in the need for self-care to allow clinicians to sustain their ability to work in a trauma focused and ultimately remain helpful to clients.

Em, particularly the person, I'm supervising at the moment is doing a lot of assessments [...] And within trauma services, if you're doing mainly assessments, you hear a lot more traumatic stories, so your potential for becoming overwhelmed or burnt out by it is much higher. So, I've spent quite a bit of time on that really. (Chris: 36)

So because part of my agenda is around, for people to be able to do this in the long term, there's an issue about sustainability and people's own emotional needs need to be able to be met, in order to do this in the long term, so that's part of it. (Pat: 82)
Because of the kind of trauma that our clients face, is such, is so dreadful, it’s the kind of stuff of your worst nightmares, or the darkest film you’re ever going to see on telly. I think you really do need a space to take that. (Robin: 201)

Although participants reflected on the need to monitor and normalise emotional reactions to content, for one, there seemed to be a lack of certainty of the legitimacy of focusing on this.

Yeah, I do more of that [debriefing about emotional impact], than I do actually direct supervision (laughs), which is maybe not a good thing. (Chris: 503)

Conversely for another participant, emotional impact is located slightly differently on their supervision agenda.

So as a supervisor, you’ve got to be looking out for that more that you might overtly do in other areas. So I need to remember to pay a lot more attention to the impact of the work on the people I’m supervising (Drew: 153)

In terms of addressing this directly with supervisees, participants reflected on the difficulty in negotiating the line between checking on the emotional impact on supervisees within the boundaries of the supervisory relationship. In order to do this, supervisor assumptions about where the limits of supervision lay were invoked.

And it’s very difficult to know in supervision how you approach that with someone who’s not your patient but is potentially your colleague....Erm, but you have to be very cautious not to start treading on toes where you’re not invited. With a client you’re invited into that material. With a supervisee you’re not in the same way. (Alex: 836)

That it’s not a therapeutic relationship, but there might be times when you have to have a conversation with people about the distress and work out whether it’s just in relation to that particular client or there’s a bigger issue where they might actually benefit from getting some help externally, which would be legitimate to do. (Pat: 422)
But it's always difficult as a supervisor to allow space talking about the more personal impact of the work, within the boundaries of the professional supervisory relationship. It's a careful balance to thread between allowing that space, and it not feeling too much like you're asking people; 'how did that make you feel?' about therapy, because it shouldn't be like that. (Drew: 159)

2) The importance of transparency and openness in the supervisory relationship

The theme of transparency and openness appeared to permeate several levels of supervision for participants. They reflected on the value of establishing a culture of openness from the outset. Transparency and openness was seen as one mechanism of establishing trust in the supervisory relationship. Equally, the demystifying of trauma work achieved by sharing of participants' own work and joint working was thought to promote a culture of openness and support the supervisory relationship. Participants reported disclosing their own reactions to emotive trauma content, which appeared to serve two purposes. The first was to normalise difficult responses to the work and the second was to model how to have difficult conversations in the context of trauma work. The ability to negotiate one's way through difficult topics in supervision was seen as practice for therapy.

2a) Establishing openness and promoting trust in the supervisory relationship

Participants spoke about their efforts to establish a culture of openness from the outset, in supervision. Comfort in doing this appeared to be something of a developmental process for two participants. Participants also reflected on the need for this openness to carry though supervision in order to develop trust in the relationship, especially in raising the 'less favourable aspects' of the work. They tended to view the facilitation of this as a supervisory responsibility.

And there's something about being explicit about one's expectations and clarifying discrepancies or where people are coming from, concerns they have and the fears that they have. And having as much of that and as open a conversation as we can from the beginning about that... So I think now, I'm able to be more explicit about things than I was, and that's helpful and perhaps more open as I get more confident in what I'm doing'. (Pat: 256).
I've learnt to be a lot more transparent about what I expect and say these things. (Drew: 411)

Participants reflected on the importance of safety in the relationship to foster supervisee openness. Participants tended to view this as their responsibility.

And, and I think the point with that is if you can set up your, your supervision in a way that it's not evaluative, that it feels safe and that you can have kind of conversations about difficult topics. (Alex: 540)

Within, supervision, to set the standard to say it's ok to say: 'I don't know' or 'this really upsets me' or, or in a sense those aspects that we think of as the less favourable aspects (Morgan: 147).

2b) Demystifying trauma work to build the supervisory relationship and increase supervisee confidence

Several participants reflected on the notion that supervisees new to trauma work can often feel out of their comfort zone, in an area that is often perceived as highly specialist and removed from more generic therapeutic work. Participants described the need for transparency about what the work entailed in order to build the supervisory relationship and also to increase supervisee confidence.

For some participants, joint working and sharing their own therapeutic work, served to facilitate transparency and develop the supervisory relationship.

I think working together is very good way of developing your relationship with someone. Sort of being able to see each other in practice. I think what it'll often do is help restore both people's faith in the person, certainly as a supervisee to see that actually a) that your supervisor has a nightmare or b) that they can have it, implement something when it's sort of expert performance. (Alex: 571)

I would probably share my own experiences with them, we'd probably share our own therapy tapes with people[ ] with PTSD maybe it serves more of a reassurance giving function. (Ash: 122)
I do lots of things like, in order to demystify things like reliving, I'm normally quite comfortable showing other people I supervise videos of me doing it, or have them sit in with me. I do quite a lot of joint work when people start, just to help people get their confidence up, that it isn't so scary doing some of these more affect based interventions. (Drew: 228)

Another participant reflected on the idea that supervision in itself acts as means of explicating therapy work in the area, and bringing it into the shared domain, for their benefit.

I think another really important aspect of supervision is that it does start to create within the qualified staff too, [...] a frame of mind or an attitude toward their clinical work that this is something that is best shared with colleagues for their enrichment. (Morgan: 8)

2c) Supervisor modelling and normalising through self-disclosure

All participants reflected on the need to create and support an ethos of openness especially with regard to how the content of the work may impact on the clinician. This had the dual purpose of modelling and normalising therapist reactions to difficult content. Similarly they believed it was important to model 'not knowing' or doing something less than expert.

One participant described introducing the acceptability of speaking about feelings of disgust, and used personal experience to support this.

Often I'll say you know 'it's quite disgusting'. I was told something that actually made me feel quite, sort of, disgusted and it was like this sort of, again normalise it again, against my own experience. (Alex: 535)

Participants believed that this process of self-disclosure permitted the supervisee to speak about similar difficulties. It also appeared to define the parameters for an appropriate level of disclosure within the boundaries of the supervisory relationship. Contained within this is the implicit idea of the acceptability and legitimacy of trauma work as having an emotional impact.
So sometimes I'll disclose something like that to my supervisees, as a way of acknowledging sometimes things can get to you and it's not always predictable what will get to you. (Drew: 177)

And so I just say that, or I might disclose that I find I'm not so easygoing about x, since working with this kind of group. Or I find it hard to watch traumatic events in a film, you know. Yeah, so I think kind of being really honest about your own sort of, you know, things that you manage and things that you struggle to manage. (Chris: 730)

I suppose eh, there's a sort of slight thing around modelling terms of being open about the both the rewards and the stresses of the job. (Pat: 112)

Equally, participants reflected on their role as supervisors to give voice to uncertainty or 'not knowing. Modelling and self-disclosure in this capacity set the standard of acceptability to admit to not knowing, and was aimed at encouraging supervisees to do the same.

By kind of just talking about all the things that I've done that haven't worked. And, in a sense giving the person permission to sort of talk about it. (Alex: 653)

Actually for the supervisor, to speak of those things, to sort of come along and say, 'well I don't know what to do with these patients'. (Morgan: 150)

And sometimes you try something and it really doesn't work, and the best thing you can do is model that it doesn't matter, and that's often what happens. (Drew: 681)

For one participant however, there was some uncertainty about negotiating the right level of disclosure.

And also I spend a lot of time, giving examples of stuff I struggled with, earlier on in my career. And, what I found kind of worked a bit better. I mean I probably give too many examples.. She's probably sick of hearing about me, struggling with everything. (Chris: 450).
2d) Giving voice to the unmentioned or unmentionable

When considering the content of the trauma work, participants described the challenges and the potential discomfort in discussing topics that might be embarrassing or difficult for clinicians, such as details of a rape for instance. Again, participants felt that they held a certain amount of the responsibility to open up these areas, and model how to talk about them in a safe and helpful way.

One participant reflected on how this might be difficult, especially if the clinician or the supervisor holds some embarrassment about obtaining this kind of detail.

*Because some of the traumas are so intimate... well I don't know if this is different to other services or not, but, there can be a little bit of a challenge in you know, how do I talk about this stuff, like different types of rape for example. And how can I discuss that in supervision. And if there's any, if a person, if a clinician has personal embarrassment about it, that kind of stuff, how do you manage that [...]. But I think potentially other people who are supervising, they really struggle; 'oh I didn't want to ask her how she felt about the details of that graphic rape'.* (Chris: 658)

Another participant reflected on the influence of gender on how this kind of discussion may play out in addition to the inherent mutual learning involved. This was mirrored somewhat in the interview process, that is, in discussing this with a female interviewer more general words like ‘things’ and ‘something’ were used.

*Er, so having to sit down with a female supervisee, or not necessarily a female, with a male supervisee, and talk about, you know, the particular things that were done during something, because it’s difficult, on both sides I think it’s also a learning experience. It helps you learn how to negotiate that sort of discomfort. Because that discomfort times a hundred is what you get in the room when you do it with a client.* (Alex: 448)

Another participant reflected on the role of supervisor as noticing when the supervisee may be experiencing difficulty with levels of detail. Similar to the reliving that is done in therapy, in this instance the participant helped the supervisee gain a high level of exposure to the material, which then supported the supervisee to carry out the same type of process with the client.
She was working with, um a young man that had been sexually assaulted and em we had a lot of discussion about the reliving and about how, wouldn't say colluding, but perhaps how, she wasn’t feeling very comfortable about getting what I would call a helpful level of detail about what exactly had happened. So you know, she’d talk about doing reliving, and rather than just think, ok, she’s doing reliving, we did actually look at a narrative, we looked at some tape excerpts, so this was in my mind to try and help her help the clients process the memories as fully as possible, by getting into as much detail as possible. So I guess thinking about areas where people might, where supervisees might be having difficulty. I guess even if they don't know they're having difficulty. (Ash: 304)

3) Supervision as not existing within a vacuum: the role of wider context and a multiplicity of views

This theme refers to the wider contexts that supervision and supervisory relationships are located within. The wider context here is thought to comprise of multiple factors, including client and therapist context, culture and language, service context, past supervisors and therapeutic orientations.

3a) Reflection on clients’ and therapists’ social environments and past experiences in supervision

Participants described the need to draw out ideas of context for the supervisees and also maintain their own awareness of how context might come into supervision. Context was likely to permeate through therapy and supervision, so supervisors assumed the dual task of stimulating reflection on how the clients’ experiences might impact on the therapy and well as being mindful of their own beliefs and perspectives as supervisors.

We pay much more attention to their environmental context and of course, people can have very serious real life problems, like having very little money or nowhere to live or not having leave to remain, these very real life problems. I think they can sometimes feel very overwhelming for both therapist and supervisors. (Ash: 548)
If somebody’s very agreeable in session you might think that means they’re very keen to do the work, whereas actually torture survivors, they’re just very agreeable because that’s what they’ve learnt to be. (Chris: 170)

So what you are doing is working with a group who are so marginalized within society, where there’s a dialogue around them, that is so sort of negative, and so you have to be very aware of the impact of that on yourself, and then on your supervise. (Robin: 369)

Two participants reflected that supervisees might experience certain reactions to the client or the work; it the clients experience resonated with that of the therapist.

And I think in some ways PTSD work and trauma work can be specifically, have issues to do with how the content erm, triggers off, keys into, sort of echo’s with personal stuff that the supervisee...has. And how you, or how much you’re responsible for creating a framework to think about that importance. (Alex: 822)

Yeah, the emotional impact, the ahm, it might actually begin to, it might bring up memories for people of things they’ve been through. (Ash: 214)

3b) The importance of considering clients’ culture and language in supervision

Participants described the need to be aware of and integrate the clients’ culture into the therapeutic work. Where necessary, supervisors would raise this with supervisees if it did not emerge naturally.

Ok so this particular thought they have about an event but what meaning does that event have in the society. What about in their family, in their community? And get the person to actually explore that with the client. And I think once you start doing that, you’re actually kind of more tuned into those ideas anyway. (Chris: 338)

And then lots of things to do with mental illness and how people see mental illness in different cultures that needs to be factored in. Now usually the supervisee will tell you because they’ve been discussing it with the client, but it may be that they are bringing some strong feelings about the client, either positive or negative that can
only be understood when you link them up with some ideas about cultures, and they themselves are not aware of so that might be your job. (Robin: 435)

Another participant reflected on the notion that beyond a linguistic difference, clients may not have access to the emotional vocabulary to describe the impact of their experiences.

I have felt that, ah, you know, there was most of all a linguistic barrier, but you know dealing with a patient, or what we dealt with was a patient who, who in his own natural language, didn't actually have, eh, the words really to give expression to, eh, the kind of things that had been evoked by a trauma. (Morgan: 350)

3c) The interpreter as another person to consider in the therapeutic relationship

Participants considered how interpreters added another facet to the work, and the additional load this can place on the supervisor. One participant conceptualised this as in some ways adding to supervisor load on thinking space.

So when you're a supervisor, working with a therapist working with a client working with an interpreter, that's just so many people to bear in mind. (Drew: 267)

Two other participants reflected on the need to be aware of the potential impact on the interpreter on being exposed to traumatic content, and saw some responsibility and agency in their roles as supervisors in this regard.

And eh, I contacted somebody within that business and said well; 'it's great that you've employed a translator but what, what have you as an employer done to make sure that, em, this employer has some opportunity to em, you know reflect and talk about what emerges in sort of trauma based sessions'. (Morgan: 325)

Sometimes interpreters have been through similar experience to clients, and then they get distressed and we need to think about how to manage that. And the fact there's also a boundary issue for us a service thinking about or where and how it should best be dealt with that. So that's a conversation that we would need to have. (Pat: 341)
Participants' dual roles as supervisors and gatekeepers of quality for the service

Participants discussed how the service needs entered into supervision, both as a given, and also how they as supervisors needed to work within service guidelines, and were representatives of the service to some extent. Participants reflected on how the needs of the service, somewhat altered the notion of an equal supervisory relationship. Participants believed that within the service needs they held certain responsibilities. Ultimately the client and their need to receive good quality treatment underpinned this service context.

Two participants described seeing themselves as having an obligation or responsibility to the service. In this way, the service context had been internalised by the participants and understood as one of their responsibilities as a supervisor. In this way, they are acting as part of or a representative of this context.

And sort of set it [supervision] up, tailored around that, and also centred around the needs of the service and what information, I need to ensure that things are happening the way they should be happening. (Pat: 40)

I have a responsibility to the service as well, to make sure that people are getting evidence-based treatment, and the right kind of evidence based treatment. (Drew: 63)

Another participant makes sense of the wider service context as 'the rules'. In this way she understands her role as perhaps more on a par with the supervisee, in that they are both bound by a system of rules, although it is she that must enforce them. In assuming this role, the participant moves from an individual perspective to positioning herself back into the service context, as part of a system.

I mean, I, there are some things, some things where we have rules, in which case obviously we would be quite firm about things. (Robin: 83)

Another participant understands one part of supervision as a means of indirectly monitoring quality in the service.
I think it's of course for the supervisor, it's [supervision] also an important part of em, monitoring the quality of services. (Morgan: 12)

3e) The influence of past supervisors on participants' current supervision (3e)

Participants described both positive and negative past supervision experiences as instrumental in their development as supervisors. For all participants with the exception of one, the assumption that what had been unhelpful for them as supervisees would be similarly unhelpful to their subsequent supervisees appeared to be embedded in this consideration of past experiences.

For one participant reflection on previous supervision was a directed exercise in order to identify what might be the most useful style to incorporate.

Well I thought quite a lot about it at the start, really about the style of supervision I would use and what I'd like in the past about supervisors and what I hadn't liked. (Chris: 409)

Other participants reflected on how previous supervision was likely to have impacted upon their current practice, often in the context of what to do or not to do.

I think I've taken something away from every supervisor, including the ones that I've hated. Ways not to do things. (Alex: 283)

I think it's come from your own supervisory experience. If you are with somebody it's very frustrating with a supervisor who proffers their great knowledge too early and is sort of convinced of their model and expertise. I think that can sometimes be quite jarring. (Robin: 791)

One participant reflected on the notion that an assumption about the most helpful mode of supervision, based on previous experience, does not necessarily guarantee good supervision.

Because I've been very fortunate in terms of my own supervisory experiences. I think it has made it easier for me to think about how set things up in a way that is facilitative. That by no means guarantees it. (Pat: 252)
3f) Influence of participants’ therapeutic stance on their supervision style

All participants believed their supervisory style mirrored their therapy style. This included a fluidity or a natural extension of therapeutic models of working, which appeared to be influenced by a personal resonance with a certain theoretical standpoint or model. Participants tended to acknowledge this explicitly.

*I suppose I try to be as Socratic as I can, both in supervision and in therapy.* (Pat: 42)

*It’s [supervision] also how I do therapy, it’s also how I work with clients as well, sort of slightly baffled, grappling eh., which again is very sort of Socratic and existential, and maybe my stance, my therapeutic stance has a lot to do with that.* (Robin: 74)

*My supervision is very CBT. It really is. It’s a combination of that’s the way I work and the model makes sense to me, but also I like that way of working. I like being very collaborative and transparent.* (Drew: 522).

One participant reflected on the potential downside of a fixed approach to supervisory style however, and described the challenge for the supervisor in tailoring the supervision to meet the needs of the supervisee at that particular point in time.

*The hardest thing I think is being very flexible in the way you, sort of are in supervision. Because, it’s got to be both consistent and adaptive and constantly changing depending on the need of the situation, the person and, and so on. And I think the easy thing is to just supervise everybody the same. But often that’s the wrong thing to do.* (Alex: 241)

4) The learning experience: the interplay between experience, knowledge, confidence and expertise

This theme explores participant reflections on how they facilitate the learning process for supervisees. Participants believed that the possession of specialist
knowledge gained through experience influenced their confidence as supervisors with less experienced colleagues although lead to some complexity with peers or senior grade colleagues. This notion was held in tandem with the implicit idea that that the supervisor must have the answer or specific knowledge in order to be helpful. Discussion and its pitfalls were also considered as a means to develop supervisee thinking in regard to clinical work. Participants described drawing on theory to counteract supervisee avoidance and also to facilitate learning.

4a) The interplay between supervisor experience, knowledge and confidence

This theme explores the interaction between participant experience, knowledge and confidence and how this relates to their supervisory experiences. Participants reflected on how their possession of more knowledge and experience led to increased confidence in their supervision and also facilitated learning with less experienced supervisees. Some tensions emerged however, when supervising peers, or superiors.

One participant believed that their experience in the area of trauma and the nature of trauma focused work as being very specific, provided them with a firm knowledge base in the area, with a focus on individual differences within the model that might not be the case in more generic services.

_The good thing I guess about being here is that we've got, you know, instead of having say twenty examples of someone with OCD, twenty examples of someone with depression, twenty examples of someone—. We've got 300 examples of people with PTSD. So much more kind of nuance. So I think that relating, sort of relating my experiences of, of patients I've treated erm, to kind of inform the discussion about the kind of very idiosyncratic nuances of a supervisee's client._ (Alex: 473)

In some ways, this participant understood the possession of niche trauma specific knowledge to normalise or act as an anchor for the supervisee who may feel lost in the unbelievable horror, perhaps by offering a kind of secure knowledge base (Bowlby, 1988) from which to explore the unbelievable.

_So one of my roles as a supervisor, with somebody who is even, who is qualified, but has less experience in that area is to talk about my kind of expert knowledge of_
torture technology. To help, to fill in gaps in understanding of somebody's description or their presentation. Erm, or even just to normalise something that sounds unbelievable. Because, if you think, a lot of trauma stories sound way out there. (Alex: 484).

For two other participants, having this set knowledge appeared to validate their belief in themselves as supervisors.

As a supervisor in a trauma service, you've just got to know about trauma, so that's a bit easier. It makes you feel a bit better. (Drew: 144)

And we're reviewing that and sort of thinking about the next stage, like I can offer specific guidance on that that answers her questions, it feels quite good as well. (Chris: 521)

Complexities in applying this knowledge base were highlighted however, when supervising peers or senior grades. For two participants this was manifested in a discomfort in assuming what might be perceived as a didactic position or senior positioning with a supervisee who is an equal.

I guess I have to remember if people come to me for supervision, it's because I have this expertise in this particular area. I know a bit more about this area than they do and I have that knowledge to give, so you know, they're still getting something from the supervisory relationship, even if they're the same level of experience as me, or actually a bit more experienced. (Drew: 397)

Erm, and in many ways I may know more about this topic than them. But I'm actually their peer and their colleague, rather than their superior, whatever you call it. [..]. It can be quite different in that you don't want to take too much of a didactic position. (Alex: 213).

4b) Complexity in facilitating supervisee learning and assumptions of supervisor omniscience

Participants reflected on the different means of facilitating supervisee learning. Some participants reflected on the use of discussion of the intricacies of the therapy
in order to explicate supervisee learning. Others described feeling that they must have the answer in order to be helpful supervisors.

At one level, participants reflected on the utility of the supervisory space to think together and reflect on difficulties.

Why it is that a particular recommended treatment hasn't worked. And eh, in that, when eh, we have a discussion, why is it that something works for one patient and not for another. (Morgan: 422)

I suppose you really are the outsider, helping to do the thinking. (Robin: 526)

Another reflected on the complexity of the learning process and the need for supervision to go beyond discussion or advising the supervisee on what to do.

It's also very easy for a supervisor to eh, if someone comes with an issue, and you think; I know a lot about this and just talk lots, and feel really good because you've talked lots and then you maybe haven't really helped the supervisee learn because you've just given them information. Again, you haven't moved them round the learning cycle, you haven't got them to reflect on their own learnings. (Drew: 553).

Some participants reflected on the assumption that the supervisor must have the answer in order to be helpful or to facilitate learning.

Although I think there is a tension, especially in services like this where, or maybe in CBT in general, that there is an answer and if only David Clark or Anke Ehlers were here, they'd have the answer. And the fact we don't have it, is a kind of deficit. (Ash: 484)

She might be looking for quite specific stuff, like say CBT work on rumination, where I would feel that I have some knowledge of it, but not really. Not really that good, [...] Em, and that kind of thing hasn't been you know.. I feel like I kind of do a really lame job of maybe thinking through it. (P3: 506)

4c) Invoking theory to address supervisee avoidance and facilitate learning
Participants reflected on times when the supervisee may be avoiding exposure work with the client. Often, in order to shift the idea of it being a case of who knows what's best for the client, participants tended to invoke theory to support supervisory discussions in this area. Equally, the use of theory was seen to facilitate learning for the supervisee and also guide the supervisor.

*I think you can end up feeling very attached to your clients... and I think then it means you can have very fixed ideas about what you feel needs to happen and what kind of therapy approaches, you can be very sort of guarded against doing exposure work with them, because you don't want them to get more distressed.... You have to be a bit of a devil's advocate at times. You know, kind of remind them... ok what do we know will actually help in the longer term.* (Chris: 199)

Another participant reflected upon the use of the theory of repetitions or parallel process in the therapeutic relationship, and how this provided supervisees with a theoretical grounding in the face of potentially overwhelming material. This process was mirrored to a certain extent by the utilisation of this theory to similarly ground the supervisory relationship. The use of the word armamoria (sic) implies an almost war like dynamic occurring in the therapeutic work.

*It became an essential part of em, ah, of, supervision and also in sense the way of steering, ah the ah, colleagues therapeutic work, was to, to give it a focus and anchor it and you know, the, not only the kind of history of repetitions. Kind of making aware of that. But how repetitions, em, occur in the current therapeutic relationship.. I think when eh, with PTSD patients and when colleagues just see how that was happening, that was felt like, you know, an important extension of ah, em, kind of therapeutic armormaria.* (Morgan: 58)

For another participant, the use of theory served to anchor their supervisory practices.

*The, you know, the sort of being able to take observations, apply a theoretical model to those observations to understand them and then let that guide an action and then see what the result of that action is to feed into the next stage.* (Alex: 339)
Discussion

This study provides a rich account of clinical supervisors' experiences of delivering supervision on trauma-focused work. Each master theme and how it relates to the literature will be considered. Limitations will be reviewed, followed by clinical implications and suggestions for further research.

'The kind of stuff of your worst nightmares': Managing the impact of the content of the work in the therapeutic and supervisory relationships.

Participants in this study reflected on the inevitability of the content and process of trauma work as impacting upon the clinician, potentially resulting in distress or challenging beliefs about helpfulness. Participants related this to the extremity of clients' experiences, which were framed as being potentially intolerable to hear. This theme is consistent with literature relating to VT and STS (e.g. Iliffe & Steed, 2000)

Extreme client experiences sometimes led to intense therapeutic relationships for clinicians, which were mirrored to a certain extent in the supervisory relationship. Participants spoke of pulls to protect their supervisee. This finding is consistent with theoretical accounts of parallel process and counter-transference in the supervisory relationship generally (e.g. Morrissey & Tribe 2001) and specifically related to work with trauma (e.g. Woodcock, 2002, Etherington, 2009).

Results from this study suggest that navigating this area can be a complex endeavour for the supervisor with regard to negotiating boundaries in peer relationships. These results provide an illuminating example of the lived experience of supervisors' roles in this area in trauma settings, which contribute to theoretical accounts as well as supporting the supervisee need to address these concerns (Sommer & Cox, 2005). For instance Wheeler & Richards (2007) suggests that the extent to which supervisors have the mandate to discuss supervisee's personal difficulties depends on the supervisory contractual agreement and supervisory relationship (p.245).

These results are also consistent with other supervisor accounts of related difficulties. For example, while Ladany, Friedlander and Nelson (2005) posit the
importance of supervisors having an awareness of the supervisees' 'vulnerability and need for support and reassurance' (p, 13), King & Wheeler (1999) note that supervisors were somewhat unwilling to suggest that supervisees take time out if distressed. Similarly, in a Korean sample, of supervisors, Bang & Park (2009) found that although supervisors saw discussion of supervisee personal issues as important, they were often inclined 'to let it go' (p1064) if they sensed supervisee reluctance. Given the difficulty that participants in the current study reported, it is possible that supervisor perceived competence and comfort in negotiating this area, in addition to the nature of the supervisory relationship, might lead to avoidance or under attention of the personal impact of the work on the supervisee.

The importance of openness and transparency in the supervisory relationship

A strong theme that emerged in this study was supervisors' commitment to creating an open and transparent culture for supervision. Although openness can be a useful counterpoint in de-stigmatising many mental health difficulties, it could be argued that there is a particular need for openness and transparency in trauma work, as a counter-point to the prevalence of secrecy and shame associated with deliberate acts of violence against the person, (e.g. Andrews et al, 2000). Participants' reflections on safety and trust through transparency in the relationship relates to Bordin's (1983) conceptualisation of the importance of safety in the supervisory relationship and replicates findings from Laurence (2001), who found that supervisors reported 'trust and safety as a perquisite for learning' (p, 133).

Participant accounts of joint working and sharing of their work in order to promote transparency and openness is consistent with some supervisee accounts of what is helpful in supervision. For example, Cushway and Knibbs (2004) found that trainee supervisees ranked the supervisor sharing their work as sixth in a list of ten most helpful supervisory behaviours. This finding may also be understood using Stoltenberg and Delworth's (1998) Integrated Development Model of supervision, which suggests that supervisees at a level one of development may be highly anxious and dependent on supervisors for more direct advice and guidance. This model acknowledges that development levels can vary across therapeutic activity, which could account for this finding in relation to the supervision recipients in this study which comprised of highly experienced therapists new to trauma work as well as experienced trauma therapists.
Several participants reported using self-disclosure to model and normalise therapist affect based reactions to clients' stories, in addition to the acceptability of bringing perceived errors to supervision. Ladany et al (2005) posit that supervisors' disclosing of reactions to trainees’ clients can be helpful in normalising the trainees’ reactions to their clients. They suggest that supervisor disclosure of therapy struggles can provide a learning experience for the trainee, as well as strengthening the supervisory relationship by increasing trust. Ladany and Walker (2003) contend that supervisor self-disclosure will support supervisee self-disclosure too. Although there is evidence (e.g Yourman, 2003) to suggest that trainee supervisee withhold aspects of their work from supervisors, it is unclear whether the same is true of more experienced practitioners. Weaks (2002) found that experienced counsellor supervisees described safety (via confidentiality and the removal of an explicit evaluative focus), as one of the key aspects of 'good' supervision. This would imply that there is a need for trust and safety in the relationship to bring honest reactions that transcend developmental stage.

Some participants spoke about potential difficulties in initiating and discussing sensitive conversations in supervision such as discussing the aspects of a rape. There is scant exploration of this phenomenon in the literature, with the available reflections coming from a psychodynamic framework or falling under the umbrella of STS. For example, Walker (2004) contends that supervisee avoidance of going into detail of sexual abuse or assault in supervision may be the result of the therapist over identifying with the client, over identifying with the material and being reluctant to disclose the 'secret' (p. 182), or as a consequence of wanting to protect the supervisor. That is, omission of detail implies a process of secondary traumatisation of the supervisee.

Whilst these are helpful aspects of the complexity of supervision to bear in mind, there is a risk that these hypotheses over theorise a process that might also be influenced by the impact of gender or diversity and levels of comfort or safety in the supervisory dyad (and certainly Walker cautions against unquestioningly attributing all process to counter transference or parallel process). For instance in the current study, one participant makes reference to the impact of gender on the difficulty of having this kind of conversation in supervision. Another considers the potential
supervisor embarrassment and supervisor/supervisee comfort with speaking about this level of detail.

Perhaps unsurprisingly, Webb and Wheeler (1998) found a high correlation between willingness to disclose sensitive issues and the good rapport or a strong supervisory relationship in a postal survey of British counsellors (qualified and unqualified) supervisees. It is argued that the current study adds the perspectives of supervisors, in considering how to go about tackling sensitive topics. While Azar (2000) advocates a cognitive behavioural approach to identify and challenge supervisee assumptions in relation to trauma work, there may be a case for a similar process to be carried out for supervisors, perhaps in supervision of their own supervision.

**Supervision as not existing within a vacuum: the role of wider context and a multiplicity of views**

Perhaps inevitably, supervision is seen to be located in multiple systems with a multiplicity of perspectives exercising influence at various points. This theme is broadly consistent with Holloway's (1995) Systems Approach to Supervision, which emphasises the inclusion of wider context and systems in supervision.

The need to be aware of the client's context is consistent with other research in the field of trauma work. For example, Tribe (1999) suggests that as many refugee or asylum seeker clients may relate the disclosing of personal information to the consequence of torture, the idea of a talking therapy may be frightening. Results from this study suggest that supervisors take on the responsibility for including a focus on this, if not already happening.

Similarly participants reflected on the need to hold awareness of the supervisees' own context and reflected on the notion that trauma material might echo with that of the supervisees' own experiences. Schroder & Davis (2004) categorise three types of therapist difficulties: paradigmatic (stable or interpersonal conflicts), situational (external factors such as clients that may be perceived as challenging to most therapists) and transient (deficits in knowledge). Wheeler & Richards (2007) argue that work with trauma material could constitute situational difficulties and the role of the supervisor is key in 'breaking the cycle of traumatisation' (p. 252). Equally I
contend that therapists' own experiences of trauma might be located on the continuum between paradigmatic and transient difficulties (e.g. experiences including sexual abuse {Benatar, 2000}, bereavement {Hayes et al, 2007} and the likelihood of being involved in a road traffic accident) and may require a focus in supervision. This seems pertinent given that the experience of trauma is associated with choosing a career in the helping professions (e.g. Murphy & Halgin, 1995). However, as previously described, this can be a complex endeavour for the supervisor.

Consideration of culture in trauma focused work, particularly when working with refugees has been the subject of much exploration in the literature (e.g. Bracken et al, 1995, Nicholl & Thompson, 2004). The current study adds the perspective of how consideration of culture may play out in supervision of trauma work in everyday practice. In the context of trauma-focused work with refugees, participants' focus on culture in this study is consistent with research that suggests the inclusion and consideration of culture forms part of good supervision for supervisees (Fukuyama, 1994). Also the inclusion of cultural aspects into supervision has been associated with a stronger supervisory relationship (Gatmon et al, 2001) and an increased personal awareness of culture (Toporek, et al, 2004). Hernandez (2008) advocates a cultural competence model of supervision in which practitioners are supported not to over pathologise or under pathologise based on assumptions of clients' culture. Lopez believes supervisor modelling of a proactive approach to understanding culture and deconstructing assumptions is key to this model, which appears to mirror the approach of participants in this study to a certain extent.

In the wider context of the supervision literature however, the theme of supervisors assuming a more proactive role in the consideration of cultural issues is somewhat at odds with other research. For example, Bukard et al (2006) reported that supervisees often find supervisors unresponsive to issues of culture. It is possible that this relates to the notion that one participant coined as 'what's in therapy is in supervision'. That is, issues related to difference and diversity may arise more frequently in supervision, as they may arise more often, or be more visible in this kind of therapy.

Participants described some of the complexity in supervising work that was conducted through an interpreter. Extending Hawkins and Shohet's (2000) model of
supervision, in which the supervisor is required to hold in mind many perspectives and processes, it seemed that participants in this study equally incorporated many 'eyes' in supervision. Participants spoke about the need to act as something as an advocate for the interpreter, the need for which is somewhat borne out in literature based on interpreter experiences of trauma (Howard et al 2009).

Participants in this study reflected on service context as having an impact on supervision. Supervisors (often in a more senior role) often identified with the service and understood part of their role as gatekeepers of quality. The informal monitoring of the use of appropriate and evidence based interventions for clients was also cited as part of supervision. This is a useful perspective from predominantly clinical psychologists to add to the current literature as much of the UK based research in supervision focuses almost exclusively on counselling supervisors who are often not part of the same service as the supervisee and sit within different organizational structures.

Participants reflected on the impact of past supervisors as models for their current practice. This corroborates much of the research in supervision (e.g. Wheeler & Richards 2007). Equally, the preponderance of supervisors supervising in their model or style of therapy is in keeping with much of the research in clinical models of supervision (e.g. Lawton, 1996, cited in Weaks, 2002). This is perhaps something of a blow to the ubiquity of supervision models hypothesised in the literature. It also raises a dilemma regarding the use of a model for supervision that does not carry an evidence base for such use.

The learning experience: the interplay between experience, knowledge, confidence and expertise

This theme refers to supervisors' experiences of facilitating the learning process. They reflected on the complex interplay between knowledge, experience, confidence and expertise and how this might play out differently with supervisees at differing developmental levels. Participants described drawing on theory to counteract supervisee avoidance and also to facilitate learning.

Some participants believed it was easier to supervise in trauma as the supervisor only had to have knowledge of one area, rather than having a large degree of
knowledge in several areas. This finding corresponds somewhat with Ronnestad et al. (1999) findings that suggest supervisor confidence cannot be predicted by amount of supervision received, or duration or type of supervisor experience but is more related to self assessed therapy skills and own experience of delivering supervision. Similarly the notion of a repository of niche trauma information that serves to substantiate the seemingly unbelievable or act as a safe base of knowledge from which the supervisee can explore from, contributes an interesting aspect of supervision in trauma to the literature. The integration of attachment theory into the supervisory relationship echoes with more recent thinking in supervision (e.g. Fitch et al, 2009).

The complexity of assuming the role of the experienced, knowledgeable supervisor emerged through participant reflections on how this played out in the supervision of peers or more senior supervisees. This offers an interesting insight into the power dynamics that may play out for clinical supervisors when supervising peers. The crux of the power differential here being that the supervisor in this context, in contrast to the most research in supervision, does not hold clinical responsibility for the supervisee.

Participants reflected on their concerns about being too didactic with peers or coming across as their 'boss', whilst at the same time wanting to offer them helpful supervision. This is broadly consistent with finding from Perris (1997), who found that supervisees prefer a nondirective style in supervisors. However, it is interesting to consider this finding in conjunction with the study carried out by Weaks (2002), in which challenge was identified as one of the core elements of 'good' supervision. Again, whilst this study focused on experienced counsellors who had the option to terminate supervisory relationships if they chose (which was one of the reported outcome in the absence of challenge), this other side to the potentially difficult balancing act of providing information and stimulating learning, within an experienced supervisory dyad, is a useful addition to the literature in the area.

Participants reflected on the use of discussion to extend supervisee thinking on clinical work, sometimes utilising their position outside the therapeutic relationship to invoke an external perspective. This fits with other research in the area that suggests case discussion and supervisee identified problems with clinical work are thought to consume a large proportion of supervision time (e.g. Townend et al
However Campbell (2004 cited in Gonsalvez & McCleod, 2008) argues that these are potentially unreliable and inefficient methods of supervision. This method of supervision is also considered ‘insensitive to key competencies, including case conceptualisation, skills training and therapist-patient variables (Gonsalvez & McCleod, 2008, p. 85). One of the participants in this study echoed the view that discussion or the supervisor ‘telling everything they know’ on a topic may not always facilitate supervisee learning, and that alternative means of learning may be enlisted in order to help the supervisee move around the learning cycle (Kolb, 1974).

In many ways, the belief regarding the importance of expert or additional knowledge was held in tandem with the pressure or assumption for some participants that they must ‘have the answer’ in order to provide helpful supervision. This idea appears to be represented in the supervisor perspective body of research (e.g. Shanfield, 1993) but interestingly does not appear to be matched in supervisee accounts of what it helpful in supervision (e.g. McNeil & Worthorn, 1996, Weaks, 2002)

Participants described the use of theory as an additional support to supervisory learning. This is consistent with findings from Townend (2008) who found that a core aspect of supervision for supervisors is the integration of theory and practice. Theory was also invoked to address therapist avoidance of exposure work in the current study. Therapist and client ‘collusion’ to avoid exposure work is anecdotally reported in trauma work as well as having some support in the literature. For example in exploring the use of imaginal exposure in trauma focused work Minnen, et al (2010) found that therapists tend to underuse this technique, and fear of symptom exacerbation or client drop out were negatively correlated with perceived suitability of the intervention. Therefore this study adds a valuable perspective of how this might manifest itself in supervision and how it is addressed.

Limitations of the study
The aim of the study is not to generalise results (as is not the case in qualitative research) to all clinical supervisors in these types of settings, but to offer a rich account of the experiences of this sample and to generalise to theory. Results however, must be considered in the context of the following limitations.

Research sample
This sample broadly fitted the criteria of homogeneity outlined in Smith et al. (2009) for carrying out IPA research. However, in considering the findings, it is important to bear in mind the diversity within the sample, for example, the dominance of clinical psychologists to counselling psychologists (6:1), and the diversity of theoretical models and trauma settings. This range of perspectives and theoretical backgrounds is relatively typical in trauma services however (e.g. Lab et al., 2008), and I would contend that this research sample goes some way to representing the typical diversity in 'real life trauma work' (Lab et al., 2008). Equally, participants who volunteered to participate were likely to have an interest in supervision. This, in combination with the range of perspectives, is likely to have impacted upon the accounts of supervision and the subsequent interpretations.

**Interviews**

At various points during the interviews, I felt the focus often fell to a theoretical account of what happens in supervision, with the supervisor as somewhat distant, e.g. speaking in the third person. It is possible that this may have been due to limitations of the interview schedule. For instance, the schedule could have explicated the personal to a greater degree. Equally however, this may relate to the dynamic between participants and I in the interviews.

For instance, in addition to two of the sample holding managerial positions, the rest of the sample held relatively senior positions in their respective services. Given that I as the interviewer was in a comparatively junior training position, it is possible that this may have influenced the degree to which participants felt comfortable sharing uncertainties or challenges. Although, my experience of the participants in the interviews was predominantly consistent with their reported supervisory styles as open and transparent, in some interviews, I wondered whether I might be receiving an account of the ideal rather than the actual, experience of clinical supervision. For example, one participant often made explicit reference to what 'should be done', and required further questioning to determine what they had done in practice. Therefore it is possible that potential power dynamics in addition to limitations of the interview schedule may have impacted on the results.

**My position as researcher**

My clinical experience of trauma focused work lies specifically within a cognitive behavioural model of understanding of traumatic stress and this orientation was
shared with several of the research sample. I aimed to undertake a reflexive approach in maintaining awareness of how this orientation and way of working may have impacted on my interpretations of the data. Also, my personal position at the time of data collection was as a novice therapist in the area of trauma. It is possible that theoretical orientation and personal position could have impacted upon my style of questioning and selection of areas for elaboration in the interview followed by focus on themes in the analysis.

Future research
Participants in this study spoke about the emotional impact of the work on therapists and also the complexity in negotiating the interface of where, as one participant put it; 'the profession meets the person'. Future research might use supervisory dyads to explore this issue in more depth and consider what is deemed as helpful and unhelpful in its negotiation in supervision with qualified staff, in trauma settings. Similarly supervisee ratings of secondary trauma or VT could be correlated with a measure of the supervisory relationship, e.g. the Supervisory Alliance Inventory (Efstation, et al, 1990) in generic and refugee specific trauma services to determine effect. Also the exploration of parallel process in trauma supervision may benefit from empirical exploration to complement theory in the area.

With regard to the supervisory relationship, openness and transparency emerged as important for participants in this sample. Given the evidenced importance of this relationship (e.g. Bordin, 1983), along with the BPS guidelines in supervision that stipulate the need for 'a good relationship to enhance the quality of clinical supervision, further research is called for in clinical psychology. Future research might focus on the development and difficulties in this relationship from the perspectives of both supervisors and supervisees in trauma settings and also beyond. Also, more accounts from qualified supervisees in these settings could be gathered to determine their perspectives on supervisor modeling and self-disclosure as means of learning and also their impact on the supervisory relationship. Equally further exploration of the tackling of sensitive and challenging topics in clinical supervision may be helpful.

The importance of culture and diversity in making sense of traumatic experiences and its inclusion in supervision emerged in the study. Future research might extend this exploration in trauma settings by for example, incorporating a broader
understanding of diversity (e.g. socioeconomic background, sexuality, spirituality etc), and how supervisors as well as supervisees understand its relevance in clinical supervision, both as part of the therapeutic work and as part of supervision. Similarly, further exploration of supervision of the work through interpreters in trauma settings could be of use to the field.

This study identified that participants' mode of supervision was largely influenced by their model of therapy and previous supervision. Further research might expand on this (and Townend's, 2002 review of British Association of Behavioural Cognitive Psychotherapist supervisors) in order to obtain a clear picture on how clinical and counseling psychologists are supervising in various settings in the UK, e.g. what theory informs their supervision, and what impacts on their supervisory style. In terms of relevance to the current study this could be across trauma specific services, although the gap in current practice suggests that it would be particularly helpful in clinical psychology. It seems that this is a particularly pertinent question given the sheer volume of theory in clinical supervision without a matched evidence base. As one participant says;

'Supervision is funny, because you train as a therapist and you do a three year doctorate, and you get supervised on your own therapy and you do all these hours and hours of training that are observed and monitored and assessed and then you become a supervisor and you might go to a couple of days workshops, and that's it. You're let loose to supervise'.

Themes about knowledge, confidence and expertise in trauma supervision in this study offer some interesting insights that further research could take further and explore more extensively. Given that within the clinical supervision literature as a whole, and especially so in clinical psychology, research into supervision with qualified practitioners is relatively limited in the UK, future research might use qualified supervisory dyads to explore the sharing of knowledge, learning and potential power dynamics in these dyads. With particular regard to trauma settings, issues of safety, containment and trust could be explored. It seems that this is an area that generalisations from counselling psychology are potentially limited due to the more general practice of counselling supervisees choosing their supervisors, who are often not based in the same service (Wheeler, 2004).
Clinical Implications

In terms of addressing the potential impact of the work on the supervisee and on the supervisory relationship, it may be helpful to include discussion and reflection on the emotional impact at the outset of the supervisory relationship. The generation of a shared understanding of where the boundaries are located in regard to this and also what support might be needed should the supervisee experience difficulty are likely to be of use to both parties. Although it is likely that many qualified practitioners will have experience in the field and therefore prior experience of this, new supervisory relationships could benefit from this type of explicit discussion. It is equally important that supervisor needs in this context are addressed, and supervision of supervision is available.

In this sample, two participants received explicit supervision of supervision, with the rest bringing any emergent issues to clinical supervision as needed. Given the challenging therapeutic encounters participants reported their supervisees experiencing, and the utility in maintaining an 'outsiders' perspective, it is contended here that explicit supervision of supervision may fulfill similar aims in the supervisory relationship. As one participant described the need to support a supervisee in an area in which they may not have had an awareness they were struggling, a similar phenomenon may be at play in supervision. Equally however, an infinite regress is not suggested, but it is perhaps more likely that that the supervisor's supervisor may be able to hold the client, supervise and supervisor in mind with sufficient distance to be able to offer insights into potential blind spots. Additionally, further consideration of transference, counter-transference and parallel process (possibly in the form of additional training or discussion in predominantly CBT orientated teams) could stimulate more explicit consideration of these issues in clinical supervision and also provide specific tools to support supervisor reflection on these areas.

A culture of openness and transparency is arguably important in generic services as well as trauma specific ones. Similarly, a supervision contract outlined at the outset with both parties’ expectations and aims could be useful across theoretical orientations. Although the sharing of recorded therapy material is often commonly utilised in CBT, it is argued here that this sharing of work can facilitate a good
supervisory relationship and thus could be helpful across theoretical orientations in regular supervisory practice. As one participant in this study put it, 'when you’re a trainee, you’re inclined to think that you know very little all the time. But it doesn’t really change!' Although this was something of a flippant remark it does raise the question of supervisor comfort in sharing their work. This is something that could be afforded an overt focus in supervision of supervision. Related to this is the issue of supervisor disclosure and modelling. The consideration of this as a potential tool in the supervisor’s toolkit could also be explored in more depth in supervision in clinical and counselling psychology.

Difficulty related to supervisee and supervisor comfort in the discussions of sensitive topics was raised in this study. Although not wanting to generalise from this sample, it is possible that other practitioners may experience similar difficulty given the intimate nature of some traumas and the potential infrequency of it occurring in everyday conversations. Although anecdotally therapists in this area report increased ease of discussion of intimate details with increased exposure, it is highly likely that personal resonance with the material in addition to the quality of the supervisory relationship, will impact on the ease with which these topics are considered in supervision. Time in supervision or in additional training may support the supervisor (perhaps more relevant to relatively new supervisors) to reflect on their own perceptions and feelings about potentially difficult topics. This might support their development and capacity for appropriate modelling for supervisees.

The understanding and incorporation of diversity and difference in a meaningful way, continues to challenge therapeutic work and its supervision (e.g. Tribe, 2004). The clinical implications from this study relate to the continued discussion of these topics in supervision, with their expansion to include the diversity in the supervisory dyad too, where not already happening. It is possible that further training may be of use to supervisors in this endeavour. Of interest here is a reflection from Fleming & Steen (2004) who note that in their practice, the only supervision workshop to be cancelled on the basis of lack of interest in several years, was one focusing on diversity. Senior trainers in the area also reported similar experiences. Although several years have elapsed since this observation, it raises the question of perceived relevance of this aspect of clinical work, which is perhaps more visible or difficult to avoid in trauma work.
Reflective practice, supervision of supervision and continued supervision training may support supervisors in maintaining awareness of the influences on their supervisory styles, (e.g. the role of previous supervisors) and how to facilitate supervisee learning in a way that is most appropriate to the supervisee needs and context.

The complex interplay between experience, knowledge, confidence and expertise may be moderated somewhat through reflective practice and the use of supervision of supervision. The inclusion of a clear supervisory contract with the expected roles and responsibilities of each party may support the supervisors use of knowledge and expertise in a way that supports experienced supervisee learning and provides an appropriate level of challenge (Weaks, 2002) consistent with the supervisees’ developmental stage.
References


Ronnestad, M.H., Orlinsky, D.E., Parks, B., Davis, J., and the Society for


Steed, L. G., & Downing, R. (1998) A phenomenological study of vicarious traumatization amongst psychologists and professional counsellors working in the
field of sexual abuse/assault. The Australasian Journal of Disaster and Trauma Studies, 2,


Tribe, R. (1999). Bridging the gap or damming the flow? Some observations on using interpreters/ bicultural workers when working with refugees, many of whom have been tortured. British Journal of Medical Psychology, 72(4), 567_576.


Appendix 1

Interview schedule
Experiences of supervisors who supervise therapists who work in trauma services

Interview Schedule

Can you describe the service you work in?
- Prompts: What is the referral pathway? What types of clients are seen?

Can you tell me what type of clinical supervision you offer?
- Is it regular or occasional? Is it with internal staff? Is it with external staff?

What do you think are the reasons for giving supervision, in the context of your service?
- Prompts: Are there tasks in supervision? Is yes, what are they?
- Are there any particular considerations in supervising this type of work? If yes, how do you make sense of them?

Do you think you as the supervisor have responsibilities in this context?
- Prompt: If yes, what are they?

Do you think this kind of work has an impact on the therapist?
- Prompt: If yes, what is your experience of this in the supervision you have given?

Do therapists work with interpreters in this service? If yes, what is your experience of supervising work that is carried out through an interpreter?
- Prompts: What have you done? What's been important in supervising this work?

Can you tell me about your experiences of the supervisory relationship?
- Prompts: Do any particular examples spring to mind? What happened?
Can you describe a time, if any, where you think supervision you have given has gone badly or did not achieve your objectives?

- Prompts: Was there something you had done? Something the supervisee had done? Something about the supervisory relationship?

Can you describe a time, if any, when you feel supervision has gone well?

- Prompts: Was there something you had done? Something the supervisee had done? Something about the supervisory relationship?

Has supervising this type of work impacted on you as a person? If yes, how is this addressed?

Do you get supervision of supervision?

Is there anything I haven’t asked you or that we haven’t talked about that you think is relevant?

Thank you
Appendix 2

Ethical Approval Documentation

a) University Ethical Approval
b) NHS REC Approval
c) Trust 1 R&D approval
d) Trust 2 R&D approval
e) Trust 3 R&D approval
f) Trust 4 confirmation letter
Dear Susan

Reference: 353-PSY-09
Title of Project: Supervisors' experiences of supervising therapists who work in trauma services

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

[Signature]

Dr Adrian Coyle
Chair's Action

Ref: 353-PSY-09
Name of Student: SUSAN BRANNICK
Title of Project: Supervisors' experiences of supervising therapists who work in trauma services
Supervisor: Professor Arlene Vetere
Date of submission: 27th July 2009

The above Project has received NHS approval and expeditious ethical approval has been granted.

Signed: [Signature]
Chair

Dated: 27th July 2009
Ms Susan Brannick
Trainee Clinical Psychologist
Surrey and Borders Partnership NHS Trust
Psychology Department
Surrey University
Guildford GU2 7XH

30 June 2009

Dear Ms Brannick

Study Title: Supervisors experiences of supervising therapists who work in trauma services.
REC reference number: 09/H0707/55
Protocol number: 1

The Research Ethics Committee reviewed the above application at the meeting held on 24 June 2009. Thank you for attending to discuss the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, 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 governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rare.org.nhs.uk. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

This Research Ethics Committee is an advisory committee to London 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.
Sponsors are not required to notify the Committee of approvals from host organisations.

Other conditions specified by the REC

1. Transcripts of focus group discussions should be fed back to individual participants for their explicit approval. This should be confirmed in writing to the committee.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

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<th>Document</th>
<th>Version</th>
<th>Date</th>
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<td>Invitation to PSYRAS</td>
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<tr>
<td>Participant Consent Form</td>
<td></td>
<td>01 May 2009</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td></td>
<td>01 May 2009</td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>v1 Trauma Clinics</td>
<td>01 May 2009</td>
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<td>Advertisement</td>
<td>v1 Psychologist magazine</td>
<td>01 May 2009</td>
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<tr>
<td>Interview Schedules/Topic Guides</td>
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<td>Compensation Arrangements</td>
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<tr>
<td>Letter from Sponsor</td>
<td>University of Surrey</td>
<td>26 April 2009</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Susan Brunnic</td>
<td>20 May 2009</td>
</tr>
<tr>
<td>Application</td>
<td>12 May 2009</td>
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<td>Protocol</td>
<td>01 May 2009</td>
<td>01 May 2009</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Professor Ariene Louise Veltiere</td>
<td></td>
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Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

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

This Research Ethics Committee is an advisory committee to London Strategic Health Authority.

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

215
Committee Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Present</th>
<th>Nature</th>
</tr>
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<tr>
<td>Prof Jane F Apperley</td>
<td>Department of Haematology</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr Tom Cairns</td>
<td>Consultant Nephrologist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr Sheila Coates</td>
<td>GP</td>
<td>Yes</td>
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<tr>
<td>Mrs Alison Collins</td>
<td>Lay member</td>
<td>No</td>
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<tr>
<td>Prof Simon Day</td>
<td>Statistician</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Prof A George</td>
<td>Professor of Molecular Immunology (Chairman?)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>The Revd Nigel Griffin</td>
<td>Hospital Chaplain</td>
<td>Yes</td>
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<tr>
<td>Ms Ann Jacklin</td>
<td>Pharmacist</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ms Victoria Latham</td>
<td>Lead Pharmacist Clinical Trials &amp; Pharmacovigilance</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr Graham Miller</td>
<td>Senior Lecturer in Management (Vice-Chair, Lay member)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Professor Melvyn Myers</td>
<td>Clinical Scientist</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ms Jo Studham</td>
<td>Joint Clinical Research Facilities Manager</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr Lidia Tyszczuk</td>
<td>Consultant in Neonatal Medicine</td>
<td>No</td>
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<tr>
<td>Dr Catherine Urch</td>
<td>Consultant Palliative Medicine</td>
<td>No</td>
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</tr>
<tr>
<td>Dr Caroline Vaughan</td>
<td>Lay member</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Ms Mo Yale</td>
<td>Lay member</td>
<td>No</td>
<td></td>
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</table>

Also in attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position (or reason for attending)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Clive Collett</td>
<td>Administrator</td>
</tr>
</tbody>
</table>
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.nhs.uk.

[991070765] Please quote this number on all correspondence.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Professor A George
Chair

Email: clive.collett@imperial.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments "After ethical review – guidance for researchers"

Copy to: Dr M John
c) Trust 1 Ethical Approval

25th November 2009

Ms Susan Brannick
Trainee Clinical Psychologist
Surrey & Borders Partnership NHS Trust
Psychology Department
Surrey University
Guildford. GU2 7XH

Dear Ms Brannick

Title: Supervisors experiences of supervising therapists who work in trauma services.

LREC Ref: 09/H0707/55
R&D ref: 09MHP53

I am pleased to confirm that the above study has now received R&D approval, and you may now start your research in Trust. May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact**: only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust’s patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent**: original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient’s notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection**: measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998.
- **Health & safety**: all local health & safety regulations where the research is being conducted must be adhered to.
- **Adverse events**: adverse events or suspected misconduct should be reported to the R&D office and the Ethics Committee.
- **Project update**: you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications**: it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics**: R&D approval is based on the conditions set out in the favourable opinion letter from the Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Ethics Committee and R&D Office as soon as possible.
Please ensure that all members of the research team are aware of their responsibilities as researchers. For more details on these responsibilities, please check the R&D handbook or NoCLoR website: http://www.noclor.nhs.uk

We would like to wish you every success with your project

Yours sincerely,

[Signature]

Research & Development Manager
d) Trust 2 Ethical Approval

Ms Susan Brannick
Trainee Clinical Psychologist
Surrey and Borders Partnership NHS Trust
Psychology Department
Surrey University
Guildford GU2 7XH

04 March 2010

Dear Ms Brannick,

Trust Approval: R&D2010/023 Supervisors experiences of supervising therapists who work in trauma services

I am writing to confirm approval for the above research project at the Borough directorate and relates only to the specific protocol and informed consent procedures described in your R&D Form. Any deviation from this document will be deemed to invalidate this approval. Your approval number has been quoted above and should be used at all times when contacting this office about this project.

Amendments, including the extension to other Trust Directorates, will require further approval from this Trust and where appropriate the relevant Research Ethics Committee. Amendments should be submitted to this R&D Office by completion of an R&D Amendment form together with any supporting documents. A copy of this is attached but is also available on the R&D Office website.

I note that the University of Surrey will be taking on the role of Sponsor for this study.

Approval is provided on the basis that you agree to adhere to the Department of Health’s Research Governance requirements including:

- Ethical approval must be in place prior to the commencement of this project.
- As Chief Investigator and/or Principal Investigator for this study you have familiarised yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework.
Compliance with all policies and procedures of the Trust which relate to research, and with all relevant requirements of the Research Governance Framework. In particular the Trust Confidentiality Policy.

Co-operating with the Trust R&D Office’s regular monitoring and auditing of all approved research projects as required by the research governance framework, including complying with ad hoc requests for information.

Informing the Trust’s Health and Safety Coordinators and/or the Complaints Department or of any adverse events or complaints, from participants recruited from within this Trust, which occurs in relation to this study in line with Trust policies. Contact details are available from the R&D Office if required.

Sending a copy of any reports or publications which result from this study to the Trust Departments involved in the study if requested.

Honorary Contracts must be in place prior to patient contact for all relevant members of the research team. Advice on this will be provided by the R&D Office at the point of obtaining R&D approval and on an ongoing basis for new members of staff joining the research team.

Sending a copy of the annual reports and end of project notification submitted to ethics.

Failure to abide by the above requirements may result in the withdrawal of the Trust’s approval for this research.

If you wish to discuss any aspect of this research approval with the R&D Office, please contact in the first instance.

I wish you every success with this study.

Yours sincerely

R&D Governance and Delivery Manager

Enc. R&D Approval Amendment Form
Dear Ms Brannick,

Research Title: Supervisors' experiences of supervising therapists who work in trauma services
Principal Investigator: Ms S Brannick
Project reference: PF436
Sponsor: University of Surrey – Department of Clinical Psychology

Following various discussions your study has now been awarded research approval. Please remember to quote the above project reference number on any future correspondence relating to this study.

Please note that, in addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, host site approval is subject to the following conditions:

1. The Principal Investigator (PI) must ensure compliance with the research protocol and advise the host of any change(s) (eg. patient recruitment or funding) by following the agreed procedures for notification of amendments. Failure to comply may result in immediate withdrawal of host site approval.

2. Under the terms of the Research Governance framework, the PI is obliged to report any adverse events to the Research Office, as well as the REC, in line with the protocol and sponsor requirements. Adverse events must also be reported in accordance with the Trust Accident/Incident Reporting Procedures.

3. The PI must ensure appropriate procedures are in place to action urgent safety measures.

4. The PI must ensure the maintenance of a Trial Master File (TMF).

Terms and Conditions of Approval, version 1.1 28/10/2009
• The PI must ensure that all named staff are compliant with the Data Protection Act, Human Tissue Act 2005, Mental Capacity Act 2005 and all other statutory guidance and legislation (where applicable).

• The PI must comply with the Trust’s research auditing and monitoring processes. All investigators involved in ongoing research may be subject to a Trust audit and may be sent an interim project review form to facilitate monitoring of research activity.

• The PI must report any cases of suspected research misconduct and fraud to the Research Office.

• The PI must provide an annual report to the Research Office for all research involving NHS patients, Trust and resources. The PI must also notify the Research Office of any presentations of such research at scientific or professional meetings, or on the event of papers being published and any direct or indirect impacts on patient care. This is vital to ensure the quality and output of the research for your project and the Trust as a whole.

• Patient contact: Only trained or supervised researchers holding a Trust/NHS contract (honorary or substantive) will be allowed to make contact with patients.

• Informed consent: is obtained by the lead or trained researcher according to the requirements of the Research Ethics Committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.

• Closure Form: On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the Research Office.

• All research carried out within NHS Trust must be in accordance with the principles set out in the Department of Health’s Research Governance Framework for Health and Social Care 2005 (2nd edition).

Failure to comply with the conditions and regulations outlined above constitutes research misconduct and the Research Office will take appropriate action immediately.

Please note, however, that this list is by no means exhaustive and remains subject to change in response to new relevant statutory online and guidance. If you have any queries regarding the above points please contact

Yours sincerely.
f) Trust 4 confirmation letter

NHS Foundation Trust
Research and Development Department

11th February 2010

Dear Sir/Madam,

As per my advice you do not require NHS approval in order to conduct your case study. Many thanks for your consideration and thoughtfulness. If you require any further guidance or assistance in the future please do not hesitate to contact me.

Kind regards.

[Signature]
Appendix 3

a) Study Invite

b) Study information sheet
Invitation to participate in a research study

Experiences of supervisors who supervise therapists who work in trauma services

My name is Susan Brannick and I am a Clinical Psychology Doctoral student at the University of Surrey. I am doing my final year dissertation on supervisors' experiences of supervising therapists who work in trauma services. I am looking to recruit clinical and counselling psychologists. Participants will have a minimum of one year's experience of delivering clinical supervision to qualified staff, in trauma services.

Participation will involve one semi-structured interview, lasting up to one hour. Participants will have the option to participate in a focus group to discuss the themes that emerge from these interviews. It is hoped that this study will add a unique and somewhat under investigated perspective to the existing literature base.

If you would like more information on the study or are interested in taking part please contact me at: s.brannick@surrey.ac.uk
Information for Participants

Supervisors’ experiences of delivering supervision in trauma settings

This study will be completed as part of the Doctorate in Clinical Psychology at the University of Surrey. Professor Arlene Vetere and Professor Renos Papadopoulos are supervising the project.

The study aims to explore supervisors’ experiences, beliefs and views about the clinical supervision they offer to qualified staff in trauma settings.

It is hoped that this research will contribute a rich, systematic, qualitative account of supervisors’ lived experiences of delivering this type of supervision to the existing literature base in trauma focused work and supervision.

Participation will involve one semi-structured interview at a location most convenient to the participant. This interview will last up to one hour.

Feedback from the study will be given informally to participants. Also, if desired, results from the study can be formally presented to the service, on completion.

In the case of any complaints or concerns about any aspects about the way you have been dealt with during the course of the study, please contact Susan Brannick (s.brannick@surrey.ac.uk) or Arlene Vetere (a.vetere@surrey.ac.uk)
Appendix 4

a) Participant consent form
b) Participant demographics form
Participant Consent Form

Title: Supervisors’ experiences of delivering supervision in trauma settings

Principal Investigator: Susan Brannick

Please read the statements below and tick the boxes as appropriate.

I have read and understood the information sheet provided about this study.

I have been given a full explanation of the nature and purpose of the study and any questions I have had about the study have been answered to my satisfaction.

I have been given a full explanation of what my participation in this study will involve.

I understand that all personal information relating to participants in the study will be stored securely and any identifying data will be anonymised.

I voluntarily agree to take part in this study and understand that I can withdraw at any time, up until I have seen my interview transcript and verified its accuracy, without having to justify my decision.

I understand that I will not be reimbursed financially for participation in this study.

Name of participant

Date:

Signature:
Participant Demographics Form

Title: Supervisors' Experiences of Delivering Supervision in Trauma Settings

Age:

Ethnicity:

Job title:

Years qualified:

Job Title:

Time supervising qualified staff (e.g. 1 year, 5 years):

Training received in delivering clinical supervision (if any):

Main therapeutic model used in clinical work:
Appendix 5
Four sample excerpts from transcribed interviews

A) Excerpt from interview with participant 1 (Alex)
B) Excerpt from interview with participant 3 (Chris)
C) Excerpt from interview with participant 4 (Morgan)
D) Excerpt from interview with participant 7 (Drew)
A) Excerpt from interview with participant 1 (Alex)

814. PI: Hmm. (5 second pause). Well I'm just trying to think what would I have
815. asked me if I was you. (8 second pause). I mean you, you've touched on, but
816. you've not really addressed the issues to do with, or I've not touched on the
817. issues to do with managing the interaction between the person and the
818. profession. And, obviously in PTSD work there's a lot of, you know,
819. unpleasant life event stuff and it's pretty unlikely that you would avoid meeting
820. individuals who you supervised who hadn't had life events that were to,
821. sometimes similar. In other words by their nature, you're likely to have
822. supervis-. I'm likely to have supervised someone's who's had a car crash, for
823. example. And I think in some ways PTSD work and trauma work can be
824. specifically, have issues to do with how the content erm, triggers off, keys into,
825. sort of echo's with personal stuff that the supervise, or the therapist or the
826. supervisee has. Erm, and how you, or how much you're responsible for
827. creating a framework to think about that importance. Because I, I think the
828. thing with trauma work and PTSD work in general is it's basically the same as
829. all other therapy, but the extreme nature of the events often means that certain
830. of the processes and the dynamics are much more powerful or extreme.
831. Simply because the extremeness of the content. So if for example you're
832. working with someone who was very violently abused you'll find I think that
833. the dynamic between feeling that you're sort of rescuing them or that you're
834. abusing them in the room through reliving or that you're being abused, for
835. example by their threats to harm themselves. That dynamic can get very
836. powerful because the. fuel of the fire, which is the trauma, is very powerful.
837. And erm, it means that. say you work with somebody who's had a loss and
838. you've had a loss er, in some ways the power for it to evoke is, is greater. And
It's very difficult to know in supervision how you approach that with someone who's not your patient but is potentially your colleague. But also is to some extent under your, erm, responsibility. In some way or other. But also, more importantly that erm, it can have a bearing on how they work with that client and what they think about them. It's, I think that's the, something I'm not sure about yet.

1: How have you done it in the past?

P1: (3 second pause). Well I know how you're meant to do it, which is, you know, kind of establish to what extent it, it's to do with the clinical issue and to what extent it's a personal issue. And have some kind of pre agreement about where do you take personal issues or where do the boundaries sit? Is this now stuff that belongs better with your therapist than with me? And blah Erm, (3 second pause) so I think I tend to do again is self disclose, as a way of normalising, erm, evoking actions. So I will talk about clients I've worked with where I've, it's say evoked or connected to something unpleasant or painful in my life that obviously I'm just about comfortable enough to talk about now. Erm, and use that as a, as a, almost like a, an analogy. Rather than. say well 'What is it in your life that you think is triggering off your intense distress at this story?' I don't think-. There, there's not an easy way to do it. I think what you start to be as a supervisor. Start to think, 'Oh god this is really difficult'. 'What can I do?'

1: What do you think makes it difficult?

P1: Erm, because, (6 second pause), well I, (5 second pause), because unlike with a client who you're trying to get them to look at it in a way that helps them to feel better, it's not necessarily your role to do that with your supervisee.
864. You're trying to get them to identify where that link might connect and then.
865. perhaps to think about where or what to do about it. Erm, but you have to be
866. very cautious not to start treading on toes where you're not invited. With a
867. client you're invited into that material. With a supervisee you're not in the
868. same way. Erm, (3 second pause) so I think that's what makes it difficult.
B) Excerpt from interview with participant 3 (Chris)

305. **P3** Yeah, that had face validity for her. And I think unless you’re quite open about all the different kinds of things that people would imagine making them better. If you’re very fixed on the only thing that can work is something that there’s been some research on, (I: yeah), and I mean that can work. But I think if you’re really kind of very rigid about evidence base and can’t think more widely, I think it could be very difficult to find somebody like that as well, you know (laughs). Em, sorry I’m smiling because they, em, CBT course last and there was some feedback thing and somebody said, ‘we discussed cultural issues’ and the guy was like ‘hmmm fascinating’, and then he moved quickly on. He didn’t know what to say, just really made me laugh- people always say it’s fascinating and they don’t mean it at all! (Both laugh). But yeah, there’s a lot of things that come up in this work, like em, for example, I have a client from Somalia who has a very fixed idea that em, when you have flashbacks it’s means that the devil’s inside you, at that point in time. And it’s not a psychotic idea, but I think unless you’re looking out for those ideas you could miss, you know, and this person’s flashbacks aren’t going to go until I get a blessing to get rid of the devil. So you’d have to combine those two things at once in treatment for it to be very likely for it to work. Because, if the person thinks there’s a devil inside them, you know, there’s going to be a problem for the potential of the flashbacks. So you know, the person I’m supervising at the moment is very aware and curious about those issues and asks a lot about them and we also discuss it a lot if we can. Equally stuff about country information. Stuff about countries and what’s happened in those countries. If people think that’s off the point I think it could be difficult to supervise them as well.

330. I How would you facilitate those kinds of conversations if the person thought it was off the point?

332. **P3** Em. I think I’d probably end up being.. providing information myself on that particular country or other people I’ve worked with, from that kind of background and various things that came up. Things that might kind of complicate treatment. I mean I suppose in terms of formulating to start with. I would never want to formulate within a very narrow way, would always have
to be; ok so this a particular thought they have about an event but what
meaning does that event have in the society. What about in their family? So
in their community and get the person to actually explore that with the client.
And I think once you start doing that, you're actually kind of more tuned into
those ideas anyway. You know, em. Yeah, so I think it would be through
case discussion and maybe kind of with some examples I'd give from my
own experience. And definitely kind of hand them over horrible books from
that shelf (both laugh), which say culture in every single one.
1. I Ok. And what do you think are the reasons for giving clinical supervision? In your service?
2. P4 Well, it's for, ah, to, for a more experienced professional to share, with a less experienced (I: ok). So it's part of the, it's an essential ingredient in the learning process. And it's an essential element of em, it's a turning out and producing good clinicians, who, who can draw upon that experience that is actually patient based or face to face contact, em. I think another really important aspect of supervision is that it does start to create within, the trainees, or indeed for the qualified staff too, eh, em, a frame of mind or an attitude toward their clinical work that this is something that is best shared with colleagues for their enrichment. And for the improvement of, and improving the quality of their own clinical work. Or I should say of our clinical work (I: ok). I em, eh, em, I think it's of course for the supervisor, it's also an important part of em, monitoring the quality of services (I: hmm) and em, I think it's also an opportunity for the supervisor to receive feedback about some aspects, or those aspects of their own work as supervisors, which is positive. And, em, which is not so favourable. I'm sure there are some other reasons why you should supervise as well, but. But yeah, those in a sense are the main..
17. I Ok.
18. P4 The main points. You tell me if I've left out something
19. I Well, I guess I'm more interested in what you see the reasons to be?
20. P4 I, ah, I think also the main points. And I think the em, just to tell you a bit about the background. I eh, when I was head of service and also head of speciality, one of the things that I insisted on, or that colleagues, eh, qualified, all colleagues and trainees should have supervision. And I thought the requirement, the minimum requirement eh, one, at least one hour per week. Em, and that was one to one and then we also had, for a number of years, eh, we had, eh, one and a half hour peer group supervision.
27. I Ah, ok, yeah. So you've had a lot of experience of giving supervision and also peer group supervision as well
28. P4 Yes, and being supervised by my colleagues
29. I Ok, and initially you said one of the main reasons was getting good practitioners out there and having them client focused. How would you say that
31. you can facilitate doing that in supervision?

32. P4 Em, I, I think that em, the work with patients is em, very difficult, or, well
difficult but is also very different from the kind of ordinary social interactions that
we have.

35. I Sure

36. R4 I don't think that this is fully kind of appreciated, em, ahm, when colleagues
start In a sense how different the interactions with patients.

38. I Ok

39. P4 Eh, both in terms of you know, what, what in a sense are the boundaries (I:
hmm)

41. for therapy. Eh, also the kind of things that it is legitimate and helpful to
actually say in therapy and the therapists own position. How that is so very
different from a social position. And em, I think, my supervision, was, eh, em,
was on the one hand was in a sense a sort of technical, ah, eh, what you
actually do. And,em, eh, and my approach was when that worked well for
colleagues, well that's fine. But then when things didn't quite work to the plan of
the manual, then, immediately in supervision offered opportunities to examine,
why it is, that certain kind of suggestions and certain advice and guidance em,
and instructions, why it works with some patients and not others. And that lead
into considering more sort of sophisticated assessments in the evaluation of
what unfolds in the therapeutic relationship. Em, and eh, in a crucial element
in, PTSD work is part of the history taking. Em, which I think is an important part
of the supervision process, is, is to attune colleagues em, repetitions of the
patients own lives. Both pre trauma and post trauma

55. I Yeah, and is that something that would come up in supervision?

56. P4 Oh, absolutely. I mean it became an essential part of em, ah, of, supervision
and also in sense the way of steering, ah the ah, colleagues therapeutic
work, was to, to give it a focus and anchor it and you know, the, not only the
kind of history of repetitions. Kind of making aware of that. But how
repetitions, em, occur in the current therapeutic relationship

61. I Ok, so when you

62. And I think when you, I think when eh, with PTSD patients and when colleagues
just see how that was happening, that was felt like, you know, an important
extension of ah, em, kind of therapeutic armoraria. Eh, em, when, when it
was possible to work with those, eh, present and concurrent repetitions.
Excerpt from interview with participant 7 (Drew)

124. a psychiatrist. And I also provide other CBT supervision within the trust.

125. I sure, ok, and would you say, what's your experience of supervising trauma work as opposed to work in (other non trauma service)?

126. P7 Em, it varies a lot. It's a bit about the people you're supervising. So for example, most of the people I supervise in the trauma service have come with, they're either psychologists already or even if they're psychiatrists or nurse therapists, they come with quite a bit of therapy experience. Em, whereas, in the other service in which I work, I might be supervising people with a lot less psychology experience, maybe even very little CBT experience. But it's also a lot about the work you're supervising. The trauma work is, in some ways it's easier to supervise, because it's much more specific. It's about knowing a lot about one small area. Whereas the other work, it's knowing a bit about a lot of things

127. I So, can you tell me a bit more about knowing a lot about one area?

128. Yeah, I think as a supervisor, it's very satisfying because you have time.

129. Well as a clinician in a specialist you have time to really get to know a body of literature and theory and you get a lot of experience of working with one presenting problem. As a supervisor, it's easier in some ways because, you have that knowledge of that specific subject. Whereas if
You're supervising say in a CMHT, your supervisee might come with an OCD case, a BDD case, a depression case, you've got to know this for everything. As a supervisor in a trauma service, you've just got to know about trauma, so that's a bit easier. It makes you feel a bit better

Yeah, sure. So that sounds like it makes you feel better. It's a good thing?

Yeah

What else have you experienced in supervising this work?

Em, the thing I find about supervising in trauma.. I think trauma work has more of an impact on the clinician then maybe a lot of other work. So as a supervisor, you've got to be looking out for that, more than you might overtly do in other areas. So I need to remember to pay a lot more attention to the impact of the work on the people I'm supervising.

And how would you go about doing that?

Again it's something I try to acknowledge from the beginning, and create a space for. But it's always difficult as a supervisor to allow for space for talking about the more personal impact of work, within the boundaries of the professional supervisory relationship, it's a careful balance to thread between allowing that space, not, it not feeling too much like you're asking people; 'how did that make you feel', about therapy, because it shouldn't be like that

So, kind of being somewhere in between?

Yeah,
And how would you say, that you as a supervisor have managed to kind of thread through, or balance it?
P7 I suppose, like I say, I try to acknowledge that trauma work can have an impact, em, I’ll often be very open about the impact that trauma might have on me. For example, it’s not always the things you think will get you in trauma work, that get you. As an example I might, during my course of day at work hear about several horrific traumas involving torture and abduction and horrible things, and then hear one thing about a car crash, and then I drive home from work and then it’s the thing about the car crash that would come back into my mind, because I’m driving home from work. So it’s surprising sometimes, what gets you. So sometimes I’ll disclose something like that to my supervisees as a way of acknowledging sometimes things can get to you and it’s not always predictable what will get to you. I try to remember to ask about it. To check in about it and just say, reflect on it and then I’ll often ask supervisees if it’s something they want to talk about more, or not and I’d leave it open to them.

So do you mean kind of modelling?
P7 Modelling a lot. And being very transparent about it. Reflecting on it and leaving more space to talk about it, if the supervisee wants to, but not that they have to.

Sure, and have you had experience where somebody has felt the emotional impact, that you’ve been supervising?
P7 Definitely. Definitely. And again it's probably been surprising what gets to people, sometimes.
Appendix 6

Researcher Reflective Account
In line with the interpretative component of the IPA approach, I offer some background information here and reflections on the research process in order to contextualise my interpretation for the reader.

I am a white Irish female, who was working as a novice therapist (to trauma work) in the latter part of this research study. The idea for this project initially grew from a desire to carry out research in the field of trauma, focusing specifically on work with women who had been trafficked into the UK or alternatively with refugee or asylum seeker clients currently in mental health services. These research interests stem from a personal interest in the psychological consequences of political oppression. I have interests in feminist conceptualisations in this area, as well as community and critical psychology. For me, work in the field of trauma offers the opportunity to practise clinical psychology with acknowledgement and awareness of the cultural and political context within which it is embedded.

Ideas for the project were discussed with professionals in the area, and after several months, I decided to focus on indirect work with trauma survivors. This decision was borne from an acknowledgement of the practical difficulties in carrying out initial proposed ideas. The selection of a feasible area to carry out meaningful research in, was perhaps one of the more difficult aspects of this study, and is certainly reflected in the frustration and uncertainty I expressed in the initial interview with colleagues about the process in the early stages of the project.

The decision to focus on supervision was borne out of the notable absence of this work in the trauma literature. Equally I was hoping to go beyond trauma and VT and consider other aspects of the supervision of this work, in order to produce a study that might be of practical use to clinicians in the field.

Prior to my final placement in a trauma service, I had no previous clinical experience of carrying out trauma focused therapy and I do not have personal experience of the traumatising experiences that are experienced in this work and referred to in this study. Much of my training and pre training experience has been in a cognitive behavioural framework and thus was shared with several of the research participants. In an effort to work with the potential biases that this commonality might have generated, I sought discussion of findings and interpretations with my field supervisor, who stimulated my own broader thinking in this area, and often helped me to unlock my often CBT perspective.
As I collected data from the participants I often found myself relating to the experiences they described. For example, the fear that reliving will make a client worse was something that I also feared in the early part of the placement. In order to try to mitigate this, I tried to maintain awareness of these resonances and not over focus on them in the interviews or the interpretation, although the extent to which this was achievable can not be definitively ascertained.

This research was quite difficult to recruit for, which in addition to posing additional pressures to the research process, also led me to wonder about the notion of transparency in clinical work that emerged in the study, in wider clinical work and supervision as a whole. I wondered whether, in addition to interest and time pressures whether there might be some reluctance on supervisors' parts to, (as one participant in this study describes) – 'go public' with the work they are doing. This echos with my own experiences during training that highlight the need to accept that one can not learn without first 'not knowing'. The going public with clinical work, through supervision, sharing of work or indeed participating in a research project is as one participant put it important to create 'a frame of mind or an attitude toward their clinical work that this is something that is best shared with colleagues for their enrichment'.
Appendix 7

Validity Measures

A) Themes and quotes discussed with colleague in research group

B) Sample of themes and quotes sent to participants with feedback from one participant

C) Changes made based on feedback from research participant
A) Themes and quotes discussed with colleague in research group

**Match that quote:**

**Selection of sub themes**

1a) *The emotional and cognitive impact of the work on the supervisee*

1b) *A parallel between complex therapeutic relationship and the supervisory relationship*

1c) *Supervisee self care and negotiating boundaries around support in this area*

3a) *The impact of the clients' and therapists' contexts*

3b) *Culture and language*

4a) *The interplay between experience, knowledge and confidence*

4c) *Complexity in facilitating supervisee learning and assumptions of supervisor omniscience*
Selection of quotes

1. So what you are doing is working with a group who are so marginalized within society, where there's a dialogue around them, that is so sort of negative, and so you have to be very aware of the impact of that on yourself, and then on your supervise (Robin:369).

2. Erm, and in many ways I may know more about this topic than them. But I'm actually their peer and their colleague, rather than their superior, whatever you call it. So it's quite a-.. It can be quite different in that you don't want to take too much of a didactic position (p1: 213).

3. I have felt that, ah, you know, there was most of all a linguistic barrier, but you know dealing with a patient, or what we dealt with was a patient who, who in his own natural language, didn't actually have, eh, the words really to give expression to, eh, the kind of things that had been evoked by a trauma. (p4: 350)

4. It's also very easy for a supervisor to eh, if someone comes with an issue, and you think; I know a lot about this and just talk lots, and feel really good because you've talked lots and then you maybe haven't really helped the supervisee learn because you've just given them information. Again, you haven't moved them round the learning cycle, you haven't got them to reflect on their own learnings. (p7:553).

5. I think I find myself feeling quite responsible for people I supervise, a bit more in the trauma service, than I do in other areas, because I know what they're listening to, I know what they're going through (p7: 197)
6 But I think if what you do is listen to stories of torture and rape one after another, day after day, it requires a more explicit focus. (p5: 170)

7 But it's always difficult as a supervisor to allow space talking about the more personal impact of the work, within the boundaries of the professional supervisory relationship. It's a careful balance to thread between allowing that space, and it not feeling too much like you're asking people; 'how did that make you feel?' about therapy, because it shouldn't be like that (p7: 159)

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Discussion about the differences between sub themes 1b and 1c were discussed and agreement was reached.

B) Sample of themes and quotes sent to participants with feedback from one participant
Summary of master themes and super-ordinate themes with example quotes

1) 'The kind of stuff of your worst nightmares': Managing the impact of the trauma content and in the therapeutic and supervisory relationship.

1a) The emotional and cognitive impact of the work on the supervisee

But I think if what you do is listen to stories of torture and rape one after another, day after day, it requires a more explicit focus. (p5: 170)

1b) A parallel between complex therapeutic relationship and the supervisory relationship

I think I find myself feeling quite responsible for people I supervise, a bit more in the trauma service, than I do in other areas, because I know what they’re listening to, I know what they’re going through (p7: 197)

1c) Negotiating boundaries around support for supervisees

And it’s very difficult to know in supervision how you approach that with someone who’s not your patient but is potentially your colleague....Erm, but you have to be very cautious not to start treading on toes where you’re not invited. With a client you’re invited into that material. With a supervisee you’re not in the same way (p1: 836).

2) The importance of transparency and openness in the supervisory relationship

2a) Safety and trust through transparency within the supervisory relationship

Within, supervision, to set the standard to say it’s ok to say: ‘I don’t know’ or ‘this really upsets me’ or, or in a sense those aspects that we think of as the less favourable aspects (p4: 147)

2b) Demystifying trauma work and building the supervisory relationship

I would probably share my own experiences with them, we’d probably share our own therapy tapes with people... with PTSD maybe it serves more of a reassurance giving function (p2: 122)

2c) The fallible supervisor? Modelling and normalising through self-disclosure

And so I just say that, or I might disclose that I find I’m not so easygoing about x, since working with this kind of group. Or I find it hard to watch traumatic events in a film, you know. Yeah, so I think kind of being really honest about your own sort of, you know, things that you manage and things that you struggle to manage. (p3:730)

2d) Initiating discussion of the unmentioned or unmentionable
Because some of the traumas are so intimate... well I don't know if this is different to other services or not, but, there can be a little bit of a challenge in you know, how do I talk about this stuff, like different types of rape for example. And how can I discuss that in supervision. And if there's any, if a person, if a clinician has personal embarrassment about it, that kind of stuff, how do you manage that?... But I think potentially other people who are supervising, they really struggle; 'oh I didn't want to ask her how she felt about the details of that graphic rape'. (p3: 658)

3) Supervision as not existing within a vacuum: the role of wider context and a multiplicity of views

3a) Impact of the clients' and therapists' contexts

When my colleague was working with a client from the same part of <country>, we just felt that her status as a woman from that part of <country> made for a particular dynamic. But she hadn't twigged that... And I said I wonder what it means for him to have you there, who's got the same accent, from the same bit. (Robin: 452)

3b) Culture and language

What we dealt with was a patient who, who in his own natural language, didn't actually have, eh, the words really to give expression to, eh, the kind of things that had been evoked by a trauma (p4: 351)

3c) The service context

I have a responsibility to the service as well, to make sure that people are getting evidence-based treatment, and the right kind of evidence based treatment. (p7: 63)

3d) The influence of past supervisors

I think I've taken something away from every supervisor, including the ones that I've hated. Ways not to do things. Absolutely. (p1: 283)

3e) The theoretical context

It's also how I do therapy, it's also how I work with clients as well, sort of slightly baffled, grappling eh.. which again is very sort of Socratic and existential, and maybe my stance, my therapeutic stance has a lot to do with that. (Robin: 74)

4) The experience of facilitating learning: The tensions between knowledge, theory and expertise.

4a) The interplay between experience, knowledge and confidence

The trauma work is, in some ways it's easier to supervise, because it's much more specific. It's about knowing a lot about one small area. Whereas the other work, it's knowing a bit about a lot of things. (p7: 139)

Erm, and in many ways I may know more about this topic than them. But I'm actually their peer and their colleague, rather than their superior, whatever you call it. So it's
quite a-. It can be quite different in that you don’t want to take too much of a didactic position (p1: 213)

4b) Interchangeable experts and the supervisor as located outside of the therapeutic dyad

But equally when you can feel that there’s an avoidance or a conspiracy to avoid, the hard stuff on the part of the therapist and the client actually you have to go the other way and sort of push the person, help the person to push forward. (p1: 178)

You have to be a bit of a devil’s advocate at times. You know, kind of remind them.. ok what do we know will actually help in the longer term. (p:3:199)

Feedback from participant

‘I’ve had a look through your analysis. Most themes seem to have clear face validity. A couple of very small points. Sections 1 and 2 are clear and logical, and the quotes seem to illustrate your headings. In Section 3, I wasn’t sure from the quotes given what the difference between 3a) and 3b) were, as the quote with 3a) seems to be mainly illustrating something about culture and language, which is the next heading. I also wasn’t sure about 3e) as the quote seems to illustrate uncertainly about a theoretical stance, rather than within a clear theoretical context! 4a) was very good, and the theme label seemed to capture what was going on in the quotes, but the title for 4b) didn’t seem to clearly match with the example quotes, which seemed to be more about overcoming avoidance on the therapist’s part and the supervisor having faith to push the supervisee to push the therapy forward.

Hope these comments are helpful’

C) Changes based on feedback from research participant

- 1c: The wording of title of this sub theme was slightly altered to make it more encompassing of the phenomenon
- 2a: The wording of title of this sub theme was slightly altered to make it more encompassing of the phenomenon
• 3a: Another quote was used to exemplify theme
• 3e: The wording of title of this sub theme was slightly altered to make it more encompassing of the phenomenon
• 4b: Data relating to this theme were reviewed and the theme was slightly reconceptualised and split into two different themes for end analysis