Clinical psychologists on clinical supervision: a Delphi survey

Thesis

UNRESTRICTED

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CLINICAL PSYCHOLOGISTS ON CLINICAL SUPERVISION: A DELPHI SURVEY.

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Attachment 3

DECLARATION FOR DISSERTATION

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This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed ..... (candidate)

Date .....

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and abstract to be made available to outside organisations.

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A project of this nature would clearly not have been possible without the generosity of all who participated in it, who willingly shared their experiences, thoughts and beliefs simply because they were asked to do so. I am much obliged to them all, and hope that those of them who read this will feel the result adequately justifies the pains they took on my behalf. Some were kind enough to give their permission to be named, as follows:

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Wherever appropriate, gender-neutral language is used throughout this report. In order to avoid the use of such cumbersome terms as her/his, the researcher has followed the old English tradition of using 'they' and 'their' as singular terms where an individual is discussed whose gender does not require specification.

Abstract

Background and aims

In the context of historical tensions from different epistemologies and traditions, and contemporary needs for guidance and clarity, the DCP has noted 'an emerging consensus' on the desirability for career long engagement in clinical supervision for clinical psychologists. The study attempts to measure this consensus and investigate current practices and beliefs.

Design and participants

A three-round Delphi survey was used, initially gathering semi-structured accounts of panelists' views and subsequently inviting more precise responses to a questionnaire derived from those accounts. The participants were 53 clinical psychologists, selected on the basis of their presumed interest or expertise in supervision.

Measures

Materials were developed for the study:

- PPI collected personal and professional information,
- DQ1 collected semi-structured accounts of opinions concerning various aspects of supervision,
- DQ2 was a 62-item questionnaire derived from DQ1 material.

Results

Most panelists were both giving and receiving supervision. There was broad agreement on most issues, including the desirability of universal engagement in supervision for clinicians, the primacy of the supervisory relationship, the need for preparation for the roles of both supervisor and supervisee, and the necessity to identify supervision as an activity distinct from both management and therapy. In contrast there was little agreement on how supervision is most appropriately related to either management or therapy, nor on the relative importance of personal therapy and supervision in the training of competent therapists.

Implications

Most panelists were deeply engaged in both the provision and the receipt of supervision, which supports current DCP policies, but the culture is not yet strong enough to guarantee that all clinicians will be offered it routinely.

More theoretical research is needed to develop models of supervision which will not assume that psychotherapy is its only legitimate focus, but will pay due heed to the wide range of tasks undertaken by both clinical psychologists and their supervisees.

KNOW THYSELF

Inscription on the walls of the temple of Apollo at Delphi: also the subject matter of the discipline of psychology, according to the Encyclopaedia Britannica (1984).

Section 1: **Clinical psychology and clinical supervision: origins and history**

The relationship between clinical psychology and clinical supervision has been formed and informed by a number of historical tensions. Psychology is a relatively young field of study: the British Psychological Society (BPS) is less than a hundred years old, and its Division of Clinical Psychology (DCP) is one of the oldest and by far the largest (BPS, 1999a). Most clinical psychologists spend a substantial portion of their time conducting therapy of one kind or another (Norcross, Brust & Dryden, 1992) and these activities too have only recent roots. The 'First Force' (Mahoney & Patterson, 1992) of the psychological therapies came not from psychology but from the medical tradition when Freud invented psychoanalysis just over a century ago. Psychology and psychological therapy, therefore, originated at around the same time but not from the same epistemologies.

Psychoanalysis

Early psychoanalytic thinkers proposed psychoanalysis as therapy, training and supervision, with few if any distinctions made among them. Some schools separated the personal analysis and the supervisory or control analysis, while others

perceived them as different aspects of a single process (see Carroll, 1996 or Edwards, 1997 for a fuller discussion). In either case, the analysis of the therapist was considered a finite if lengthy endeavour and the final outcome was hoped to be a fully analysed therapist who was, thereafter, competent to practice without further supervision. Psychoanalytic supervision literature still uses the terms supervisee and trainee interchangeably (Binder & Strupp, 1997; Dewald, 1997). Freud, however, recommended periodic reanalysis to help therapists cope with work-related distress (Macran & Shapiro, 1998), thereby recognising the need for some continuing professional support.

A psychoanalytic legacy

The relationship between psychological therapy and clinical supervision has struggled ever since with these legacies from its origins:

- should receiving therapy be a core requirement for training as a therapist?
- can monitoring and supporting therapeutic work through supervision be differentiated from providing therapy for the worker?
- ought therapists aim to become able to practice without supervision?

The earliest pioneers in the construction of psychological therapy continue to influence theory, training, therapeutic practice and supervision throughout the developed world although in British clinical psychology their influence has been muted and their reputation highly contentious. In addition, as the following section will explore, the role of supervision has been extended to a variety of purposes that were never anticipated by those who established schools of psychological therapy. This combination of the root distinctions between British psychology and psychoanalysis on one hand and numerous additional uses of supervision on the other

has meant that the practice of supervision by British clinical psychologists has never developed a generally accepted and coherent theoretical base: this might benefit from investigation.

Clinical psychology in Britain and the rise of behaviourism

Hans Eysenck, a key founder of the profession of clinical psychology in the UK, was fiercely anti-psychoanalysis (Mollon, 1989) and early training courses in clinical psychology judged psychoanalytic principles and practices unworthy of attention (Nichols, Cormack & Walsh, 1992). Such historical antipathy may explain Norcross, Brust & Dryden's (1992) finding that 57 per cent of a sample of DCP members specified the psychodynamic/analytic (including Kleinian) approaches as *least* like their own, and only 12 per cent (including 1% Kleinian) described these approaches as *most* like their own. Among American clinical psychologists, 23 per cent identify psychodynamic/analytic theories as providing their primary orientation.

Eysenck's original position was that clinical psychologists should keep to assessment and research and not involve themselves with the unscientific business of treatment at all (Eysenck, 1949), but early developments in behaviour therapy coincided with the establishment of clinical psychology as an autonomous discipline. Since the Maudsley Hospital was home to both Eysenck and Wolpe, who was among the first behaviour therapists, it was perhaps inevitable that the new profession and the new theoretical approach to treatment should form a strong alliance.

Behaviourism and techniques based on learning theory (Mackay, 1984) formed the 'Second Force' (Mahoney & Patterson, 1992) of psychological therapies. The practice of therapy and the training and supervision of therapists were considered technical matters without interpersonal significance, and they are not referred to in the

early literature beyond the necessity for therapists to adhere to the treatment programme. In a historical review of clinical psychology training, Nichols et al. (1992) noted that 'the denial of feeling was both taught and modelled' (p.30). Neither personal distress as a response to the work nor the personal development needs of the worker are readily addressed in such an interpersonal vacuum. No developments in thinking about supervision emerged from this 'dark age in clinical training' (ibid).

The human potential movement and a new emphasis on supervision

The 'Third Force' (Mahoney & Patterson, 1992) of therapies came from the humanistic school pioneered by Rogers in the USA and established the counselling movement (Thorne, 1984). These therapies identified the therapeutic relationship as the key effective component and it was the therapist's task to provide this relationship, characterised by empathic understanding, respect, genuineness and concreteness (Patterson, 1997).

Counselling trainings suggested, and some insisted, that trainee therapists received counselling, and where training was single-model the trainee's therapy was usually expected to follow the same model. This match of training and therapy usually meant that supervision models were therapy-bound (for example, Patterson, 1997). More generic training bodies and institutions rarely monitored either compliance or outcome and there may have been no match between the therapeutic models taught to the trainee and those used by the trainee's therapist.

This looser position stimulated the development of supervision models which were not tied to a particular model of therapy but could be used across models (Inskipp & Proctor, 1988; Hawkins & Shohet, 1989; Carroll, 1996; Page & Wosket, 1994). The impetus for investigating and developing clinical supervision as an

activity distinct from the practice of therapy came largely from the counselling movement on both sides of the Atlantic.

In America most counselling trainings, like traditional analytic and other psychotherapy trainings, assumed that supervision was a training activity (Holloway, 1995). For example, in the most comprehensive recent review of psychotherapy supervision the American psychologist Watkins (1997) cites LeShan's (1996) view that all practising therapists should be in supervision. Watkins questions this position:

> Whereas such supervision for either supervisors or therapists need not be continuous, as LeShan seems to prefer, periodic supervision can be...*a growth option we may wish to exercise* [emphasis added] time and again (p. 613).

In contrast, clinical supervision has always been seen as an on-going requirement for the lifetime of practice by the British Association of Counselling (BAC) (BAC, 1998; Carroll & Holloway, 1999). This emphasis on post-qualification supervision led to an unprecedented amount of research and professional activity devoted to the construction of models of the supervision process, of supervisor development and of supervisor training and accreditation (Hawkins & Shohet, 1989; Dryden & Thorne, 1991; Page & Wosket, 1994; BAC, 1996; Carroll, 1996). What might be called the professionalisation of clinical supervision came primarily from the British counselling movement. This literature has now provided several different models of supervision which are not necessarily tied either to one therapeutic tradition or to assumptions about the experience level of the supervisee: all models, however, assume that the supervisee's task is to provide therapy and the supervisor's task is to facilitate that provision. It is not clear whether clinical supervision as practiced by clinical psychologists fits comfortably into these models.

The admission of cognition

The 'Fourth Force' (Mahoney & Patterson, 1992) in the psychological therapies comprised cognitive models such as those of Beck (1964) and Ellis (1962). In America early behaviourists rapidly became disenchanted with the simpler conditioning models of human behaviour (Kanfer & Phillips, 1970), but the absolute rejection of subjectivity by highly influential thinkers such as Eysenck (1976) in Britain meant that cognitive therapies were slow to be adopted (Mackay, 1984). Eventually increasing numbers of therapists rejected this inattention to the clients' private experiences and cognitive and behavioural approaches collectively became known as cognitive-behaviour therapy (CBT).

As cognitive therapies derived, at least initially, from conditioning models of human behaviour their practice was seen primarily as a technical matter. No form of CBT required its practitioners to undertake therapy. Training and supervision requirements reflected this emphasis on technique but recent literature on supervision in cognitive therapy has paid considerable attention to interpersonal issues, including transference and countertransference (Liese & Beck, 1997; Perris, 1997). The supervision process, if not its focus, is usually seen as identical to the therapy process (Fruzzetti, Waltz & Lineham 1997; Woods & Ellis, 1997; Liese & Beck, 1997). Supervisors are expected to use the same techniques of educating, encouraging and challenging therapists as therapists use with patients.

In the American literature supervision is generally perceived as limited to trainees (for a rare exception see Fruzzetti et al., 1997). In contrast, the British Association of Behavioural and Cognitive Psychotherapy (BABCP) is a member of the United Kingdom Council for Psychotherapy (UKCP) and, as such, requires its accredited members to continue in supervision throughout their careers. Supervisor

training and development are largely unexplored, although Perris (1994, 1997) almost single-handedly has attempted to remedy this.

Systemic approaches

A recent fundamental shift in psychotherapeutic thinking has been a focus away from persons and towards interpersonal systems such as couples and families. There would be obvious difficulties of both ethics and taste if trainings in such therapies insisted trainees bring their partners or families into therapy. However, there is an ethos that personal therapy offers a valuable growth experience for would-be therapists and trainers tend to hold the view that, on occasion, they can insist trainees enter therapy (Rudi Dallos, personal communication).

Family therapies are highly innovative in their development of both therapeutic and supervisory procedures. The use of reflecting teams and various kinds of live supervision (Liddle, Becker & Diamond, 1997) are radical departures from previous traditions. Therapist(s) and supervising team are also seen to form a system which inevitably relates to the original family system in ways that could be usefully explored (Rothberg, 1997). Supervision is generally considered integral to practice rather than confined to training and supervisor training attracts considerable attention in the professional literature (Barnes, Down & McCann, 2000; White & Russell, 1995).

Section 2: **Clinical psychology and clinical supervision: new forces**

Clinical psychology now faces pressures from a number of sources to formalise its relationship with clinical supervision. The profession has undoubtedly been shaped by its historical association with behavioural and cognitive philosophies,

and it is no surprise that in a survey of DCP members 48 per cent declared their primary orientation as one or other of these (Norcross, Brust & Dryden, 1992). Among the rest, however, there may be practitioners from all therapeutic traditions and contemporary opinion and practice may reflect historical legacies and conflicts arising from this variety. Training as a clinical psychologist has never involved receiving therapy and, although supervision has long been highly valued in training, its subsequent role in professional practice is unclear (Green, 1995).

The conflict is vividly expressed in the wording of the BPS's Royal Charter, Statutes and Rules which heretofore has enshrined the association of supervision and junior status. Until April 2000, Statute 12(3) of the Society's Royal Charter, Statutes and Rules (BPS, 1999b) read that to be included in the Register of Chartered Psychologists

> an applicant... shall be judged by the Council to have reached a standard sufficient for professional practice in psychology without supervision (p.1).

Following widespread lively debate a proposal to amend this by omitting the phrase 'without supervision' was passed at the 2000 AGM. The DCP has been extremely active in encouraging the sea-change in the status of supervision and has for the past couple of years recommended that all psychologists, at all levels and grades, should have access to supervision (DCP, 1998a). Post-qualification supervision is promoted as an important aspect of both quality control and Continuing Professional Development (CPD) (DCP, 1998a, 1998b).

A new Division in the BPS

More recently some psychologists have sought to develop therapeutic practice within the broad humanistic school, and the autonomous profession of counselling psychology has been established. The Division of Counselling Psychology (DCoP) is one of the newest of the Society's Divisions and already the second largest (BPS, 1999a), with a growing voice concerning all aspects of psychotherapeutic training and supervision.

In line with its roots in the British counselling movement, the DCoP requires its members to receive therapy as part of their training, and this requirement is highly valued by practitioners (Williams, Coyle & Lyons, 1999). Similarly it has always required members to remain in regular supervision throughout practice, and it is perhaps an indication of the degree of upheaval and flux within the profession of psychology generally that widespread attention was never drawn to the potential conflict between this requirement and Statute 12(3).

Legitimacy and usurpation

The existence of a sibling Division in the Society with very different views on various matters of professional psychotherapeutic practice (Ryder & Shillito-Clarke, 1998) might in itself be enough to provoke debate on these matters within the DCP. Clinical psychologists spend much of their time either carrying out therapy or supervising others (Norcross, Brust & Dryden, 1992) but their competence in both has recently been vigorously questioned by some counselling psychologists (Richards, 1998), and even within the profession some claim a widespread sense of a 'fraudulent identity' (Mollon, 1989; Jones, 1998a, 1998b; see Marzillier, 1998 for a response).

Further aspersions on the legitimacy of the therapeutic practice of clinical psychologists have been cast by the UKCP's refusal to guarantee them registration. Several years of discussions have failed to resolve the question of whether clinical psychologists should be entitled to call themselves psychotherapists (see Division News in *Clinical Psychology Forum*, 1997- present, and *The Psychologist* over the same timespan).

The proposed BPS register of psychotherapists

The BPS is developing its own psychotherapist registration and regulation procedures, independently of the UKCP, so that appropriately qualified psychologists who wish to be professionally recognised as psychotherapists do not have to follow yet another training course. However, even within the single body of the BPS it has proved no easy matter to define psychotherapy, to distinguish it from other procedures and further distinguish what legitimate variations of it may exist, and to decide on the requirements for its safe and effective practice.

At the time of writing, it seems likely that the BPS will establish a two-level register of psychotherapists, with level I called Practitioner level and level II called Consultant level. The various schools of therapy, including a generic school, will produce their own policies, and advancement from level I to level II will be permitted only within schools. Successful completion of an accredited training in either clinical or counselling psychology will automatically permit registration as a generic psychotherapist at level I but continuing registration will depend on demonstrated adherence to the school's practice requirements, which will include on-going supervision (Margie Callanan, personal communication).

It should, however, be noted that not all clinical psychologists are happy at this strengthening of the identification of clinical psychology with psychotherapy. Some who work in the Learning Disabilities field, for example, emphasize that clinical psychologists have several important services to offer, only one of which is psychotherapy (Suzanne Conboy-Hill, personal communication). Client care may be significantly restricted if one professional activity is over-valued by having separate registration procedures.

Increased demand and fragmentation

Growing demands have brought all aspects of clinical practice under intense scrutiny. Psychology generally, and applied psychology particularly, has an increasingly visible and socially valued profile. More posts are being created and an ever-increasing range of activities and situations are seen to require the contributions of psychologists.

Although counselling psychology has declared its complete independence of clinical psychology, other highly specialist fields are still intertwined with it. At present, clinical psychologists may be appointed to health psychology or forensic posts, particularly since many such posts are combined with more general clinical duties. However, Chartered Health Psychologists and Chartered Forensic Psychologists without full clinical training cannot be appointed to clinical posts, and will not gain automatic admission to the proposed BPS register of psychotherapists. The speciality of neuropsychology is just beginning this process of differentiation and most members of the newly-established Division of Neuropsychology are clinical psychologists.

There are pressures to develop and expand in different ways and further fragmentation within the DCP seems inevitable. For example psychologists with forensic experience may have an important role in the implementation of the government's proposals to detain indefinitely "dangerous people with severe personality disorder" (DPSD)(Cohen & Baldwin, 1999): neuropsychologists need to keep abreast of unprecedented rapid advances in a number of fields with relevance to brain injury rehabilitation (Beaumont, 2000).

The supervision requirements for practitioners in the health, forensic and neuropsychology fields may have little in common beyond the generic requirements for any kind of supervision in the human care services. It seems timely to begin enquiries among clinical psychologists across a broad range of settings to assess the range of views as to what those requirements might be.

Implications for initial training

Clinical psychology training schemes have already expanded enormously, trying to deal with larger numbers of trainees and to equip them with a larger number of skills to use in a larger number of different settings. More supervisors with more skills must be found, and training courses are currently devoting considerable efforts to adapting their curricula to meet the new demands (Ashcroft, Callanan, Adams, Roth, Gray & Lavender, 1997; Llewelyn & Kennedy, 1999; Marshall & Collerton, 2000). In this situation, supervisor training and/or accreditation is attracting more attention than ever before (Green, 1997, 2000a) and research to identify effective and efficient formats is underway (Milne & Oliver, 1999).

Disseminating and maintaining quality services

Clinical psychology is only one of a number of health professions in the NHS struggling to cope with a demand for service that greatly outstrips supply, resulting in severe tensions between the need to disseminate skills as widely as possible and the need to maintain professional standards (Milne, 1998a).

Providing good quality supervision is seen as one way to reduce this tension (Lewis & Perrin, 1997; Miller, 1990). Despite the serious reservations and criticisms epitomised by Richards (1998) and Jones (1998a, 1998b) within the NHS generally there is an apparently insatiable demand for clinical psychologists to teach and supervise people in a range of health settings (Milne, 1999; Burton, 1999; Crocket, 1999), which has further highlighted the issues of training in supervisory skills and involvement in continuing supervision for clinical psychologists.

Continuing Professional Development (CPD)

All health professions are increasingly aware of the need to promote the concepts of life-long learning to meet changes in health care, whether driven by technological advances, political movements or consumer sensitivity. However prolonged or thorough one's initial training, it cannot suffice to see one through decades of practice and the philosophy of CPD has been established as central to many professional bodies and societies (Fountain, 1998) including the BPS (Green, 1998).

Clinical supervision is seen to have a key role in CPD in many professions, including nursing of all kinds (Butterworth & Faugier, 1992), physiotherapy (Maxwell, 1995) and speech and language therapists (Royal College of Speech and Language Therapists, 1996). The DCP's Guidelines for Continuing Professional

Development (DCP, 1998b) explicitly locate post-qualification clinical supervision within this arena, among alternative activities such as undertaking formal study programmes, attending conferences and workshops and doing literature searches.

The relationship between CPD and supervision is complicated by the fact that the status of each is different in different professions. For example, in nursing, CPD is mandatory and supervision is one possible (but not mandatory) component of CPD. The BAC (1998) requires counsellors to 'maintain continuing professional development *as well as* [emphasis added] regular and ongoing supervision,' which implies the latter should not be seen as an optional component of the former. In the DCP, CPD is obligatory but not mandatory so that employing bodies may not feel it is incumbent upon them to resource CPD for psychologists (Green, 2000b). If clinical supervision is a CPD activity, does this mean practitioners must negotiate with their employers for the time and other resources needed for its provision? Will that reduce resources available for other CPD?

Evidence-based practice (EBP), clinical governance and accountability

Health practitioners are unfortunately not immune from the general human tendency to mistake familiarity for validity. We may all be prone to overvalue whatever seems to support what we do; to diminish the significance of whatever seems to challenge what we do, and to fail to perceive the constraints that our own conceptual preferences place on our understanding (Gould, 1981; Meehl, 1997; Thouless & Thouless, 1990).

It is from a growing awareness of the extent to which clinical practice is shaped by historical accident and practitioner idiosyncrasy that EBP has been promoted (Milne, Keegan, Paxton & Seth, 1998). Unfortunately, it has yet to be

established to universal satisfaction just what constitutes acceptable evidence (Jones, 2000). What does it actually mean to say someone has schizophrenia? (Boyle, 1999). What is the relationship between evidence and knowledge? Practitioners from different traditions may disagree sincerely and irreconcilably on every facet of assessment and treatment (Newnes, 1999). These are core differences of philosophy, and many clinicians are concerned that adoption of EBP as the gold standard of validity in psychotherapeutic practice may be profoundly detrimental to patient care (Nieboer, Moss & Partridge, 2000; Roth, 1999).

Both the strengths and the difficulties of the commitment to EBP can be seen in the supervision literature as clearly as in any other area of practice (Milne & James, 1999). The literature is vast, comprising numerous descriptions of practice, models of aims, processes and procedures, and attempts to measure the essential qualities of good practice. Unfortunately, as numerous authors have pointed out (e.g. Green, 2000a; Milne, 1998b; Lambert & Ogles, 1997) very little research has produced evidence which can be demonstrated to be both reliable and valid. Few studies have even attempted the most crucial task of measuring the impact of supervision on client outcome and of those that have, Ellis & Ladany (1997) have remarked that 'the quality and rigor of these studies were poor overall' (p. 457), and Green (2000a) has suggested that 'unambiguous research findings are inherently improbable' (p.1) due to the sheer number of intervening links between the two end variables.

On the other hand, just as meta-analyses of psychotherapy research increasingly point to the vital importance of the therapeutic relationship in determining outcome, regardless of therapeutic model (Clarkson, 1995), so reviews of the supervision research suggest that the supervisory relationship is the key element in determining how successful the supervision is considered to be (Ellis & Ladany,

1997). For example, Holloway's (1995) systems model of supervision places the supervisory relationship at the core of practice. She and her colleagues have investigated the relationship intensely, tracing the impact of gender differences, power imbalances and aspects of the maturity of the relationship on the strength of the supervisory alliance (Nelson & Holloway, 1999; Wampold & Holloway, 1997; Holloway, 1997).

Clinical governance is another way of trying to ensure clinical practice remains available to scrutiny and is based on collectively generated and owned principles rather than the whims of individual practitioners (DOH, 1999). Unfortunately, social validation and scientific validation are completely unrelated activities (Meehl, 1997). However, if regular debate and dissent are encouraged and managed, we may at least be more aware of the 'consensus collusion' (Reason & Heron, 1995, p.137) to which all of us are susceptible and that may maintain ineffective and even dangerous and cruel practices in all fields of human endeavour. Clinical supervision has been proposed as the crucial forum in which counselling practice might be examined in this way (Feltham & Dryden, 1994) but whether clinical psychologists share this view has not been explored.

Both health care purchasers and consumers are more aware than even ten years ago of their rights to information, routes of complaint and the need to identify lines of responsibility and accountability.

Clinical supervision is seen as potentially valuable in all these areas. As Milne (1998b) summarises,

> [S]upervision occupies an exceptionally important place at what might be considered to be the 'crossroads' of professional practice and merits our scholarly attention (p. 2).

Section 3: **An emerging consensus?**

In responding to both the old ambivalences and the new demands to clarify and standardise, the DCP (1998b) has recommended that

> Every clinical psychologist should ensure the continual supervision of their own work throughout their career (p. 2.1)

as one of the guiding principles for CPD. The DCP promotes both the giving and the receipt of supervision as legitimate CPD activities and anticipates that the majority of clinical psychologists will occupy both roles. A commitment to CPD is obligatory, and clinicians are responsible for their own development. What they include in their development programmes cannot be imposed by the DCP. However, the guidelines also make it clear that the old idealisation of the self-sufficient, fully autonomous clinician who never needs supervision is rapidly disappearing and

> There is an emerging consensus within the profession that all qualified clinical psychologists, whatever their level of experience, should have access to and be prepared to make constructive use of, some appropriate supervisory facility to support their work (p. 5.2).

What is this consensus? Does it refer to supervision as professional maintenance, professional monitoring or professional development? The aim of the current research is to explore this consensus by surveying the practices and opinions of a number of qualified and experienced clinical psychologists. The Delphi method was selected as appropriate for investigating such a complex and largely unexplored area. This methodology has been in existence for over 40 years (Dalkey & Helmer, 1963) but is relatively uncommon. For this reason, an outline of its main tenets is provided below.

An introduction to Delphi methodology

Of the tales we tell of ancient Greece, some concern the oracle at Delphi. Those seeking guidance about the wisdom of a particular course would ask the oracle to predict the future and use that prediction to identify their best opportunities for success. In the 1950's the Rand Corporation worked to find ways of predicting future developments in the field of defence, by consulting a panel of experts, who were not brought together physically but were informed of each other's views and invited to refine their predictions following consideration of their colleagues' opinions (Dalkey & Helmer, 1963). Since the derivation of consensus predictions was its primary purpose, the methodology was named after the oracle at Delphi.

The basic procedures have now been adopted for, and adapted to, a variety of purposes and situations, often seeking to measure the range and diversity of opinion, rather than produce consensus, and to describe current or emerging trends, rather than make predictions about the future. For example, a Delphi survey was used by Stone Fish and Osborne (1992) to enquire into family therapists' views of the current strengths and weaknesses of the U.S. family. The methodology has been popular in some health-related fields for the last two decades, but serendipidy seems to have produced a small but notable increase in its use in clinical psychology in the very recent past (Green, 2000a; Llewelyn & Kennedy, 1999).

The literature so far has established few conventions of procedure, analysis or presentation of results but all Delphi studies attempt to structure communication within a selected panel of experts, in a way which permits the exchange of views while minimizing the pressures to conform which live discussions may produce (Linstone & Turoff, 1975; Stone Fish & Busby, 1996). They share the following characteristics:

1. A group of people are invited to become panelists based on their specialist knowledge or particular interest in the topic of the survey.
2. Panelists contribute their initial views, which are fed back to the group anonymously.
3. Following this feedback, panelists are invited to respond to the group's views. The cycle of feedback and response may be repeated.

There is at present a divide among psychology researchers concerning which research methods may be valid. The quantitative paradigm privileges objectivity, neutrality, quantification and replicability (Cook & Campbell, 1979; Morgan, 1996). The qualitative paradigm privileges the unique meaning(s) that both researcher and researched make of the experience of the research process, and the context in which it occurs. The researcher's position neither can nor should be neutral, but should be articulated and thereby open to scrutiny (Smith, Harre & Van Langenhove, 1995). These paradigms may be seen as philosophically irreconcilable (Stevenson & Cooper, 1997), or as potentially complementary (Moon, Dillon & Sprenkle, 1991; Sells, Smith & Sprenkle, 1995).

Delphi surveys offer a procedural structure that may incorporate both methodologies. The first round may define the area of enquiry to panelists, suggest a number of issues within it and invite opinion and comment in an open-ended way. Such semi-structured accounts are commonly used in qualitative research (Smith, 1995) and a lengthy analysis of them may constitute the research project. Alternatively a less exhaustive analysis may produce material which can be re-presented to the participants in a form which invites more structured, closed responses which can be subject to quantification. The literature on the Delphi survey has not explicitly explored its use as a means to combine positivist and constructionist

approaches to psychological knowledge, but it would appear suited to the combination.

Clinical psychologists on clinical supervision: a Delphi survey

The current project used the Delphi method across three rounds, not to forecast trends in the future but to take the pulse of present informed opinion among those who are most likely to be involved in the development of future policies because of their interest and status. Further, this was not an attempt to encourage consensus in the group, but was an attempt to clarify current beliefs and assess such consensus as may naturally be present. Such a clarification may have implications for professional identity, CPD and training.

More precisely, the aims are:

i. to offer a description of key personal and professional characteristics of a group of clinical psychologists selected for their expertise or interest in clinical supervision, and to clarify how these characteristics relate to their experiences or views of supervision;

ii. to describe panelists' current experiences of clinical supervision, both given and received;

iii. to identify the key issues in clinical supervision for clinical psychologists, by collecting semi-structured accounts from the group in round one of a Delphi survey;

iv. to measure the degree of consensus on the importance of those issues by means of a questionnaire derived from the accounts, which then constitutes round two of the Delphi survey;

v. to feed back the group's responses to its members and invite their comments, in round three of the Delphi survey, which will further clarify the convergence and variability of opinion within the population studied, and to describe the strength and dimensions of the consensus on clinical supervision.

Method

Section 1: **General remarks**

Three rounds may be excessively demanding on busy professionals, which may make drop out rates high. On the other hand, panelists have time between rounds, feedback from others and repetition of the task, all of which provide opportunities to correct mistakes and misunderstandings, and reflect upon their commitment to their original position.

There is also a much greater sense of a personal contact between the researcher and the panelists than is usual in surveys. Although information and opinion is shared between panelists anonymously, panelists are obviously not anonymous to the researcher, who selects potential panelists after deliberation, and remains in contact with them over the cycles of enquiry and feedback. Such prolonged contact requires careful attention from the researcher so that panelists feel engaged but not exploited.

Section 2: **Selection of panelists**

Panelists were selected on the belief that they had an expertise or interest in clinical supervision. A list of possible participants was drawn from several sources:

- authors of articles which referred to supervision in *Forum* or *The Psychologist,*
- members of relevant committees, subcommittees and Special Interest Groups within the BPS and DCP,
- speakers on supervision at DCP conferences,
- colleagues known by the researcher or the supervisor to be interested in the topic,
- people suggested by any of the above.

In addition, invitees to round one were invited to extend the invitation to other clinical psychologists who might be interested in the topic. In all, one hundred clinical psychologists were invited to participate and fifty-three did so at some stage.

Section 3: **Materials**

All materials were designed for the present study and were largely developed within the study, as participants' responses shaped subsequent enquiries. Materials, procedures and results are therefore highly interconnected. To avoid repetitions, materials will be described within the context of the procedures section below. In all three rounds, materials were accompanied by a covering letter appropriate to the individual participant, stage of research and point of contact. Materials and letters were attached by a short treasury tag so that pages could be removed without tearing and both sides of any sheet could be written on, and an s.a.e. was enclosed.

Section 4: **Procedures**

A. Ethical Considerations

Panelists were asked for information concerning their professional experiences and their opinions on various aspects of professional practice. They were approached individually and thereby asked to publicly (at least to the researcher) own the information they supplied. Furthermore, clinical psychologists are a small population, and that subset which might be termed expert in clinical supervision is even smaller. Both researcher and research supervisor are also experienced clinical psychologists

with a particular interest in clinical supervision, and possibly known personally or by reputation to the invitees. A number of dual-relationship dilemmas might arise.

It seemed, therefore, particularly important that both the research process and the position of the investigator were as open and 'owned' as possible (Reason & Heron, 1995). Panelists were given various ways to contact the researcher and research supervisor, and invited to discuss any aspect of the project.

Letters were addressed to individuals by name and were personally signed. Research invitees may feel more motivated to participate in projects carried out by colleagues and researchers must not abuse this motivation by pressurising invitees to participate. All covering letters were carefully worded so that panelists felt properly acknowledged and thanked for their contributions, and invited but not obliged to continue the interaction.

Wording on the documents also paid attention to the boundaries of confidentiality. Panelists were reminded that personally identifying information would be seen by the (named) investigator and the (named) supervisor. They were assured that such information would *never* be available to anyone else. Information shared with the group was anonymous: handwritten forms would be destroyed at the end of the project: panelists would not be named in the acknowledgements unless they explicitly agreed. Information stored on computer was identified only by number: the single record linking names and numbers was a handwritten one kept by the researcher. Only the researcher had access to the computer used, and the files would be deleted at the conclusion of the research. A single floppy disc would store the non-identifying information together with the final report.

In addition, at each stage panelists were invited to comment on the research process and its impact on them, in the interests of empowering the traditionally weak

position of the research participant, encouraging reflexivity and inviting the development of a genuinely mutual enquiry process (Reason & Heron, 1995; Stevenson & Cooper, 1997). The research proposal was granted full approval by the relevant Ethics Panel (appendix I).

B. Sequence of procedures

1. Round one

1.1. Instruments

A two-part survey instrument, comprising the PPI (Personal and Professional Information) and the DQ1 (Dephi Questionnaire 1) (appendix II), was designed by the researcher following discussions with colleagues and consideration of both the literature and the issues discussed in the Introduction. Provisional materials were piloted on six clinical psychologists who commented on timing, readability, lay out, comprehensibility and face validity. Their feedback was used to make modifications and give details of timing in the final version.

The PPI contained five sections:

- **background**; including qualifications, professional status, years in service, spine point, gender.
- **preparation for supervision**; including familiarity with the literature and attendance at training events.
- **current supervision practice**; including time spent supervising and number and identity of supervisees.
- **current experiences of receiving supervision**; including frequency, modality and variety.
- **current experiences of teaching, training or supervising others to supervise**.

DQ1 outlined a range of opinions from the literature (references were given separately: the list is included in appendix II) and posed open-ended questions in six areas:

- **clinical supervision and training;** how strongly did panelists support post-qualification supervision?
- **clinical supervision and management;** did panelists think clinical supervision could be subsumed within management?
- **models of clinical supervision and psychotherapy;** how did the panelists think these activities are related to each other?
- **ethics and clinical supervision;** did panelists see supervision as serving an important ethical function?
- **continuing professional development (CPD) and clinical supervision**; did panelists see supervision as a CPD activity?
- **the professionalisation of clinical supervision;** how did panelists think supervisors are most appropriately prepared or trained?

Participants were invited to respond as briefly or fully as they wished, and to identify other areas they believed important. Panelists were also asked to indicate if they would like a summary of the project after completion, and if they were willing for their names to appear in the project's acknowledgements. The covering letter was backed with a description of the methodology (appendix III).

1.2. Respondents and procedure

Initially, 70 people were contacted. An acknowledgement was sent to those who indicated that they would not become panelists: one of these had forwarded the

documents to a colleague and another suggested someone else. Both these secondary recruits from people who did not themselves join the project became panelists. One panelist suggested two others, both of whom had already received invitations and one of whom became a panelist.

Thirty-four usable sets of the PPI and DQ1 were returned. Several factors decided the researcher against repeating the round one invitation to non-responders:

- panelist motivation needs sustaining across repeated rounds in a Delphi survey if the material which emerges initially is to be refined and consolidated by the same group. People who did not freely respond in the first instance were felt unlikely to stay the distance without further prompting which would consume considerable research resources;
- non-responders to round one could be invited to round two. People who were happy to participate but who had overlooked the first-round invitation could still make a useful contribution;
- the researcher is from the same population as the invitees. Empathy for over-burdened colleagues and a desire not to compromise professional relationships, present and future, urged caution in the use of possibly intrusive repeated demands.

Two of those who declined to take part on the grounds that their current professional experience was not relevant to the research questions, were responsible for the training of clinical psychologists (on different courses). A trainer on a third course wrote to decline, expressing reservations which the researcher felt could be overcome, and in the acknowledgement letter asked the invitee (successfully) to join in at round two. Table 1 below describes the participants in round one.

descriptor	*N* (%)	range *M* ± SD
invitees	72	
responders	34 (47)	
female male	18 (53) 16 (47)	
age		31- 58 45 ± 6
doctorate	17 (50)	
separate therapy qualification	9 (26)	
currently studying for further qualification	8 (24)	
years of practice		4-28 17 ± 7
head of service	13 (34)	
spine point range grade B missing data	 22 (65) 4 (12)	32-50+
teacher or trainer	14 (41)	
full-time post	26 (76)	

Table 1. Description of round one participants

2. Round two

2.1. Instruments

The main instrument used in this round was DQ2, derived from DQ1 responses. The semi-structured accounts generated by the panelists on DQ1 were collated into the six categories given in the instrument, and remaining material was put into a seventh category (appendix IV).

Repeated reading of these accounts identified both recurring concerns and unusual viewpoints. It was intended that DQ2 items would address all major themes but also indicate the range of minority opinions. Many items, especially those referring to unusual viewpoints, were direct quotes or slight paraphrases of panelists' responses. No attempt was made to ensure DQ1 categories generated predetermined numbers of items on DQ2.

The DQ2 was piloted on six clinical psychologists who offered comments on comprehensibility and readability of instructions and items, face validity and timing. Their most frequent complaint was that they might wish to answer one way under

some circumstances and another under others. Considerable discussion failed to find ways to phrase items broadly enough to avoid the need for extensive qualifications, bearing in mind the need for succinctness in the production of DQ2 items and fidelity to the opinions as expressed on DQ1. Multiple responses could be a way of indicating such variability.

Panelists were offered four response categories for each item on DQ2:- strongly agree, slightly agree, slightly disagree, strongly disagree. There was no midpoint. Such midpoint response categories, usually labelled 'neither agree nor disagree' fail to differentiate between indifference, indecision and ambivalence (Oppenheim, 1992) and in this case the researcher was interested to capture these differences if possible. Panelists were, therefore, invited to show neutrality by omitting the item, and indecision or ambivalence by choosing more than one response category.

To improve its content validity an independent researcher was supplied with anonymous copies of panelists' responses and comments to DQ1 with the proposed items for DQ2. The second researcher was asked to say whether or not each of the proposed items was derived from the material, and to identify any major or notable themes in the material which were not referred to in any items.

The modified questionnaire, following feedback from both the pilot group and the second researcher, contained 58 items about supervision. The second researcher agreed that 50 were derived from participant material (86% agreement). Four additional items were reflexive, asking participants about their experience of participation, and inviting them explicitly to indicate whether or not they felt the questionnaire adequately addressed the topic of investigation.

The PPI was included with DQ2 except to DQ1 responders, who had already completed it in round one. Covering letters in this round were modified for the different situations of subsets of respondents and contained information concerning the project, its methodology and progress so far, as appropriate to each participant (see appendices V- VIII inclusive). As promised in the first round, DQ1 responders were also sent a description of the group (appendix IX) for their interest.

2.2. Respondents and procedure

One hundred clinical psychologists were invited to complete DQ2:

- 34 who completed DQ1,
- 34 non-responders to round one who had not actively declined to take part,
- 32 more clinical psychologists identified from the same sources.

By the deadline, 27 DQ1 responders had returned DQ2. It was decided in the name of respondent or testimonial validity to try and persuade as many DQ1 responders as possible to indicate their views of the questionnaire that had been produced from their contributions. The reservations expressed above relating to considerations for colleague-participants were still operational, and dictated an encouraging but non-coercive follow-up. Phone calls and sea-side postcards brought in four more replies. Ten DQ1 non-responders and nine new invitees returned the PPI and DQ2.

Table 2 below describes the participants in round two. The differences from Table 1 above are due to the loss of the three DQ1 respondents who dropped out after round one and the addition of the 19 who joined the project with DQ2.

descriptor	*N* (%)	range *M* ± SD
invitees	100	
responders	50 (50)	
female male	26 (52) 24 (48)	
age		31- 60 45 ± 7
doctorate	23 (46)	
separate therapy qualification	11 (22)	
currently studying for further qualification	13 (26)	
years of practice		4-32 17 ± 7
head of service	17 (34)	
spine point range grade B missing data	 32 (64) 7 (14)	32-50+
teacher or trainer	22 (44)	
full-time post	38 (76)	

Table 2. Description of round two participants

3. Round three

3.1. Instruments

To manage the final round of information exchange efficiently, it was decided to return each panelist's original DQ2, with the addition of information concerning the group's responses handwritten on them. At this stage in the project, methods of analysis had not been finalised. Panelists had been explicitly offered the choice of making no response, one response or multiple responses to each DQ2 item, and the researcher wished to consider the range of responses made before developing or selecting the most appropriate ways of classifying and analysing the data.

The information fed back to the group reflected an initial attempt to make use of the multiple responses which were made by panelists in round two. Ultimately, however, there were only 39 of them, too few for worthwhile exploration, and later methods of analysis did not use them. This discarded analysis is not further reported

here: for the sake of completeness, however, it is detailed with the copy of DQ2 at appendix X.

To permit participants to register any changes in their responses, a feedback form (FF) was designed (appendix XI) and enclosed with DQ2. The FF also offered another opportunity to indicate if panelists would like a summary of the project, and if they were willing to be named in the acknowledgements.

It was anticipated that where panelists were content with their original DQ2 responses they were unlikely to participate in round three, and the instructions stated that if the FF was not returned, panelists' original DQ2 responses would go forward into the final analysis. Some people had written extensive comments over their questionnaires and in returning them, it seemed important to acknowledge their submissions positively. The final covering letters which accompanied the DQ2 and FF were therefore carefully worded to take account of panelists' contributions (appendices XII and XIII).

3.2. Respondents and procedure

All 50 round two participants were invited to take part in round three. By the deadline, 26 FF's had been returned (52%), although only 16 people actually wanted to alter their replies. Others had used the FF to comment on the project, or the feedback, or their satisfaction with their original answers (examples at appendix XIV).

Of the 53 participants, 33 requested a summary after the project's completion, and 28 gave permission to be named in the acknowledgements.

Statistics

A. Creating the database

Data from the PPI and DQ2 were entered on an SPSS.9 (SPSS, 1999) database. Panelists were assigned identity numbers and names were not entered. Many of the data were dichotomous (such as gender, Head of Service, whether currently studying for a further qualification), some were interval (such as age, years of practice), and some were ordinal (such as responses to DQ2 items).

B. Developing methods of analysis for DQ2

Response rates for each item were noted, and responses coded as follows:

- strongly agree = 1
- slightly agree = 2
- slightly disagree = 3
- strongly disagree = 4

B.i. The strength of the consensus

A measure of consensus, termed the consensus index (CI), was developed to rank items using the following procedure on each item separately:

- sum the percentage of agree responses (coded 1 or 2)
- sum the percentage of disagree responses (coded 3 or 4)
- calculate the difference.

The CI could theoretically vary between zero (if 50% of panelists agreed and 50% disagreed with the item) and 100 (if 100% of panelists chose the same response valency). It will be noted that the CI alone does not describe the valence of

consensus. It shows to what extent the panelists agreed with each other, not whether they agreed or disagreed with the item as phrased.

B.ii. The dimensions of the consensus

This research did not seek to confirm or disconfirm preexisting hypotheses concerning the sources of variability in opinions on supervision, but sought relationships within the data collected which might, at a later stage, provide such hypotheses. In exploring subgroup variability on DQ2, several different ways of grouping and examining the data were performed and various constraints of time and space discourage the reporting of every observed result: therefore, only those results with probability levels of more than .05 are reported in the analysis of the dimensions of the consensus.

This necessary selection of reported results may introduce biases and artefacts, two of which could be of particular relevance here. First, it may be that some of the null results not reported are in fact of enormous actual (as opposed to statistical) significance. Second, in such speculative searches for correlations it is likely that at least some of those found reflect the methods used and the operation of the laws of chance, rather than relationships in the real world. What follows should be approached with these reservations in mind.

Subgroups were created using variables from information from the PPI. Two different methods for investigating subgroup diversity were used. For each item, the median response was used as the basis for investigating subgroup variation.

B.ii.i. Item variability

Item variability was examined if:

- the median response of any subgroup differed in valence (agree or disagree) from the median of the rest of the group,
- one valency (agree or disagree) was selected, or avoided, only by a subgroup, in contrast to the rest of the group.

B.ii.ii. Individual variability

A measure of individual variability, termed the diversity score (DS) was developed. For each individual, the differences between the group's median response and the individual's response on each item were summed. Where the group median response is 1 or 4, the individual's difference score on that item varies between 0 and 3: where the group median is 2 or 3, the individual's difference score varies between 0 and 2. Theoretically, the sum of the difference scores for the entire questionnaire could vary between zero (if an individual's response profile was identical to the group's median profile) and 152 (if an individual's response profile was maximally different from the group's median profile). The sum of the difference scores is converted to a percentage of the theoretical maximum, and this percentage is the DS.

When calculating the difference scores, missing responses (which were recorded as 99) were assigned a difference score of 1. This is obviously a purely arbitrary assignment but it was hoped thereby to indicate that the panelist dissented from the group's consensus without implying that the dissent was necessarily great. It is not an entirely satisfactory procedure, but appeared the best of those available. Low DS's therefore indicate that the individual did not register extensive dissent from the group median profile but do not differentiate mild dissent from indifference or ambivalence.

Table 3 below illustrates the calculation, using responses from a mythical individual whose DS would be 43 (6 expressed as a percentage of 14) on these five items. It will be noted that the direction of the difference does not influence the outcome.

item	1	2	3	4	5	Σdiff	DS
group median	1	1	4	2	4		
responses of individual x	2	1	3	99	1		43
difference	1	0	1	1	3	6	
max. possible difference	3	3	3	2	3	14	100

Table 3. Example of calculation of Diversity Score (DS)

C. Standardized statistical tests employed

Tests were selected with regard to the often small numbers of participants and not assuming that the data had parametric properties. The following statistical tests were applied:

- Chi-square where both variables were dichotomous, provided *N* was over 20, and at least 80 per cent of cells had an expected frequency of at least 5;
- Fisher's exact where both variables were dichotomous but either *N* or percentage of cells with an expected frequency of at least 5 was too low to permit the use of chi-square;
- Spearman's rho where both variables were ordinal, provided the variable had no more than three response categories;
- Kendall's tau-c where one variable was dichotomous and one interval; and where one variable was dichotomous and one ordinal with more than three response categories;
- Kendall's tau-b where both variables were interval;
- Mann-Whitney where two groups were compared on an interval measure.

Results

Since only 30 per cent of panelists completed all sections of the PPI and all 62 items on DQ2, it was decided to use all available data in the analyses and to specify numbers at each point.

Section 1: **The panelists**

The first two aims of the project are:

i. to offer a description of key personal and professional characteristics of a group of clinical psychologists selected for their expertise or interest in clinical supervision, and to clarify how these characteristics relate to their experiences or views of supervision;

ii. to describe panelists' current experiences of clinical supervision, both given and received.

This section displays and analyses the information provided on PPI by panelists either at round one or round two, which partly meets the first aim and fully meets the second. The first aim is further met by the analysis of the dimensions of the consensus on DQ2 items considered in the following section. Table 4 below collapses the background data given separately in Tables 1 and 2 in Method, and describes all participants.

descriptor	*N* (%)	range *M* ± SD
invitees	100	
responders	53 (53)	
female male	28 (53) 25 (47)	
age		31-60 45 ± 7
doctorate	25 (47)	
separate therapy qualification	13 (25)	
currently studying for further qualification	13 (25)	
years of practice		4-32 17 ± 7
head of service	19 (36)	
spine point range grade B post not applicable	 34 (64) 8 (15)	32-50+
teacher or trainer	24 (45)	
full time post	41 (77)	

Table 4. Description of all participants

When relationships were examined between the characteristics of the group, it was observed that those currently studying for a further qualification had fewer years of practice (Kendall's tau-c = -.527, $p < .001$, $N = 53$) and were less likely to have a doctorate (Chi-square = 6.629, d.f.1, $p < .01$, two-sided, N = 53). The four panelists with only four years in practice all had doctorates, which are now the professional standard, and two of them were currently studying for a further qualification. Of the remaining 49 panelists, none who *either* had a doctorate *or* had more than 16 years of practice (34 panelists altogether) was currently studying for a further qualification, but most of the others (11 of 15) were. It seems that formal CPD programmes are established among the more recently qualified but are not standard for the most experienced members of the profession. It also seems that postqualification doctoral programmes are currently a popular form of CPD, but little is known from this study of post-doctoral CPD activities.

None of the men but 43 per cent of the women held part-time posts. Despite this, gender was not significantly associated with professional status as measured by

being Head of Service (Chi-square = 1.984, d.f.1, $p = .159$, n.s., two-sided, $N = 47$) or having a grade B post (Chi-square = 0.363, d.f.1, $p = .547$, n.s., two-sided, $N = 45$).

A. Preparation for Supervision

Six per cent of the group said that they were not at all familiar with the literature on supervision, 60 per cent claimed some familiarity and 32 per cent felt very familiar with it. Nobody had attended no training events on supervision, 68 per cent had attended a few and 30 per cent had attended many events. Familiarity with the literature and attendance at training events were highly positively correlated (Spearman's rho = .511, $p < .001$, two-tailed, $N = 52$).

Twenty-two per cent indicated they were unsatisfied with their level of preparation for supervision, twenty-two per cent were uncertain and 49 per cent were satisfied. Level of satisfaction was highly positively correlated with both familiarity with the literature (Spearman's rho = .456, $p < .001$, two-tailed, $N = 50$) and attendance at supervision training events (Spearman's rho = .463, $p < .001$, two-tailed, $N = 50$).

Two panelists remarked that although they both provided supervision and taught others on the topic, they had read very little about it and one of them noted the usefulness of the reference list provided by the researcher. Three others commented that they had learned about supervision not through reading or training events, but through having supervision on both their therapeutic and their supervision work.

B. Receiving Supervision

B.i. Frequency

All those in grade A posts were among the 81 per cent of psychologists who said they had received supervision within their posts in the past six months.

Seventeen per cent of the panelists said they had not ($N = 9$). Thirty-four per cent did not indicate frequency, 19 per cent had monthly, 13 per cent fortnightly, 11 per cent weekly, two per cent three times monthly and two per cent sixweekly meetings (frequencies given here are the highest given by participants). Twenty-six per cent ($N = 14$) therefore *specified* they had received supervision at least twice a month.

Variability was even greater than these frequencies imply, because among those receiving regular supervision, some were involved in several different types. One person identified five separate forums including weekly live supervision in a family therapy clinic, monthly individual supervision with an external consultant, two different six-weekly meetings, and another meeting to 'pull threads together' every eight weeks.

Table 5 below offers a comparison of the group who specified receiving supervision at least twice a month (HR) and the group who had received no supervision (NR). For ease of comparison, the main figures given are percentages and N follows in brackets.

	HR: high supervision $N = 14$	NR: no supervision $N = 9$
% females (N)	57 (8)	33 (3)
% males (N)	43 (6)	67 (6)
years of practice: range	4-28	4-32
$M \pm$ SD	17.07 ± 8.32	19.78 ± 7.34
% doctorate (N)	50 (7)	89 (8)
% separate therapy qualification (N)	14 (2)	22 (2)
% head of service (N)	21 (3)	56 (5)
% provides supervision for others (N)	100 (14)	89 (8)

Table 5. Comparison of HR (has received supervision at least twice a month) and NR (has received no supervision) subgroups.

The total numbers in the subgroups as specified above are small, which makes assessing the statistical differences between them difficult. No significant differences were observed in:

- gender (Fisher's exact $p = .400$, n.s., two-sided, $N = 23$),
- years of practice (Mann-Whitney Z = -0.569, $p = .570$, n.s., two-tailed, $N = 23$),
- having a doctorate (Fisher's exact $p = .086$, n.s., two-sided, $N = 23$),
- having a separate therapy qualification (Fisher's exact $p = .587$, n.s., two-sided, $N = 20$),
- being a Head of Service (Fisher's exact $p = .319$, n.s., two-sided, $N = 19$),
- providing supervision for others (Fisher's exact $p = .391$, n.s., two-sided, $N = 23$).

B.ii. Status of supervisor

Table 6 below displays participants' descriptions of the status of their supervisors. Just under half of the group indicated only one kind of supervision but various combinations were described. The most frequent combination was peer plus external consultant (15%). To provide continuity with the text, in this table the main figures are percentages and *N* follows in brackets.

supervisor status	% taking part (*N*)	% reporting this only (*N*)
peer(s)	60 (32)	21 (11)
senior colleague (CP)	21 (11)	11 (6)
senior colleague (not CP)	8 (4)	0
manager (CP)	13 (7)	8 (4)
manager (not CP)	2 (1)	0
external consultant	19 (10)	2 (1)

Table 6. Supervisor status: percentages of sole and combined provision

B.iii. Individual or shared supervision

Sixty-four per cent had individual supervision, including the 34 per cent for whom this was the sole source. Twenty-five per cent took part in small group supervision, and for six per cent this was the sole source. Fifteen per cent shared supervision with one other, and nine per cent indicated this source only. The most frequent combination was individual plus small group (19%).

B.iv. Choice of supervisor

Sixty per cent reported some freedom of choice in the selection of their supervisory arrangements. Only fifteen per cent reported having no choice at all.

B.v. Supervision on supervision

Forty-nine per cent of the group indicated that they had the facility to access supervision on their supervisory practice, although several commented that this was not a routine part of their practice. Others commented that within their service structures attempts to discuss their supervisees would create dilemmas concerning confidentiality and could breach the trust necessary to the supervisory relationship. Some had already identified this as a service problem, and were seeking developments to permit more freedom for supervisors to discuss their supervisory experiences without breaking boundaries.

B.vi. Satisfaction with supervision received

No-one who responded to this item wanted less supervision. Fifty-eight per cent were satisfied with their supervision and 30 per cent said they would like more.

Three individuals who had received no supervision were satisfied with this situation, two on the grounds that extensive and intensive psychoanalytic therapy and supervision already undertaken was sufficient for routine work and they would seek consultation if needed: one on the grounds that the post involved little direct clinical contact.

Two of those with no supervision did not indicate satisfaction or disatisfaction. One commented that working in a psychotherapeutic service kept supervision issues to the fore: consultation with colleagues as and when required was available and more

formal arrangements were unnecessary. Four indicated they were disatisfied. One was training (in Cognitive Analytic Therapy (CAT)) and receiving weekly supervision for CAT patients as part of this training, but had been unable to arrange any supervision within the post; two stated or implied practical difficulties of establishing suitable supervision arrangements ('Each time I get a supervisor they go off sick or some disaster – is it me?') and one described a 'culture of fear' in which attempts to find supervision had been demeaned.

One person who had received supervision in post indicated satisfaction but this was not due to the supervision provided. This panelist was personally paying for additional supervision, and wrote, 'If I were not receiving private supervision I would be extremely disatisfied'.

Three panelists noted that in order to maintain their UKCP registration a certain level of specialist supervision was required (two belonged to the Institute of Family Therapy (IFT) and one to BABCP). Another commented that supervisory practices in their multidisciplinary department, which specialised in Family Therapy, were currently being changed to bring them into line with UKCP requirements.

C. Giving supervision

C.i. Identity of supervisees

- Ninety-four per cent of the participants were involved in delivering supervision to over thirty different groups, including relatives of people with a diagnosis of psychosis running a self-help group, nurses working with terminally ill clients and students undertaking clinical research (appendix XVII for full details). Supervisees most frequently identified, and the percentage of panelists who said they supervised people from these groups, were as follows:

- trainee clinical psychologists (55%)
- qualified clinical psychologists (53%)
- members of Community Mental Health Teams including Community Psychiatric Nurses, Occupational Therapists and Social Workers (36%) (participants did not always specify which profession)
- counsellors (32%)
- assistant psychologists (28%)
- counselling psychologists (22%)

C.ii. Frequency and type of supervision

The amount and modality of supervision undertaken by panelists varied enormously. Measures related to this are described in Table 7.

variable	range	$M \pm SD$
hours per month giving supervision	0 – 48	13 ± 9
number of contacts per month	0 – 36	11 ± 7
number given individual supervision	0 – 20	5 ± 3
number of groups supervised	0 – 5	1 ± 1

Table 7. Amount and modality of supervision offered by panelists

There were no significant correlations between supervision load and seniority. For example, hours of supervision given per month does not correlate significantly with years in practice (Kendall's tau-b = -.051, $p = .608$, n.s., $N = 49$). Two of the 13 panelists who gave at least 20 hours of supervision a month had been qualified only four years. Similarly, number of people supervised does not correlate significantly with spine point (Kendall's tau-b = -.084, $p = .442$, n.s., $N = 49$). Four of the 12 who gave supervision to more than five individuals were grade A psychologists.

D. Teaching, training and supervising others to supervise

Fifty-seven per cent indicated that in the previous six months they had been involved in teaching, training and supervising others to supervise, including 36 per cent who identified teaching or training as a major component of their jobs. Twenty per cent (six individuals) of those who said they had had offered this service had not received supervision themselves in that period, and seven per cent (two individuals) had not provided any supervision for others (one person who indicated involvement in teaching others about supervision had neither provided nor received any supervision in that period). Seventy-four per cent said they were satisfied with their degree of involvement, and 13 per cent wanted more.

Section 2: **Gathering opinions and measuring the consensus**

The third, fourth and fifth aims of the project are:

iii. to identify the key issues in clinical supervision for clinical psychologists, by collecting semi-structured accounts from the group in round one of a Delphi survey;

iv. to measure the degree of consensus on the importance of those issues, by means of a questionnaire derived from the accounts, which then constitutes round two of the Delphi survey;

v. to feed back the group's responses to its members and invite their comments, in round three of the Delphi survey, which will further clarify the convergence and variability of opinion within the population studied, and to describe the strength and dimensions of the consensus on clinical supervision.

The third aim was met by the use of DQ1 and the derivation of DQ2 as described in Methods. The fourth and fifth aims are not fully distinct since most panelists did not choose to modify their round two responses in round three. Three people used FF to supply a total of 11 responses (range 1-8) which had been missing from round two. Sixteen people, including two of these three, made 35 alterations (range 1-6) to their earlier responses. There was a tendency for the amendments to become more extreme: 37 per cent of the original 35 responses were strongly agree or strongly disagree and 71 percent of the amendments fell into these categories. All but one of these alterations moved the participant's response closer to the majority response of the group (appendix XVIII for details).

Valid responses to all items were supplied by twenty-three people (46%). Most others missed one (8) or two (5) but one panelist omitted 21 items. There was a loss of 22 responses when ambivalent responses were discarded (full details at appendices X and XV).

Final questionnaire responses

A measure of the balance of positive and negative responses to each item, termed the consensus index (CI) was developed as described in Statistics. The CI of every item is given at appendix XIX.

Participant validity

The final four items on DQ2 attempted to measure panelists' perceptions of the acceptability and accuracy of the instrument. Table 8 below shows the items, ranked in order of CI magnitude. The number of responding panelists is specified for

each item. The median response of the whole group is also given, indicating the valence of the majority response (however small).

item	*N*	CI	median
59. This questionnaire addresses most of the key issues in clinical supervision.	45	66	2
60. This questionnaire omits many crucial issues in clinical supervision.	47	66	3
61. Completing this questionnaire has been an unpleasant or tedious experience.	46	60	4
62. Completing this questionnaire has been a pleasant or interesting experience.	45	54	2

Table 8. Participant validity items from DQ2

1. The strength of the consensus

The following two tables follow the conventions established above to present items with CI's of 80 and above, and CI's of 20 and below. Table 9 following details high consensus items: note that a CI of 80 indicates that no more than five individuals (10%) gave responses opposite to the majority.

item	*N*	CI	median
2. It is highly desirable for all supervisors to receive supervision or consultation on their supervision practice.	49	98	1
1. All initial training courses should include some teaching in the use of supervision.	50	96	1
45. It is unwise for clinicians to offer therapy to people they are supervising.	50	96	1
47. Therapy and supervision have several features in common but they can and should always be clearly distinct.	50	96	1
6. Once the criteria for registration as a chartered clinical psychologist have been met, people should be able to work without regular supervision.	49	94	4
29. Adequate management includes clinical audit, case management and professional development. Separate clinical supervision is an unnecessary addition.	49	94	4
28. All clinicians should be enabled to seek consultation or supervision from practitioners other than their manager.	50	92	1
40. Regular consideration of ethical issues is a crucial component of good supervision.	50	92	1
48. The supervisee's personal feelings about the work with a client are frequently a very useful source of important information about the client and should be explored as such in supervision.	50	92	1

item	*N*	CI	median
49. Clinical work often arouses strong personal feelings. These require support and validation in supervision.	48	92	1
16. Supervision needs to be precisely tailored to the therapy model used by the supervisee. Generic training in supervision is therefore not useful.	49	90	4
46. It is unwise for clinicians to offer supervision to their therapy clients who are training or practising as therapists themselves.	48	88	1
58. The quality of the supervisory relationship is probably the most important factor in determining how much the supervisee will gain from supervision.	50	88	1
5. Until a sound evidence base is established, training in supervision is probably a waste of time.	49	86	4
8. Supervision need not be a routine requirement for highly experienced practitioners.	50	84	4
9. Clinical psychologists who work with distressed people in any clinical or research setting should have regular supervision for as long as they practise.	50	84	1
13. Both supervisee and supervisor are likely to benefit from some kind of role induction to clarify expectations and responsibilities.	50	84	1
17. Regular supervision is a core requirement for routine clinical practice and should not be considered an optional element of CPD.	50	84	1
37. A way to reduce abuse in therapy is to ensure that therapists working with emotionally or sexually traumatized clients are not of the same gender/sexual orientation as their clients' abusers.	48	82	4
52. The interpersonal and emotional issues which are most important in a particular therapy can often be present in the supervision, and require exploration as a parallel process.	49	82	2
53. It can be very stimulating to have supervision with someone whose therapeutic orientation is quite different from your own.	48	80	2

Table 9. High consensus items (CI ≥ 80) from DQ2

Table 10 below details items where a CI of 20 or less indicated a low consensus in the group.

item	*N*	CI	median
33. The most appropriate relationship between management and supervision cannot be nationally prescribed as local needs, resources and preferences will outweigh general principles.	49	18	2
42. Frequently clinicians lack a clear perspective on ethical issues in routine clinical work, which leads to many difficulties in supervision.	46	16	3
56. Therapy-specific models of supervision are likely to inhibit creativity and innovation in both supervisor and supervisee.	46	8	3
11. Having personal therapy is as important a component as clinical supervision in the training of competent psychological therapists.	50	4	3
44. All human conduct has an ethical dimension. Clinical psychologists are generally sufficiently aware of this.	48	4	2
51. Applying therapy techniques in supervision is a highly effective way of teaching those techniques to supervisees.	48	4	3
54. Therapy-specific models of supervision are likely to miss key aspects of a clinical psychologists' work, which makes their value very limited.	49	2	2

Table 10. Low consensus items (DQ ≤ 20) from DQ2

2. The dimensions of the consensus

2.1. Item variability

2.1.1. Low response rate

Nine items had a response rate of 92 per cent or less. Three of these (nos. 59, 61 and 62) were participant validity items, and are presented under that heading in Table 8 above. Two others (nos. 42 and 56) appear in Table 10 above and no. 15 appears in Table 12 below. The remaining items appear in Table 11 immediately following.

item	*N*	CI	median
12. Clinical psychologists as a group are not as familiar as they need to be with the literature on clinical supervision.	45	78	2
20. The Division of Clinical Psychology is developing guidelines for CPD, including monitoring procedures, so it is sensible to include supervision within this area.	45	70	2
34. Supervisors should occasionally observe their supervisees in action.	46	64	2

Table 11. Low response items without further distinguishing characteristics

2.1.2. Subgroup comparisons

The median response to each item was calculated for various subgroups and the relationships between item response and subgroup membership were examined (using Kendall's tau-c). Significant correlations were found for ten items, five of which (nos. 11, 42, 51, 54, and 56) also have low CI scores and appear in Table 10 above. The other five items are shown together in Table 12 below for ease of reference. (N.B. There is an error in item 15, where 'six' should read 'three').

item	*N*	CI	median
15. Registration as a chartered clinical psychologist means one has had six (sic) years of supervised practice. This is a sufficient basis for offering supervision to others.	44	24	3
18. If supervision is seen as CPD there is a danger that other forms of CPD will be ignored.	48	28	3
25. Separating supervision and management is often impossible for practical reasons.	49	30	2
50. Supervisors who feel the supervisee's personal issues are significantly interfering with their clinical effectiveness should suggest the supervisee seeks appropriate, separate therapy.	48	72	1.50
57. It is important for supervisee and supervisor to have the same therapeutic orientation.	47	38	3

Table 12. Items showing significant subgroup variability but with CI above 20.

Tables 13-18 following show which subgroupings were significantly associated with which items. It should be noted that numbers given are variable because they include only those participants who could properly be assigned to or excluded from the subgroup. So for example when examining the effect of having grade B status, those whose status was unknown, or who were not paid on this scale, were excluded.

Four items each were associated with gender (female *N* is specified) and grade B status (B).

item	*N* (f)	effect	significance
11	50 (26)	female median is 2: male median is 4	t = .387, $p < .01$
15	44 (23)	female median is 3: male median is 2	t = -.403, $p < .01$
18	48 (25)	female median is 3: male median is 2	t = -.313, $p < .05$
50	48 (25)	female median is 1: male median is 2, but all disagree responses (*N*=6) were from males	t = .458, $p < .001$

Table 13. Item response and gender

item	*N* (B)	effect	significance
25	43 (32)	B median is 2: others' median is 3	t = -.307, $p < .05$
42	39 (30)	B median is 2: others' median is 3	t = -.295, $p < .05$
54	42 (31)	B median is 2: others' median is 3	t = -.340, $p < .01$
56	40 (29)	B median is 2: others' median is 3	t = -.285, $p < .05$

Table 14. Item response and grade B status

Three items were correlated with having a separate therapy qualification (STQ).

item	*N* (STQ)	effect	significance
11	47 (11)	STQ median is 2: others' median is 3	t = -.273, $p < .05$
51	45 (11)	STQ median is 3: others' median is 2	t = .326, $p < .01$
57	44 (11)	median of both groups is 3, but all agree responses (*N*=13) were from those **without** STQ	t = .434, $p < .001$

Table 15. Item response and possession of separate therapy qualification

Two items were each correlated with being a Head of Service (HOS) and currently studying for a further qualification (CS).

item	*N* (HOS)	effect	significance
11	50 (17)	HOS median is 4: others' median is 2	t = .254, $p < .05$
42	46 (16)	HOS median is 2: others' median is 3	t = -.208, $p < .05$

Table 16. Item response and Head of Service status

item	*N* (CS)	effect	significance
11	50 (13)	CS median is 2: others' median is 3	t = -.274, $p < .05$
18	48 (13)	CS median is 2: others' median is 3	t = -.385, $p < .001$

Table 17. Item response and whether currently studying for further qualification

Five subgroups were each correlated with one item: has received no supervision in post over past six months (NR); has received supervision in post at least twice a month over past six months (HR); being a teacher or trainer (T); having a doctorate (Dr), and has given at least 14 hours of supervision per month over past six months (HG).

item	*N* (subgroup)	effect	significance
15	43 (NR = 9)	NR median is 2: others' median is 3	t = -.350, $p < .05$
15	29 (HR = 11)	HR median is 4: compare with NR above	t = .518, $p < .01$
18	48 (T = 18)	T median is 3: others' median is 2	t = .451, $p < .01$
51	48 (Dr = 22)	Dr median is 2: others' median is 3	t = -.316, $p < .05$
51	44 (HG = 22)	HG median is 3: others' median is 2	t = .519, $p < .001$

Table 18. Item response and other subgroup membership

2.2. Individual variability

The median responses of the whole group (displayed at appendix XIX) were also used to derive a diversity score (DS) for each individual, as described in Statistics. An individual's DS is a measure of individual-group profile matching, expressed as a percentage, such that the lower the DS, the less the individual's response profile varies from the group's median profile. The range, mean and standard deviation of the DS of the whole group and various subgroups were calculated, and correlations between DS variability and subgroups examined (using Kendall's tau-c). Significant results are reported in Table 19 below.

group (*N*)	DS range	DS *M* ± SD	significance
whole group (50)	9-34	22.10 ± 5.70	
females (26)	9-25	19.23 ± 3.91	{DS by gender:
males (24)	16-34	25.21 ± 5.76	t = .579, $p < .001$}
has doctorate (23)	9-34	23.65 ± 6.15	t = .334, $p < .05$
currently studying (13)	14-28	19.62 ± 3.75	t = -.278, $p < .05$
has no supervision (9)	16-34	26.11 ± 5.04	t = .343, $p < .01$
has high supervision (13)	14-34	20.38 ± 4.98	t = -.543, $p < .01$

Table 19. The significance of DS variability

Section 3: **Panelist comments**

Feedback from participants included comments on the style and content of DQ2 as well as omissions they felt were important. A major theme was the wish to qualify and contextualise responses. The solution to this dilemma when raised by the original DQ2 pilot group was to introduce the concept of multiple responses, as described in Methods. However, few multiple responses were made and the concept did not appeal to participants as a way of adequately capturing the range of their desired responses. For example, a panelist wrote, 'answers often depend on individual personalities and circumstances'. Panelists frequently made the point that the term supervision may cover a variety of activities which hold little in common. One panelist wrote, ' The nature of the supervision contract (is it training? is it consultancy?) determines the range of acceptable supervisor behaviour.' There were several facets to this general point, as follows:

- is the supervisee qualified or in training?
- does the supervisor report to others on the quality of the supervisee's work?
- what is the developmental stage of the supervisee?
- different modalities and procedures are appropriate in different settings.
- each supervisee in each supervision session has individual learning needs. How are these assessed and met?
- generalisations will give way to the untidiness of human variability and relationships.

The relationship between the activities of supervision and therapy also attracted a number of comments, and considerable disagreement among them.

- whether supervision is tied to a therapeutic model or not is less important than how thoughtfully supervision is carried out.

- using therapy techniques in supervision is OK if it's role play or explicitly labelled as modelling; otherwise not.
- ideally supervision should use similar methods to therapy.
- psychotherapy is <u>not</u> the supervisor's task.
- I find a great deal of overlap.
- therapy techniques can be very, very useful in supervision.
- there is a tenuous relationship at most. Personally none. On reflection, it's impossible not to use your personal therapeutic skills during supervision: maybe it's slightly stronger than tenuous.
- semantics, dear, all semantics.

The relative roles of personal therapy and supervision in preparing and sustaining practitioners in their therapeutic work was, as indicated by the variety of responses to item 11, another source of disagreement:

- patients are in deep distress and have gone out of their way to ask for help. For supervisees to ask for 'therapy' seems to me to be belittling the needs of our patients. If the person undergoing supervision does not need therapy in the 'patient' sense they should not be seeking it.
- therapy is more important than supervision for training therapists.
- the demand for rules and legislation is a response to anxiety.
- the scientific basis for folks' commitment to their therapy-specific beliefs (e.g. the need for personal therapy) is generally zilch!
- extensive training, therapy and supervision in psychoanalytic psychotherapy is sufficient to sustain subsequent practice. Continuous supervision is infantilising.

Finally, there were some issues raised by only one participant:

- abuse in supervision.
- what action should be required of supervisors when they encounter untoward events (re: ethics of therapy) during supervision?
- shame and supervision.
- psychologists in multidisciplinary peer supervision groups.

Discussion

Section 1: **The method**

A. Response rates

1. Round one

Mail surveys typically produce " low and slow response rates" (Oppenheim, 1997, p. 105). Previous postal surveys of clinical psychologists have reported response rates of just under 50 per cent (Knight & Devonshire, 1996) or even 40 per cent (Gabbay, Kiemle & Maguire, 1999) and the round one response rate of 47 per cent in the present study can therefore be considered within the usual range.

2. Round two

Delphi surveys may have high attrition rates (White & Russell, 1995). The eventual completion of DQ2 by 91 per cent of DQ1 responders, following the researcher's prompt, can perhaps be seen as an indication of satisfactory testimonial validity. However, fewer than 30 per cent of either the DQ1 non-responders or the new invitees completed DQ2. Since all invitees were drawn from the same sources, this low response rate may be a function of the methodology.

Perhaps being invited to respond to a questionnaire they had not been involved in developing tempered any enthusiasm they may otherwise have had for the project. If this were so, then invitees would have needed an extra motivation to overcome that reservation and become panelists. It may be relevant that six of the 19 who joined at round two were personally known to the researcher, and sent personal greetings and news with their replies. Whatever the reasons for this low response rate, it must raise concerns as to the wider meaningfulness of the questionnaire beyond those who contributed to its development.

3. Round three

It is an essential feature of Delphi surveys that the group's range and distribution of responses is fed back to participants, with each individual's response pictured privately for that individual against that background. Where the aim is to develop consensus, for example in predicting future trends (Norcross, Alford & DeMichele, 1992), or designing policies or curricula (Green, 2000a; White & Russell, 1995), panelists' responses to the feedback of their initial results provide a crucial component in the survey process. There was no expectation in the present project that panelists would attempt to influence each others' opinions nor compromise their own initial opinions in order to work towards unity. The final round was conceived as largely a reward (of information) to panelists, and a check on testimonial validity in that it permitted the correction of misunderstandings and mistakes, and invited participants to comment on the intuitive plausibility of the researcher's findings.

The response rate was therefore expected to be low and the actual response of 52 per cent was surprisingly high, especially since over one third of those who responded did not wish to change any of their answers. Sixty-eight per cent of DQ1 responders responded to round three. In contrast, only five (26%) of those who joined the project at round two responded to round three, and three of them had personal connections with the researcher as detailed above.

These response patterns suggest that panelist engagement was at least partly a function of either the stage of the project at which they joined, or the individual relationship with the researcher. This could be an argument for more vigorous follow-up: or possibly an argument against any kind of follow-up. Perhaps people's initial reactions, whether they will or will not take up an invitation, give a highly

accurate indication of their overall motivation to participate. This may be related to the strength of their interest in the topic, or in the experience of being a participant in this kind of research. It may simply be that people are good judges of their own stamina, and know at the outset how likely they are to sustain their involvement.

B. The position of the researcher and the role of anonymity

The results of the project may have been shaped by the methodology, the position of the researcher as a member of the investigated group, or an interaction of those factors. Their respective contributions to the present study cannot be teased out, but may be of relevance to another researcher using the same methodology.

Invitees to a Delphi survey are not anonymously drawn from a reference group. Anonymous participation is held to offer key advantages for the researcher, including higher response rates and a greater degree of openness from participants (Barker, Pistrang & Elliott, 1996; Gabbay, Kiemle & Maguire, 1999; Oppenheim, 1997). Anonymity may also make it easier for invitees to refuse the invitation altogether or to be critical of the investigation.

As a member of the population under scrutiny, the researcher found the methodology deeply satisfying. It seemed a rare opportunity to give people feedback about their peers' opinions, and give them the opportunity to respond to that, as well as look again at their own responses to check whether what they said was actually what they meant. There was a feeling of deep engagement not only with the material of the project but with the individuals who produced the material. However, panelists may have found either the researcher's position as a colleague, or their own visibility to the researcher, problematic and felt obliged to give more time and thought to the project than they would otherwise have wished.

The lack of anonymity and prolonged personal contact may also have had a distorting effect on attempts to measure the range of opinion among clinical psychologists. It is possible that invitees who are highly critical of current DCP moves towards universal supervision and obligatory CPD felt unable to join the project at all, or if they joined felt unable to voice strongly dissenting views. On the other hand, despite widespread agreement on a number of issues, panelists were able to express vigorous disagreement at various points both with each other (e.g. the role of personal therapy) and with DCP policies (e.g. the relationship of supervision and CPD).

C. The construction of DQ2

The accounts elicited by DQ1 in round one contained a wealth of diverse information, experience and opinion. Qualitative research methods (Barker et al., 1995; Smith, 1995) suggest various ways in which such material might be analysed to identify its main themes or constructs. However, such procedures were not considered appropriate to the present task, which was to generate a number of statements concerning supervision, derived as closely as possible from the semi-structured accounts and encompassing as much of their diversity as possible.

Many, but by no means all, (e.g. Green, 2000a; Norcross, Alford & DeMichele, 1992) Delphi surveys follow this path of an initial broad-brush gathering of information from panelists which is then used to generate a more specific enquiry instrument. The methodology seems to require a degree of test-construction sophistication that the literature assumes rather than explicates. Stone Fish and Busby (1996) for example, wrote of 'pulling together the individual information' (p.473), but their study generated two separate questionnaires each containing over 200 items,

which this researcher did not believe was likely to be acceptable to panelists in this survey. No single method for devising a questionnaire of an acceptable length from the amount of material supplied by the panelists in the first round of the present project could be found in the literature. As Stone Fish and Busby (1996) stated, 'How these phases are accomplished is left up to the research team' (p. 473).

Since standardised procedures were not used, it was particularly important to guard against 'unconstrained subjectivity' (Sherrard, 1997, p.162). The development of procedures to enhance the validity of qualitative analyses is under debate at present (Barker et al., 1994), although since this project attempts to combine qualitative and quantitative procedures, it seemed appropriate to explore all procedures which might address the issue. Validation of DQ2 was sought in four ways:

- an independent researcher examined the content,
- DQ1 contributors were chased to maximise response numbers to DQ2,
- reflexive items directly assessed panelist opinion,
- round three permitted panelists to reassess their responses.

D. Content validation of DQ2

An independent researcher was provided with the proposed items for DQ2, as previously described in Methods. Such procedures promote the 'researcher reflexivity' which is proposed as a desirable characteristic of good qualitative research (Stevenson & Cooper, 1997; Stiles, 1999) and offer the possibility of an alternative interpretation of the original material.

Their relationship to traditional measures of reliability and validity, however, is unclear. To begin with, dealing with such a mass of material is extremely labour-intensive, and obviously the second researcher cannot be expected to give the same

level of scrutiny to the material as the first, and therefore cannot be asked to propose their own analysis de novo. Further, research on priming in human perception and judgement (Chartrand & Bargh, 1997; Epley & Gilovitch, 1999) suggests that the exposure of the second researcher to the proposed analysis of the first may preclude a genuinely independent analysis. It is possible that a number of very different questionnaires could have been derived. On the other hand, because the Delphi methodology is iterative, panelists were given the opportunity to say for themselves whether or not the opinions they had offered in round one were adequately addressed in DQ2.

E. Participant validation

Panelists were asked to comment on the questionnaire and on the whole research experience, in a number of different ways and at every stage of the project. Some of their responses to the open invitations to comment are at appendices VI, XIII, XIV and XVI but here the last four items of DQ2 (Table 8) will be considered. None of these items attracted a 100 per cent response, and few panelists responded in the socially undesirable direction (i.e. critical of the questionnaire). One of those few added the qualifying comment, '[Completing this questionnaire has been] *necessarily* [emphasis added] somewhat tedious, and now I need a cup of tea!'

Responses given to these items were generally confirmatory. However, the high level of non-response and the apologetic tone of at least one of those who voiced some negative feelings about participation must raise the possibility that participants felt pressurised by their position in the research process. This may have been particularly so because panelists and researcher were known to each other at least by name, and panelists may have wished to avoid offence or upset. It is not clear how

this may have distorted their responses, but the points in subsection B above are relevant here.

Panelists used round three to validate their own responses as well as to compare and possibly modify them in the light of their peers' views (appendices XVIII and XIV). They made very few references to changes necessitated by poorly-worded items (but see discussion below on items 15 and 44). The absence of dissent is not equivalent to support: perhaps, however, the group's willingness to remain involved with the project through the high round three response rate (52%), requests for copies of the final report (62%) and willingness to be named as participants (53%), may together be considered to support the case for satisfactory testimonial validity.

F. Analysis

If the Delphi literature is not altogether satisfactory in demonstrating how the material gathered in the first round might best be used to generate investigatory instruments for later rounds, it is unhappily no more definitive in recommending methods of analysing the final body of material. Methods are inconsistent and do not permit any comparisons from one study to another.

Panelists have been asked to respond to second-round investigations in a number of ways, including Likert scales of four (Gibson, 1998), five (Thomson, 1990; White & Russell, 1995) seven (Green, 2000a; Stone Fish & Busby, 1996; Stone Fish & Osborne, 1992) and nine (Jones & Hunter, 1995) points. Analytic methods are simple, ranging from the median and interquartile ranges for each item (Stone Fish & Busby, 1996; Stone Fish & Osborne, 1992; White & Russell, 1995) or the means and standard deviations for each item (Green, 2000a; Norcross, Alford & DeMichele,

1992) to an unspecified ranking system of items (Gibson, 1998; Jones & Hunter, 1995).

The two measures developed in this study, the Consensus Index (CI) which applies to individual items and the Diversity Score (DS) which applies to individual participants, offer a way of comparing results from studies using various ways of collecting and analysing information. They are unaffected by the number of points on a Likert scale, unlike medians or means, or by the number of items, unlike many ranking systems. The CI permits items to be ranked quite finely – even in the present study where there was broad agreement on most items the CI range (2-98) occupied almost the whole of the theoretical range (0-100). The DS offers a simple way of assessing both individual and subgroup variability across the whole questionnaire so that where subgroups have different patterns of response this may be seen.

Section 2: **The results**

A. Selection of panelists

Clinical psychologists were invited to participate in the project on the basis of their presumed expertise or interest in the topic. As detailed in Methods, invitees suggested four others, three of whom had already been selected by the researcher, which indicates a good match between researcher and invitees as to appropriate participants. Further, variables such as years of practice, having a grade B post or being a Head of Service indicate a highly experienced group of clinicians, and since the majority were both giving and receiving supervision, a reasonable match may be claimed between the intended and actual target group.

One anomaly, however, deserves mention here. Many of the original invitees were trainers of clinical psychologists, but the range of responses from this subgroup

suggests that different training courses may have very different understandings of the role of supervision in the profession.

Some trainers declined to participate because they were not directly involved in supervision, or even because none of the trainers on their course were directly involved. The absolute number of these trainers was very small. However, the annual report 1999-2000 of the Group of Trainers in Clinical Psychology (Roth, 2000) describes workshops held during the year on six topics which reflected 'critical issues facing all courses' (ibid), two of which concerned supervision. It is alarming but also puzzling that any clinical psychologists responsible for training might see themselves as not directly involved in supervision. Other trainers said they were involved to a variable degree: at the extreme some said they gave, received and taught supervision, and were involved in the development of supervisor training, but all combinations existed. Thus the entire possible spectrum of involvement in supervision can be found within the relatively small group of trainers and while such a range persists in this group it is most unlikely to diminish in the profession as a whole.

It is also true that in successfully capturing the target group of clinical psychologists with an interest in supervision, one cannot say how typical the views and experiences described might be of clinical psychologists generally. The DCP recommends that all qualified psychologists should both receive and provide supervision (DCP, 1998a), but even in this selected group the recommendation is not universally followed and across the whole profession, adherence is likely to be lower. Whether the patterns of agreement and dissent found here would be replicated elsewhere cannot be predicted. The current panelists, because of their special interest, might be more likely to be involved in the development of procedures and policies

concerning supervision in their workplaces or even in the DCP, but there may be profound differences between these views on the cutting edge of practice and the views held by less committed clinicians.

B. The PPI

B. 1. Learning about supervision

There seems to be a failure of coherence between participating in supervision and developing an academic or theoretical foundation to that participation. The majority of the panelists were both giving and receiving supervision, yet only half said they were satisfied with their level of preparation for supervision. Some participants said that receiving supervision (on both therapeutic and supervisory work) had been more helpful to them than reading or attending training on supervision, but overall these latter activities were significantly correlated not only with each other but also with satisfaction with level of preparation. The question may therefore be asked that if these activities are generally found to be useful, why do not clinical psychologists partake in them more frequently?

Panelists were asked to specify how they had been involved in teaching, training or supervising others to supervise but, unfortunately, many gave no details and it is not altogether clear that they were responding to the specific question as asked. Almost all of those who identified teaching or training as a major component of their jobs ($N = 23$) said they had been involved in teaching, training or supervising others to supervise ($N = 19$). This seems to indicate a much higher level of involvement in *providing* these services than would be expected by the level of involvement in *receiving* them. A number of explanations are possible: perhaps clinical psychologists in general are not the recipients of these particular services;

perhaps they are given to clinical psychologists currently in training rather than to post-qualification clinicians such as the present panelists; or perhaps the question was not phrased clearly enough, and many people were indicating their involvement in teaching or training generally, rather than with specific reference to supervision. Whatever the source of these confusions, they display the variable and disjointed relationship between clinical psychology as a profession and clinical supervision as a professional activity.

B. 2. Clinical psychologists as supervisees

All grade A psychologists were receiving supervision in post but apart from this there was no significant relationship between amount of supervision received and any of the other variables recorded. Panelists were not asked to specify their preferred therapeutic model but several offered information concerning this in the context of their supervision requirements. The UKCP's definition of supervision as an ongoing practice requirement was noted as a guiding principle by most of those who said they practiced Family Therapy. However, some individuals who allied themselves with the psychoanalytic/dynamic therapies saw the demand for universal supervision as 'infantilising' and 'a response to anxiety'. It should be noted that these divisions were not absolute: one person working with families did not want routine supervision and conversely some highly trained and experienced psychoanalytic practitioners did.

It can therefore be concluded that most panelists receive supervision and almost all would prefer this position, but the very small group who are averse to receiving it do not share any characteristics which reliably distinguish them from others.

B. 3. Clinical psychologists as supervisors

There seemed less conflict in the group concerning their identification as supervisors than as supervisees, with only three (two of whom were trainers) saying they had given no supervision in the previous six months, indicating a widespread acceptance of the role. Although other clinical psychologists (both pre- and post-qualification) were by far the most frequently identified supervisees, a substantial number of panelists were offering supervision to a large number of qualified, training and voluntary groups whose tasks were extremely disparate, not necessarily involving any kind of psychological therapy, and whose supervision needs therefore were also likely to be extremely disparate.

Since trainers as a group show such a range of involvement in supervision, there may be little consistency in the extent to which trainee clinical psychologists are taught either to use, or later to offer, supervision. Current panelists certainly did not seem to feel their own experiences of training in clinical psychology gave them a sufficient grasp of supervision to practice as supervisors, and it is therefore not clear to whom the profession should look to provide supervisor training.

C. The DQ2

C. 1. General remarks

The two measures used to describe the distribution of panelists' responses, the CI and the DS, show that the group was in broad agreement across most of the issues raised. As shown in Tables 9 and 10, the distribution of the CI was heavily skewed towards the higher end, indicating the panelists have a much bigger pool of shared beliefs than pools of contested beliefs.

Similarly, if an individual disagreed by only one point with the group median on every item, their DS would be 41, and the highest DS in the group was only 34. As shown in Table 19, females and those who were currently studying had the lowest means and the lowest standard deviations of DS. Individuals from these groups are therefore highly likely to have response profiles extremely close to the group median profile. The highest DS group means were found in males, those who had received no supervision in post and those with a doctorate. In this last group alone the DS range was as great as in the whole group, although it should be noted that all three groups with the highest means had higher standard deviations than the groups with the lowest means. It is therefore less easy to predict how likely an individual from these groups is to conform to the group profile, although even those whose individual responses were most different from the group's responses agreed more often than they disagreed with the group. The relatively small variability in scores and the low numbers in most of these subgroups demand that results are interpreted tentatively but the apparent importance of gender in determining response pattern was striking. Considered together, the four items most affected by gender imply very different patterns of understanding the interface of therapy and supervision, and the responsibilities of the supervisor. Gender is rarely addressed in supervision literature, and supervisors may not perceive it as particularly important (Green, 2000a) but where it is actually examined it is found to be of enormous influence (Nelson & Holloway, 1999). It may be important to ensure supervision policies and models are designed with due regard for these gender differences.

One theme which recurred throughout the project was a desire to reject general principles in favour of close attention to the context of supervision. This wish to avoid definitive statements, the 'It all depends...' viewpoint, was evident even in the

pilot group for DQ2, and it must be said that the present project did not succeed in its attempts to map out what decisions might be particularly delicately balanced, and what they might be balanced on. DQ2 items did not attract the multiple responses that might have begun to delineate where general principles are especially likely to break down. Thorough exploration of these issues for clinical psychologists must await further research, although the present results may be taken to suggest that the range of tasks undertaken by both clinical psychologists and their supervisees do not easily fit into any of the currently available models of supervision.

C. 2. Consensus indicators

Twenty-one items attracted valid responses from at least 96 per cent of the group and had CI's of at least 80. They may therefore be considered to express the most widely and strongly held beliefs in the current group and to show where the consensus is high. Low consensus may be identified by three measures: items with low response rates (≤ 92%), items with CI's of 20 or below, and items where subgroup membership was significantly correlated with particular responses. Eighteen items were affected by at least one of these factors. Three were participant validation items as previously discussed. Thirty-six items can therefore be said to describe the range of consensus among the panelists, and they are considered below grouped under the original headings on DQ1 for convenience.

1. Clinical supervision and training

Three items (6, 8 and 9) were high consensus, showing the group's strong endorsement of the principle of universal, regular supervision. Indeed, endorsement for these items was higher than one might predict from panelists' reports of their own

experiences, indicating a discrepancy between what panelists did and what they thought should be done. One interpretation might be that if the DCP *imposed* supervision as a core practice requirement there would be more relief than resistance among those who currently practice without it: another might be that participants were more strongly convinced of the need for other people to have supervision than they were of their own need for it. Further exploration of this discrepancy will be required if DCP recommendations are to become a reality in practice.

2. Clinical supervision and management

Four items were notable. Two (28 and 29) were high consensus, showing the group's wish to establish clinical supervision as a distinct activity, not to be subsumed within even a broad managerial programme. The opinion that practical constraints might make their separation impossible (25) was correlated with Grade B status, but not with HOS status. This perhaps indicates that Heads of Service were able to make satisfactory supervision arrangements for themselves outside management structures, but it is not clear whether B-grades felt this freedom cannot be granted to them, their supervisees or both. Perhaps the concept of supervision has a variety of relationships with management at different levels of seniority. A more detailed exploration of this relationship might be particularly pertinent with the introduction of formal lines of accountability, clinical governance and EBP, which may fit more comfortably into managerial structures than non-managerial ones. The present research indicates no emerging consensus on the most useful relationship between management and supervision (33).

3. Clinical supervision and therapy

Six items (45-49 inclusive and 52) were high consensus, and show again the group's belief that clinical supervision is a distinct activity: more specifically, it must not be confused or combined with therapy. The supervisee's feelings in response to the work, however, are widely seen to deserve supervisory attention, both to support the supervisee and to explore parallel processes and countertransferences.

Two items (11 and 51) were low consensus. It is worth noting that item 11 did *not* ask whether or not panelists had experienced personal therapy but only whether they thought it was *as important as supervision* in training therapists. This was one of only 12 items which elicited a 100 per cent response rate, and several panelists offered comments indicating strong commitment: but the consensus across the group was virtually at the theoretical minimum (CI=4). Panelists who were female, or who had a separate therapy qualification, or who were currently studying, were more likely to agree with the item. Panelists who were male, or who were Heads of Service, were more likely to disagree. Significant gender differences were found on several measures, but the biggest difference was on this item. Item 51, which suggests that using therapy techniques in supervision is an effective teaching method, was more frequently positively endorsed by those with a doctorate and disputed by those with a separate therapy qualification and by those who gave the most supervision.

The group is therefore agreed that supervision must attend to interpersonal and emotional processes, while avoiding a primarily therapeutic stance. This provides an interesting contrast to point 2 above. Panelists wanted the functions of supervision and management separated but many felt (or hoped) that both could occur within the same relationship: supervision and therapy, however, are not only separate functions

but must not occur within the same relationship. There was, unfortunately, no agreement on how similar or different the processes in each might be.

4. Clinical supervision and ethics

The high consensus on item 40 showed a general commitment to regular examination of ethical issues, although items 42 and 44 require more clarification. Both grade B and HOS status were associated with more concern that clinicians may lack a clear ethical perspective (42). There was low consensus and no significant subgroup variance on item 44, which may be badly worded: one panelist commented that they agreed that all human conduct has an ethical dimension, but not that clinical psychologists are sufficiently aware of this. Responding to the item was therefore problematic. There seems general agreement that clinical supervision is an appropriate forum for consideration of ethical matters, and this has implications for both policy-making and model development.

5. Clinical supervision and CPD

Three items suggest that the DCP's desire to bring supervision under the rubric of CPD is not widely understood or shared within the profession. The group wanted regular supervision as a core practice requirement and not an optional CPD activity (17: high CI). Men, and people who are currently studying, were likely to agree, and women and teachers or trainers to disagree, that other forms of CPD might be ignored if supervision is seen as a CPD activity (18). There was only mild endorsement of the DCP's moves to include it in guidelines and monitoring procedures for CPD (20: low response rate).

Five items which did not specifically mention CPD might nevertheless be usefully considered here. Items 54 and 56 suggest that therapy-specific models of supervision may have various drawbacks, and Grade B's (but not Grade A's) were inclined to agree with this position. The high consensus on items 53 and 58 showed that the quality of the supervisory relationship is seen as more important than whether or not the parties share a therapeutic orientation and indeed a difference in orientation may be welcome, while item 57 (low consensus) showed that a desire for supervisee-supervisor concordance for therapeutic orientation was found only from some *without* a separate therapy qualification.

Perhaps concordance is only necessary where the supervisee is seeking to establish therapeutic practice and is not sufficiently well-rehearsed to take a broader perspective. As in the earlier discussion of the relationship of supervision and management, supervision and CPD might be related in different ways at different points in one's career path. This is further discussed in Section 3 below.

6. The professionalisation of clinical supervision

Seven items related to the professionalisation of clinical supervision drew notable responses from the group. Item 12, suggesting the profession is not as familiar as it should be with the literature, had only a 90 per cent response rate which is especially interesting given that only a third of the panelists indicated that they themselves were very familiar with the literature on clinical supervision. It is almost as if the literature occupies a kind of scotoma in the profession's view.

The high consensus on five items (1, 2, 5, 13, and 16) showed that panelists want teaching and role induction for both supervisees and supervisors to be much more widely available, and want supervision to continue for supervisors.

Item 15 had the lowest response rate (88%), which may be related to the error in its wording. Chartering requires three years of supervised practice, not six as stated. Some who gave no scoreable response highlighted the error with query marks. Such a mistake on this item was unfortunate as the responses that were made indicated several sources of variability. The more experience panelists had as *supervisees*, the less they agreed that the three years of supervision one receives as a trainee clinical psychologist is sufficient preparation for offering supervision to others. This could suggest that the more familiar one becomes with the process of supervision, the more subtle and complex one's appreciation of it becomes; conversely one could argue that continuing to receive frequent supervision causes one to become deskilled and lose confidence that one can function in the more powerful role. Clarification of this must await further research. Intriguingly, there was also a gender effect on this item such that men were more likely to agree with it, and women to disagree.

7. Other notable items

Three items which do not easily fit into the above categories require discussion. The low response to item 34 (92%) is difficult to interpret since it attracted no comments and showed no significant subgroup variance. The group overall gave cautious positive endorsement to its proposal that supervisors should occasionally observe their supervisees in action. Since live supervision is common practice in family therapy, it may be that therapeutic allegiance significantly affects response to this item but the current survey did not request this information. Item 37 suggested that therapists should not work with clients who had been traumatized by people of the same gender or sexual orientation as the therapist, but the group strongly

disagreed with this position. These items were each derived from a passionately-argued opinion offered on DQ1 by one respondent (not the same one) but in neither case is the passion widely shared.

Item 50 proposed that supervisors should suggest supervisees seek therapy if personal issues were significantly interfering with clinical effectiveness. All those who disagreed were men, two of them commenting that there might be more appropriate ways of supporting a colleague who is struggling. Perhaps some of the gender variance on item 11 is related to this, with women being more inclined to see therapy as an opportunity for nurturance and development, and men as healing something which must, perforce, be considered damaged. Perhaps men and women are inclined to view the power dynamics of the supervisory relationship somewhat differently such that women might consider the suggestion of therapy supportive but men be more likely to consider it intrusive or pathologising. How the supervisor's decision might also be affected by the supervisee's gender is unknown, but if this gender difference in supervisors is repeated in supervisees, one might predict that if a female supervisor suggests to a male supervisee that he seek therapy they might both be surprised by the difficulties this presents to the supervisory relationship.

D. Free comments

Many panelists, in all three rounds, wrote comments showing a deep engagement with clinical supervision both by their involvement in its delivery and by their familiarity with the theories and models which may shape its practice. However, many also commented that taking part in the survey had made them realise how little attention they had given to this latter aspect of the process. One wrote, " I don't think

about it, I just do it" and more plaintively one wrote, next to item 59, "No idea – I don't think as closely as you".

Section 3: **General discussion**

The Introduction chapter considered the historical development of clinical supervision, identified some of the legacies it inherited from its beginnings in psychoanalysis and explored some of the contemporary issues in professional practice which may influence clinical psychologists' views. The present study clarifies where clinical psychologists are divided and where they are in accord in relation to those legacies and contemporary issues.

A. Establishing and maintaining professional competence

Supervision, long recognised as an essential component in initial training, is shown in this study to have an equally valued place in maintaining professional competence. For most practitioners, supervisee is no longer a synonym for trainee. A comparison with earlier studies of clinical psychologists is illuminating here: in 1992 Alexander asked, 'Should there not be a requirement that all psychologists who work clinically with clients receive supervision?' (p.17) and by 1996 Knight and Devonshire were able to report that, '[S]upervision is widely adopted within clinical psychology, with a fair majority receiving regular clinical supervision from their line manger or peer group' (p. 41).

The most recent study is an anonymous and unselected survey by Gabbay et al. (1999) who found that 28 per cent of their group were not receiving supervision but only 11 per cent of these (four individuals) were satisfied with this. Interestingly they found a positive association between accessing supervision and working

psychodynamically whereas three present participants who were not receiving supervision indicated that previous experience of psychodynamic supervision diminished their current need.

Putting the present study into the context provided by these three articles indicates that within the profession generally there are now very few individuals who are actively opposed to career-long supervision, but there is not yet a sufficiently buoyant culture supporting the principle to encourage those who find themselves without it to demand it as a routine requirement for good practice.

In marked contrast, whether training should include personal therapy as well as supervision is clearly not something on which the profession is likely to develop a single viewpoint in the forseeable future. No research has demonstrated any benefit from the therapist's own training therapy, in terms of either improved client outcome or improved therapist welfare (Macran & Shapiro, 1998). However, research by counselling psychologists is beginning to explore the dimensions of the perceived benefits and emotional costs of undertaking therapy as part of training (Williams et al., 1999). Both papers suggest that a significant minority of trainees, particularly in the early stages of training, experience distressing negative effects on personal and professional functioning as a result of their therapy.

The combination of low consensus in the profession and lack of supporting research evidence probably means that training as a clinical psychologist will never include personal therapy as a requirement. If, however, continued research confirms preliminary suggestions that therapy undertaken at a later stage is less likely to produce destabilisation and more likely to enhance professional confidence and resilience (Macran & Shapiro, 1998) then perhaps it may become a recognised postqualification CPD option.

B. Monitoring professional practice

As well as maintaining professional competence, this group is happy to assign ethical monitoring to clinical supervision. It is not clear, however, what role practitioners are willing for clinical supervision to play in other monitoring systems such as EBP, accountability and clinical governance. The career stage of the supervisee, the relative positions of supervisor and supervisee in the employing agency, and the preferred therapeutic and supervisory models of the supervisor all seem likely to shape this willingness, leading to confusions and inconsistencies even within a single clinician's practice. It is probable that where supervisees are trainee clinical psychologists, adequate liaison between training courses and supervisors will clarify the role expected from each party in these monitoring functions: but such trainees are only a small part of most supervisors' practice, and in all other cases it is difficult even to know whom one might approach for clarification. The fact that the present group could not even agree on whether or not national guidance might be useful indicates that widely acceptable solutions are some way off.

C. Supervision as CPD

Supervision has a dual role in CPD and both are distinct from the functions considered above. Professional development may be promoted by either receiving specialist supervision or by becoming a supervisor: these activities are not necessarily related. In either role, the group did not have a preferred model of supervision (although several mentioned the usefulness of the Hawkins and Shohet (1989) model). Few were keen for the supervision model to be therapy-bound, and there was an

awareness of the benefits of supervision which offered a challenge to one's own therapeutic thinking, provided the supervisory relationship was of good quality.

From the view of the supervisee, this is particularly interesting in view of the increasing degree to which accrediting bodies such as member organisations of UKCP are demanding that in order to maintain registration, practitioners must receive supervision from clinicians who themselves are accredited in the relevant therapeutic model. It remains to be seen whether the BPS's Register of Psychotherapists will also produce guidelines demanding supervisor-supervisee therapeutic concordance. Where a practitioner wants to specialise within a single therapeutic model, their continuing professional development may well be best served by adherence to the requirements of many therapy organisations for supervisee-supervisor therapeutic concordance. Such requirements, however, may restrict practitioner development in several ways:

- practitioners who see themselves as generic or eclectic (or simply not committed) may be discouraged from seeking supervision with specialist, single-model supervisors,
- practitioners who wish to retain accreditation in a single therapeutic model may be discouraged from seeking supervision outside a very small range of practice,
- the idealisation of orthodoxy may take precedence over the development of dialogue between traditions to establish common ground and permit the growth of ways to determine what works for whom (cf. Roth & Fonagy, 1996).

Perhaps the validation of eclecticism provided by the establishment of the school of generic psychotherapy for BPS registration purposes will encourage clinical psychologists to develop generic models of supervision. There is certainly a need for much broader supervision models. Much of what clinical psychologists do is not

therapy, and much of the supervision they offer is to others whose task is not therapy, either. This may help to explain both the group's relative failure to familiarise themselves with the literature on supervision and their very strong but undefined uneasiness with attempts to explore possible universal principles for supervision – the 'It all depends...' view referred to at various points in this report. The range and amount of supervision given by the panelists in this study indicate a significant gap in both literature and supervisor training.

Training as a supervisor is available in various therapeutic traditions, including eclectic traditions, as described in the Introduction. There is currently much effort from some clinical psychology training courses to design training programmes for clinicians who wish to supervise clinical psychology trainees. None of this is likely to offer sufficient guidance to clinicians who wish to commit themselves to supervision as a significant career development without wanting to restrict their supervision to either therapists or trainees. Since supervisor training in clinical psychology is still at an early stage, perhaps it might be possible to enhance the CPD appeal of becoming a supervisor by ensuring that proposed training programmes pay heed to the real variety of those who currently ask clinical psychologists for supervision - individuals and groups; unqualified, pre-qualified and qualified; clinical and non-clinical; statutory and voluntary.

D. Implications for practice and future research

In order to strengthen the growing culture of clinical supervision, several aspects of current practice require examination.

- Where the culture of clinical supervision is weak, likely objections to it must be anticipated and resolved. A fairly obvious one is the possible cost. Lost clinical

time, travelling expenses or fees to external consultants may all be seen as extra demands on already overcommitted budgets. Wider discussions concerning the variety of means used to resource the supervision requirements of members might give encouragement to those still struggling to find the professional support they need. Within the DCP, clarification of the relationship between receiving supervision to maintain professional competence and receiving supervision as an optional CPD activity might also assist in the strengthening of this culture.

- With the amendment of Statute 12(3), the BPS no longer defines professional competence as meaning one practices without supervision. This is not equivalent to an endorsement of post-qualification supervision, but it removes a significant barrier to it. Perhaps various Divisions might now begin to explore what common ground there may be in their understanding of supervision which might eventually form the basis of a unified BPS position to guide all practitioners.

- Further investigation is needed of those factors which have emerged as significant in the present study to assess their reliability. Various aspects of qualification, experience and status might be expected to correlate with views on a range of professional matters, but the apparent significance of gender both on a number of individual items and on the overall level of dissent from group opinions on DQ2 was unexpected. However, this was a small group and the subgroups within it even smaller. All the apparent sources of variability need replication before they can be claimed to show real differences.

- Academic attention is needed to the practice of clinical supervision particularly as carried out by clinical psychologists, since both their own professional roles and

the tasks of their supervisees are frequently not confined to psychotherapeutic practice. The development of models of supervision that could encompass not only a range of therapeutic approaches but also a range of non-therapeutic tasks would be welcome, and would assist a recognition and development of the wider role of clinical supervisor within the profession.

E. Conclusions

The aims of the study were to investigate current beliefs and practices concerning clinical supervision among a group of clinical psychologists selected as experienced or interested in the topic, and to consider these beliefs and practices in the light of the most recent recommendations of the DCP.

The Delphi methodology has proved a useful tool to carry out such an investigation. This expert group of British clinical psychologists has a clear commitment to the position that the quality of the supervisory relationship is paramount. Within that relationship, therapeutic modality matching appears less important than many current professional bodies suggest. In contrast, gender appears to influence the relationship in several subtle ways, in particular in determining individual views concerning the meaning of personal therapy, the interface of therapy and supervision, and the power differentials in supervision. Overall, results support the DCP's position. The emerging consensus on the importance of continued supervision to both maintain and develop practice includes the vast majority of the present group, most of whom are eager not only to provide supervision in an extremely wide range of situations, but also to receive supervision themselves, on both their direct clinical work and their supervision.

References

Alexander, P. (1992). Psychology, clinical practice and community mental health teams. Clinical Psychology Forum, 40, 15-18.

Ashcroft, J., Callanan, M., Adams, M., Roth, A., Gray, I. & Lavender, A. (1997). Clinical Psychology Training and the Core Placements issue: Ways Forward. Leicester: Committee on Training in Clinical Psychology of the British Psychological Society.

BAC. (1996). British Association for Counselling Code of Ethics and Practice for the Supervision of Counsellors. Rugby: BAC.

BAC. (1998). British Association for Counselling Code of Ethics and Practice for Counsellors. Rugby: BAC.

Barker, C., Pistrang, N. & Elliott, R. (1994). Research Methods in Clinical and Counselling Psychology. Chichester: Wiley.

Barnes, G. G., Down, G. & McCann, D. (2000). Systemic Supervision. London: JKP.

Beaumont, G. (2000). Clinical neuropsychology in practice. The Psychologist, 13, 16-17.

Beck, A. T. (1964). Thinking and depression II. Theory and therapy. Archives of General Psychiatry, 10, 561-571.

Binder, J. L., & Strupp, H. H. (1997). Supervision of psychodynamic psychotherapies. In C. E. Watkins, Jr.(Ed.), Handbook of Psychotherapy Supervision, pp.44-62. New York: Wiley.

Boyle, M. (1999). Diagnosis. In C. Newnes, G. Holmes & C. Dunn (Eds), This is Madness, pp.75-90. Ross-on-Wye: PCCS Books.

BPS. (1999a). Annual Report. Leicester: BPS.

BPS. (1999b). The Register of Chartered Psychologists. Leicester: BPS.

Burton, M. (1999). Training a consultant surgeon in Rogerian counselling techniques. Clinical Psychology Forum, 123, 13-15.

Butterworth, C. A. & Faugier, J. (Eds) (1992). Clinical Supervision and Mentorship in Nursing. London: Chapman and Hall.

Carroll, M. (1996). Counselling Supervision. London: Cassell.

Carroll, M. & Holloway, E. L. (Eds) (1999). Counselling Supervision in Context. London: Sage.

Chartrand, T. L. & Bargh, J. A. (1997). Automatic activation of impression formation and memorization goals: Nonconscious goal priming reproduces effects of explicit task instructions. Journal of Personality and Social Psychology, 71, 464-478.

Clarkson, P. (1995). The Therapeutic Relationship. London: Whurr.

Cohen, L. & Baldwin, S. (1999). "Personality disorder", dangerous behaviour and public safety: a role for psychologists? Clinical Psychology Forum, 134, 3.

Cook, T. D. & Campbell, D. T. (1979). Quasi-experimentation: Design and Analysis issues for Field Settings. Chicago: Rand-McNally.

Crocket, C. (1999). Training health visitors to detect and treat postnatal depression: a preliminary report. Clinical Psychology Forum, 123, 16-19.

Dalkey, N. & Helmer, O. (1963). An experimental application of the Delphi method to the use of experts. Management Science, 9, 458-467.

DCP. (1998a). Guidelines for Clinical Psychology Services. Leicester: British Psychological Society.

DCP. (1998b). Guidelines for Continuing Professional Development. Leicester: British Psychological Society.

Dewald, P. A. (1997). The process of supervision in psychoanalysis. In C. E. Watkins, Jr.(Ed.), Handbook of Psychotherapy Supervision, pp.31- 43. New York: Wiley.

DOH (1999). Clinical Governance: Quality in the new NHS. London: DOH.

Dryden, W. & Thorne, B. (Eds) (1991). Training and Supervision for Counselling in Action, London: Sage.

Edwards, D. (1997). Supervision today: the psychoanalytic legacy. In G. Shipton (Ed.), Supervision of Psychotherapy and Counselling, pp.11-23. Buckingham: OUP.

Ellis, A. (1962). Reason and Emotion in Psychotherapy. New York: Lyle Stuart.

Ellis, M. V. & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: an integrative review. In C. E. Watkins Jr. (Ed.), Handbook of Psychotherapy Supervision, pp. 447-507. New York: Wiley.

Encyclopaedia Britannica, 15th edition. (1984). Volume 15, p.149. Chicago: Encyclopaedia Britannica Inc.

Epley, N. & Gilovich, T. (1999). Just going along: nonconscious priming and conformity to social pressure. Journal of Experimental Social Psychology, 35, 578-589.

Eysenck, H. J. (1949). Training in clinical psychology: an English view. American Psychologist, 4, 173-177.

Eysenck, H. J. (1976). The learning theory model of neurosis – a new approach. Behaviour Research and Therapy, 14, 251-267.

Feltham, C. & Dryden, W. (1994). Developing Counsellor Supervision. London: Sage.

Fountain, L. (1998). Does CPD matter? Clinical Psychology Forum, 120, 47.

Fruzzetti, A. E., Waltz, J. A. & Lineham, M. (1997). Supervision in Dialectical Behavior Therapy. In C. E. Watkins Jr. (Ed.), Handbook of Psychotherapy Supervision, pp. 84-100. New York: Wiley.

Gabbay, M. B., Kiemle, G. & Maguire, C. (1999). Clinical supervision for clinical psychologists: existing provision and unmet needs. Clinical Psychology and Psychotherapy, 6, 404-412.

Gibson, J. (1998). Using the Delphi technique to identify the content and context of nurses' continuing professional development needs. Journal of Clinical Nursing, 7, 451-459.

Gould, S. J. (1981). The Mismeasure of Man. London: Penguin.

Green, D. (1995). Supervision for qualified clinical psychologists. Clinical Psychology Forum, 80, 40-41.

Green, D. (1997). Credit where credit's due. Clinical Psychology Forum, 104, 28-31.

Green, D. (1998). Society-wide CPD policy. Clinical Psychology Forum, 116, 44.

Green, D. (2000a). How should we Train Clinical Supervisors? A Delphi survey. University of Leeds: in preparation.

Green, D. (2000b). Who pays for CPD in clinical psychology? DCP Information Leaflet no. 3. Leicester: BPS.

Hawkins, P. & Shohet, R. (1989). Supervision in the Helping Professions. Milton Keynes: OUP.

Holloway, E. L. (1995). Clinical Supervision: a Systems Approach. Thousand Oaks: Sage.

Holloway, E. L. (1997). Structures for the analysis and teaching of supervision. In C. E. Watkins Jr. (Ed.), Handbook of Psychotherapy Supervision, pp. 249-276. New York: Wiley.

Inskipp, F. & Proctor, B. (1988). Skills for Supervising and being Supervised. Hastings: Alexia Publications.

Jones, A. (1998a). "What's the bloody point?": more thoughts on fraudulent identity. Clinical Psychology Forum, 112, 3-9.

Jones, A. (1998b). Letter. Clinical Psychology Forum, 117, 3.

Jones, A. (2000). How to resolutely refuse to worry about not doing research, ever – yes, ever! – again. Clinical Psychology Forum, 138, 9-14.

Jones, J. & Hunter, D. (1995). Consensus methods for medical and health services research. British Medical Journal, 311, 376-380.

Kanfer, F. H. & Phillips, J. S. (1970). Learning Foundations of Behavior Therapy. New York: Wiley.

Knight, T. & Devonshire, P. (1996). A survey of the needs for CPD in a group of clinical psychologists in the South Thames (West) Region. Clinical Psychology Forum, 87, 40-42.

Lambert, M. J., & Ogles, B. M. (1997). The effectiveness of psychotherapy supervision. In C. E. Watkins Jr. (Ed.), Handbook of Psychotherapy Supervision, pp. 421-446. New York: Wiley.

LeShan, L. (1996). Beyond Technique: Psychotherapy for the 21st Century. Northvale, NJ: Jason Aronson.

Lewis, V. J. & Perrin, A. (1997). Editorial: Teaching ourselves and others. Clinical Psychology Forum, 109, 3.

Liddle, H. A.., Becker, D. & Diamond, G. M. (1997). Family Therapy supervision. In C. E. Watkins Jr. (Ed.), Handbook of Psychotherapy Supervision, pp. 400-420. New York: Wiley.

Liese, B. S. & Beck, J. S. (1997). Cognitive Therapy supervision. In C. E. Watkins Jr. (Ed.), Handbook of Psychotherapy Supervision, pp. 114-133. New York: Wiley.

Linstone, H. A. & Turoff, M. (Eds) (1975). The Delphi Method: Techniques and Applications. Reading, MA: Addison-Wesley.

Llewelyn, S. & Kennedy, P. (1999). Delphi study on Clinical Psychology Training in the UK. Warneford Hospital: in preparation.

Mackay, D. (1984). Behavioural psychotherapy. In W. Dryden (Ed.), Individual Therapy in Britain, pp. 264-298. Milton Keynes: OUP.

Macran, S. & Shapiro, D. A. (1998). The role of personal therapy for therapists: a review. British Journal of Medical Psychology, 71, 13-25.

Mahoney, M. J. & Patterson, K. M. (1992). Changing theories of change: recent developments in counseling. In S. D. Brown & R. W. Lents (Eds), Handbook of Counseling Psychology, pp. 665-690. New York: Wiley.

Marshall, R. & Collerton, D. (2000). The resourceful provision of supervision. Clinical Psychology Forum, 135, 27-30.

Marzillier, J. (1998). Identity crises and clinical psychology. Clinical Psychology Forum, 120, 9-13.

Maxwell, M. (1995). Problems associated with the clinical education of physiotherapy students: a Delphi survey. Physiotherapy 81, 582-587.

Meehl, P. E. (1997). Credentialed persons, credentialed knowledge. Clinical Psychology: Science and Practice, 4, 91-98.

Miller, R. (1990). The role of the DCP in continuing professional development (CPD). Clinical Psychology Forum, 28, 36-37.

Milne, D. (1998a). Clinical supervision: time to reconstruct or to retrench? Clinical Psychology and Psychotherapy, 5, 199-203.

Milne, D. (1998b). Evidence-Based Clinical Supervision. Paper read at Annual BPS conference.

Milne, D. & James, I. (1999). Evidence-based clinical supervision: review and guidelines. Clinical Psychology Forum, 133, 32-36.

Milne, D., Keegan, D., Paxton, R. & Seth, K. (1998). Evidence-Based Practice: a survey of Psychological Therapists. Project report for Northumberland Mental Health NHS Trust.

Milne, D. & Oliver, V. (1999). Flexible Formats of Clinical Supervision: Description, Evaluation and Implementation. University of Newcastle: in preparation.

Milne, D. (1999). Training others to train others: an illustration of the educational pyramid. Clinical Psychology Forum, 123, 7-12.

Mollon, P. (1989). Narcissus, Oedipus and the psychologist's fraudulent identity. Clinical Psychology Forum, 23, 7-11.

Moon, S. M., Dillon, D. R. & Sprenkle, D. H. (1991). On balance and synergy: family therapy and qualitative research revisited. Journal of Marital and Family Therapy, 2, 187-192.

Morgan, M. (1996). Qualitative research: a package deal? The Psychologist, 9, 31-32.

Nelson, M. L. & Holloway, E. L. (1999). Supervision and gender issues. In M. Carroll & E. L. Holloway (Eds), Counselling Supervision in Context, pp. 23-35. London: Sage

Newnes, C. (1999). Histories of psychiatry. In C. Newnes, G. Holmes & C. Dunn (Eds), This is Madness, pp.7-28. Ross-on-Wye: PCCS Books.

Nichols, K., Cormack, M. & Walsh, S. (1992). Preventive personal support: a challenge to the training courses. Clinical Psychology Forum, 45, 29-31.

Nieboer, R., Moss, D. & Partridge, K. (2000). A great servant but a poor master: a critical look at the rhetoric of evidence-based practice. Clinical Psychology Forum, 136, 17-19.

Norcross, J. C., Alford, B. A. & DeMichele, J. T. (1992). The future of psychotherapy: Delphi data and concluding observations. Psychotherapy, 29, 150-158.

Norcross, J. C., Brust, A. & Dryden, W. (1992). British clinical psychologists; I. a national survey of the BPS Clinical Division. Clinical Psychology Forum, 40, 19-24.

Oppenheim, A. N. (1997). Questionnaire Design, Interviewing and Attitude Measurement. London: Pinter.

Page, S. & Wosket, V. (1994). Supervising the Counsellor: a Cyclical Model. London: Routledge.

Patterson, C. H. (1997). Client-centred supervision. In C. E. Watkins Jr. (Ed.), Handbook of Psychotherapy Supervision, pp. 134-146. New York: Wiley.

Perris, C. (1994). Supervising cognitive therapy and training supervisors. Journal of Cognitive Psychotherapy, 8, 83-103.

Perris, C. (1997). Supervision of cognitive psychotherapy: expectations of the supervisees. Clinical Psychology and Psychotherapy, 4, 25-31.

Reason, P. & Heron, J. (1995). Co-operative enquiry. In J. A. Smith, R. Harre & L. Van Langenhove (Eds), Rethinking Methods in Psychology, pp.122-142. London: Sage.

Richards, J. (1998). Letter. Clinical Psychology Forum, 120, 5-6.

Roth, A. D. & Fonagy, P. (Eds) (1996). What Works for Whom? A Critical Review of Psychotherapy Research. New York: Guilford Press.

Roth, T. (1999). Evidence-based practice: is there a link between research and practice? Clinical Psychology Forum, 133, 37-40.

Roth, T. (2000). Group of Trainers in Clinical Psychology. Annual Report 1999-2000. Agenda & Annual Report, A.G.M. of DCP. Leicester:BPS.

Rothberg, N. (1997). Family therapist supervision: philosophy and process. The Clinical Supervisor, 15, 167-173.

Royal College of Speech and Language Therapists (1996). Forums on Tutoring for Experiental Learning. London: RCSLT.

Ryder, J. & Shillito-Clarke, C. (1998). Counselling psychologists: upstarts, competitors or colleagues? Clinical Psychology Forum, 121, 35-38.

Sells, S. P., Smith, T. E. & Sprenkle, D. H. (1995). Integrating qualitative and quantitative research methods: a research model. Family Process, 34, 199-218.

Sherrard, C. (1997). Qualitative research. The Psychologist, 10, 161-162.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre & L. Van Langenhove (Eds), Rethinking Methods in Psychology, pp. 9-26. London: Sage.

Smith, J. A., Harre, R. & Van Langenhove, L. (Eds) (1995). Rethinking Methods in Psychology. London: Sage.

SPSS for Windows, Rel. 9.0.0. (1998). Chicago: SPSS Inc.

Stevenson, C. & Cooper, N. (1997). Qualitative and quantitative research. The Psychologist, 10, 159-160.

Stiles, W. B. (1999). Evaluating qualitative research. Evidence-Based Mental Health, 2, 99-101.

Stone Fish, L. & Busby, D. M. (1996). The Delphi method. In D. H. Sprenkle and S. M. Moon (Eds), Research Methods in Family Therapy, pp. 469-482. New York: Guilford.

Stone Fish, L. & Osborne, J. L. (1992). Therapists' views of family life: a Delphi study. Family Relations, 41, 409-416.

Thomson, B. R. (1990). Appropriate and inappropriate uses of humor in psychotherapy as perceived by certified reality therapists; a Delphi study. Journal of Reality Therapy, 10, 59-65.

Thorne, B. (1984). Person-centred therapy. In W. Dryden (Ed.), Individual Therapy in Britain, pp. 102-128. Milton Keynes: OUP.

Thouless, R. H. & Thouless, C. R. (1990). Straight and Crooked Thinking. London: Hodder & Stoughton.

Wampold, B. E. & Holloway, E. L. (1997). Methodology, design and evaluation in psychotherapy supervision research. In C. E. Watkins, Jr. (Ed.), Handbook of Psychotherapy Supervision, pp.11-30. New York: Wiley.

Watkins, Jr., C. E. (1997). Some concluding thoughts about psychotherapy supervision. In C. E. Watkins, Jr. (Ed.), Handbook of Psychotherapy Supervision, pp. 603-616. New York: Wiley.

White, M. B. & Russell, C. S. (1995). The essential elements of supervisory systems: a modified Delphi study. Journal of Marital and Family Therapy, 21, 33-53.

Williams, F., Coyle, A. & Lyons, E. (1999). How counselling psychologists view their personal therapy. British Journal of Medical Psychology, 72, 545-555.

Woods, P. J. & Ellis, A. (1997). Supervision in Rational Emotive Behavior Therapy. In C. E. Watkins, Jr.(Ed.), Handbook of Psychotherapy Supervision, pp. 101-113. New York: Wiley.

Word 97. (1996). Washington: Microsoft Corporation.

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Appendix I

Salomons

Centre for Applied Social & Psychological Development

Ms B Roberts

15 April 1999

Direct line 01892 507665
Direct fax 01892 507660
E-mail t.lavender@salomons.org.uk
Our Ref LT

Dear Brenda,

Ethics Approval - Engagement and non-engagement in clinical supervision by clinical psychologists: a Delphi Survey

The Ethics Panel is pleased to provide full ethical approval for your research project. The Panel were impressed with the thoroughness of the proposal and the way in which the ethical issues had been considered and taken into account.

There is one issue we would like you to consider and that is how you will feedback the overall results of the study to participants. A short report could perhaps be sent to those indicating on a slip on the consent letter that they would wish to hear the results of the study.

We wish you well with the project and would be extremely interested to see the results.

Yours sincerely,

Professor Tony Lavender
Chair of Ethics Panel

c.c. Caroline Hogg
Nigel Armstrong

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Appendix II
Materials sent to invitees to round one:
PPI (here labelled Part I), DQ1 (here labelled Part II) and reference list.
N.B. text and spacing here reduced in size

Clinical Psychologists on Clinical Supervision

There are two parts in this round. The first part is included ***in the first round only****, and takes about 10 minutes to complete. It asks for factual information, which will be used to generate a description of the participants as a group. This description will be circulated with the second round, for the interest of participants, although no means of identifying individuals will be given.* ***Personally identifying information will be seen by the researcher, Brenda Roberts and the supervisor, Margie Callanan, only****. When the project is complete it will be destroyed. The second part is the Delphi proper. Responses to this will be used to generate the questionnaire which will be sent out in round two. All data from this may be stored without personal identifiers. Original handwritten forms will be destroyed.*

Part I

Background information
If you hold more than one post please adapt this form or photocopy it as necessary.

1. Please print your name, and indicate your age and gender. age M F

2. What is your job title or professional title?

3. Please list your professional qualifications, the country which awarded them and the year you obtained them.

4. If you are studying for a further qualification please give its title & awarding body.

5. How long have you practiced as a qualified clinical psychologist?

6. What are the main functions of your post or the department in which you work?

7. How long have you held your present post?

8. Is your post full or part-time?

9. What is the spine point, or spinepoint range, assigned to your post?
Comments _____

Your current experiences of clinical supervision
A - preparation
1. How familiar are you with the literature on clinical supervision?
not at all somewhat very

2. Have you attended lectures, workshops or other teaching/training events on clinical supervision?
many events a few events none at all

3. Are you satisfied with this level of preparation?
no uncertain yes
Comments_____

B - giving supervision (in past 6 months)

1. How many *hours per month* have you spent giving clinical supervision to others?

2. How many people have you provided clinical supervision for?

no. seen as individuals no. of groups no. of people per group

3. How many *contacts per month* have you had providing supervision?
(count a group as one contact)

4. Please indicate the professions and genders of these supervisees, and whether you also manage them. Use ticks or numbers.

I supervise	I manage	gender	profession
❑	❑	m/f	assistant psychologist
❑	❑	m/f	trainee clinical psychologist
❑	❑	m/f	other trainee (please specify)
❑	❑	m/f	clinical psychologist
❑	❑	m/f	counselling psychologist
❑	❑	m/f	counsellor
❑	❑	m/f	CPN
❑	❑	m/f	other mental health team member (please specify)
❑	❑	m/f	other (please specify)

Comments_____

C - receiving supervision (in past six months)

1. How often have you received supervision?

2. Who provides your supervision? Please indicate status and gender.

❑ peer(s) m/f
❑ senior colleague (clinical psychologist) m/f
❑ senior colleague (not clinical psychologist) m/f
❑ manager (clinical psychologist) m/f
❑ manager (not clinical psychologist) m/f
❑ external consultant m/f
❑ other (please specify) m/f

3. Please indicate if you have individual or shared supervision.

❑ individual
❑ shared with one other
❑ small group (three or four plus supervisor)
❑ other (please specify)

4. How much choice did you have in the selection of your supervisor?

❑ none - imposed by organisational structure
❑ none - no alternatives available
❑ limited choice offered among alternatives
❑ free choice from wide range

5. Do you discuss any issues arising from the supervision *you provide* in any of the supervision *you receive*?

❑ no
❑ yes - please specify

6. Are you satisfied with this amount of supervision?
would like more satisfied would like less

Comments_____

D - teaching, training, supervising others to carry out supervision (in past six months)

1. Have you been involved in any of the above activities?

❑ no
❑ yes – please specify

2. Are you satisfied with this degree of involvement in these activities?
would like more satisfied would like less

Comments_____

Thank you for your time. Please proceed to part II.

Part II
The Delphi Survey

Your thoughts and opinions regarding clinical (case) supervision
Six areas of interest are indicated below. They have been selected following discussions with supervisors and supervisees from various psychotherapeutic professions, and consideration of the literature. Please write as much or as little as you wish to indicate your own views of them. Both general observations and specific examples will be welcomed. In addition, please identify, as briefly or fully as you wish, any other important aspects of clinical supervision.

1. **Clinical supervision and training**

Whereas all the psychotherapeutic professions require supervised practice as a component of initial training, there are differences in requirements for post-qualification supervision. Some professional bodies require supervision to continue throughout the practitioner's career (1,2), as a condition of registration; others do not. What do you think about this?

2. **Clinical supervision and management**

Within the NHS there is an increasing emphasis on accountability and professional monitoring of all kinds (3,4). The relationship between such issues and clinical supervision is seen very differently by different groups, with some insisting that clinical supervision must not be offered within a managerial relationship (1), and others perceiving managers as the most appropriate providers of all supervision (5). What do you think?

3. **Models of clinical supervision and psychotherapy**

Early psychotherapeutic models saw supervision and therapy as similar or even identical processes. Some practitioners still adopt this position, on the grounds that the best way to support the therapist's work is by offering psychotherapeutic help with the emotional problems raised by it (6,7). Others differentiate the activities by keeping the supervisory focus on the client, rather than the worker. Within this group, some supervisory models are therapy-specific (8,9) while others can be applied to any psychotherapeutic endeavour (10,11). How do you see the relationship between the two activities?

4. **Ethics and clinical supervision**

Clinical supervision is widely seen as having an ethical function (11,12), and supervisors may be required to pass or fail trainees (11), or point out to supervisees that their preferred models of working are not the most appropriate for the client (13), or challenge unethical practice (12,13). Supervisors vary in the amount of time and attention they give to teaching or monitoring ethical matters (12). What do you think?

5. **Continuing professional development (CPD) and clinical supervision**

Within various divisions of the BPS there is currently intense activity devoted to the development of guidelines and policies concerning CPD. Recommendations from the DCP (14) locate clinical supervision within CPD. What is your view on the relationship between them?

6. **The professionalisation of clinical supervision**

At present, no clinical or psychotherapeutic training program requires its supervisors to be trained in supervision, and it is frequently assumed that a qualification and experience in practice is a sufficient basis for offering supervision (15,16). Neither supervisor nor supervisee will necessarily have received any teaching about supervision. What do you think about this?

Any other comments?

The final report will be available in July 2000. If you would like a summary, please underline this sentence.
If you are willing to be named in the acknowledgements, please underline this sentence.

Thank you for your time and help. Please return this questionnaire in the supplied prepaid envelope.

References

1. BAC. (1996). *British Association for Counselling code of ethics and practice for the supervision of counsellors.* Rugby: BAC.
2. DCoP. (1995). *Guidelines for the professional practice of counselling psychologists.* Leicester:BPS.
3. Milne, D. (1998). Clinical supervision: time to reconstruct or to retrench? *Clinical Psychology and Psychotherapy, 5,* 199-203.
4. Hughes, L. & Pengelly, P. (1997). *Staff supervision in a turbulent environment.* London: JKP.
5. Kohner, N. (1994). *Clinical supervision in practice.* London: King's Fund.
6. Edwards, D. (1997). Supervision today: the psychoanalytic legacy. In G. Shipton (Ed.), *Supervision of psychotherapy and counselling,* pp.11-23. Buckingham: OUP.
7. Henzell, J. (1997). The image's supervision. In G. Shipton (Ed.), *Supervision of psychotherapy and counselling,* pp. 71-79. Buckingham: OUP.
8. Patterson, C. H. (1997). Client-centred supervision. In C. E. Watkins, Jr. (Ed.), *Handbook of Psychotherapy Supervision,* pp. 134-146. New York: Wiley.
9. Fruzzetti, A. E., Waltz, J. A. & Lineham, M. (1997). Supervision in Dialectical Behavior Therapy. In C. E. Watkins, Jr. (Ed.), *Handbook of Psychotherapy Supervision,* pp.84-100. New York: Wiley.
10. Hawkins, P. & Shohet, R. (1989). *Supervision in the helping professions.* Milton Keynes: OUP.
11. Holloway, E. (1995). *Clinical supervision: A systems approach.* Thousand Oaks: Sage.
12. Carroll, M. (1996). *Counselling supervision.* London: Cassell.
13. Feltham, C. & Dryden, W. (1994). *Developing counsellor supervision.* London: Sage
14. DCP.(1998). *Guidelines for continuing professional development.* Leicester: BPS.
15. Mander, G. (1993). Dyads and triads. Some thoughts on the nature of therapy supervision. *Journal of the Institute of Psychotherapy and Counselling, 1,* 1-10.
16. Allen, C. & Brazier, A. (1996). Support for clinical supervisors: from training to play space. *Clinical Psychology Forum, 87,* 37-39.

Appendix III
Covering letter and description of methodology in round one.

PLEASE READ THIS – IT TAKES ABOUT THREE MINUTES

Dear

Congratulations! You are hereby declared an expert in clinical supervision, and as such are most cordially invited to be a participant in a Delphi survey on that topic. For those unfamiliar with the Delphi method, details are overleaf. The survey forms part of a research project I am undertaking for the Doctorate in Clinical Psychology based at Salomons.

My presumption in terming you an expert is based on your publications, or your professional status within the BPS/ DCP. I am writing to about 70 clinical psychologists identified in these ways. I may well have missed someone whose opinion might be influential, so if you know of another clinical psychologist who has a special interest or expertise in clinical supervision, please extend this invitation to them.

The topic is one of enormous interest in the profession at present. In becoming a participant, I hope you would enjoy adding to the development of this area of professional activity, assisting in devising a useful way of collecting important information, adding to your knowledge of how your professional peers are thinking, and seeing how your own views are located in that thinking. Further, I hope to publish the findings, so you may have the added pleasure of knowing your opinions contribute to the cutting edge of the profession's views.

I do hope that you will agree to participate, and I look forward to the pleasure of working with you. You can opt in by returning the enclosed forms. PLEASE RETURN THEM BY 28 MAY. If you would like to take part but cannot manage this time limit, please contact me – I am sure we can work something out.

Thank you very much for your time.

Brenda Roberts, B.A. Hons., M.Sc.
Chartered Clinical Psychologist

researcher's home address
telephone
email

researcher's work address
telephone

Delphi surveys

Delphi surveys differ from conventional surveys in a number of ways. Participants are not anonymously or randomly drawn from a target population, but selected either because of their general expertise in the topic under investigation or because they may be able to offer a particular minority view. Participation requires not the more usual one-off form-filling session, but three separate and distinct rounds. The survey instrument is not pre-written, but constructed after round one, the initial consultation of the participants.

The first round asks for your opinions on the topic in a fairly general way, encouraging you to identify the issues you believe to be important and to comment freely on the issues offered. A questionnaire is devised from this information, and this questionnaire, constituting round two, is sent to participants a few weeks later. The responses to the questionnaire are collated, and you are contacted for the final round with information concerning the range of received responses, and how your responses relate to this. Participants are not given any means of identifying any individual's opinion except their own. You are invited to amplify or amend your responses in any way you see fit as a result of seeing how they relate to the consensus.

If you would like more information about Delphi surveys, there is a good chapter by Linda Stone Fish and Dean M. Busby, called 'The Delphi Method', in Research Methods in Family Therapy, edited by Douglas H. Spreckle and Sidney M Moon, published by Guilford Press, New York, in 1996. Alternatively, you could look on the internet on www.ncbi.nlm.nih.gov/PubMed/, which will give you more information than any reasonable person wants to know.

If you would like more information about this project, or about me, please do contact me – details at the top of this page – or my supervisor, Margie Callanan, at Salomons – details overleaf.

Appendix IV
DQ1 responses

Clinical supervision and training

1. Some clinical psychologists do very little work that would be called therapy, so I'm not sure that it should be a requirement for registration. People who practice as therapists should have supervision. Given that recent paper in Forum that suggests clinical psychologists are particularly stressed by professional self-doubt, most would probably opt for more supervision if offered & validated by the professional culture. Psychologists on the whole seem to value doing it more than having it!

2. I think it is essential, but if it is made a condition of registration, the registering body should also facilitate it, for example, by accrediting supervisors and publicising a list of their names. In the NHS context, it would need to become mandatory through the 'clinical governance' route to be achievable.

3. I do believe supervision for all psychologists (whatever grade & experience) should be a mandatory requirement & that the ideas underlying life-long learning needs to be incorporated. For too long, senior & mature qualified psychologists have got away with little or poor supervision. Personally, as a way of compensating for this problem, I write professionally & therefore keep up to date via recent articles, chapters, etc.

4. (panelist has underlined the phrase 'condition of registration'). A good idea. I think 1:1 is good but also that access to additional group/peer supervision is important to get a wider view.

5. (panelist has underlined the phrase 'throughout the practitioner's career'). It is desirable for many, & not necessary for others. I have reservations about requiring it for all. Far more important, in my view, is the fact that clinical psychologists in the U.K. are not required to have a personal therapy. This, I think, really should be a requirement in order to practice.

6. I think it's an excellent idea in theory in that it would provide support for those who want supervision throughout their career and may currently meet resistance in their attempts to get it. However, supervision may refer to a wide range of activities including 'keeping an eye on' people and supervision as a requirement could result in some sterile or even destructive supervisory relationships i.e. it might be more effective to focus on attitude change within the profession rather than a change of rules.

7. Definitely think supervision should be part of regular CPD

8. I think continued supervision is essential at all levels of the profession. I'm not sure whether it should be a condition of registration though. However, I think we need to pay a lot of attention to the type and quality of supervision & in particular whether supervision is available within the model in which one practices. This is often more difficult, especially in a small dept, & therefore would raise problems for any condition of registration.

9. I agree that supervision should continue throughout the practitioner's career. I would be happy if this were to be a condition of registration. But there are substantial training and resource implications. Poor quality supervision can be destructive and demoralising for supervisees. The evidence base for supervision efficacy needs to be addressed.

10. Compulsory supervision is as useful as compulsory therapy. If I wanted to insist on people doing things I'd join the armed forces. I employ people who want to learn and develop. We all have supervision (all 51 of us) because we value it.

11. In my opinion every individual who works with people one-to-one or in groups in a counselling or therapeutic role should receive supervision throughout their career. I believe that not to do so is at best unprofessional and at worst positively dangerous. For me this holds true whatever approach the practitioner is adopting. As Masson says "the ways that a therapist can harm a patient are as varied as they are in any intimate relationship", but I would suggest more so given the power differential. The recent case of Peter Slade demonstrates in a horrifying way how much damage can be caused by unmonitored practice. (Additionally I am a strong advocate of personal therapy for practitioners).

12. Agree – seems anomalous that it is compulsory for counselling, but not clinical, psychologists.

13. I would regard some sort of supervision as essential although I am not clear in my own mind what sort of supervision it should be. I feel that different tasks require different supervision.

14. I think supervision should be seen as an integral part of all clinical psychologists' ongoing development throughout their career. I also think it should be as a condition of registration because then it would be easier to monitor practice and trainees would be more likely to be part of a fairer and more equitable system when it came to placement experience. I'd even go as far as saying mandatory attendance at least one supervision workshop a year should be stipulated by the BPS.

15. I think that it is important for all professionals working with people with psychological difficulties to have supervision of their work. It seems to me that supervision fulfils a number of important functions for both the safety of the client and the wellbeing of the therapist that cannot be adequately met in other ways. Of course this is the bottom line – the issue of quality is also important and it seems to me that the quality of therapeutic work is also dependent upon supervision and a space to think – supervision is not only about learning, but about monitoring, reflecting and developing.

16. I believe supervision should be an ongoing process. Records of attendance should be available for registration procedures.

17. Supervision throughout one's career is good practice and is certainly encouraged (though not required) for clinical psychologists. If we get statutory registration I would expect it to become a requirement. There may be some difficulties for Heads of Services in finding appropriate supervision, however.

18. More should be available for trained staff. Peer co-supervision is my preference. having had a traditional mode of psychotherapy supervision in the past I think that the danger with hierarchical supervision within one style or ideology is anti-democratic and constraining. Co-supervision is more likely to be democratic and non-judgemental about ways of working with clients.

19. I think continued supervision should be mandatory on clinical psychologists.

20. I support the idea of continuing supervision throughout a career, and I think it should include direct or indirect observation.

21. I believe that supervision from a suitably experienced person is invaluable to maintaining skills and developing them further. I do think that the role of a clinical psychologist is very varied and that different aspects of the task may require different sorts of supervision, not necessarily all held in a single person. At a certain level of seniority/experience I feel the term consultation is more appropriate than supervision.

22. I think all professionals involved in clinical practice and private psychotherapy work should have this as part of their practice requirements for all the time they continue to practise their skills – NO MATTER HOW EXPERIENCED OR WHATEVER THEIR POSITION WITHIN AN ORGANISATION. I also think this should be a requirement for professionals involved in Clinical Research, particularly in the light of 'the Peter Slade' case.

23.Principle of continued supervision throughout the career v. easy to defend on grounds both of CPD for the psychologist and quality assurance for the public (eg malpractice often associated with professional isolation, lack of accountability, etc). Much harder when it comes to practicalities:

a) how much? Min. dosage to make a difference v. unwarranted time out of direct service activity.
b) in what form? Expert, peer, group, part of research programme etc.
c) to what purpose? – skill development, support, specific project, variety of legitimate goals whose achievement could be audited.
d) how policed? Self-report, demonstrable outcomes, professional monitoring, etc.

24.I think it depends, in part, on the therapeutic stance of the clinician, for eg a pure CBT approach, because of its reliance on technique over process, may need less ongoing supervision. When one is working with process, the containment & accurate interpretation of transference & countertransference necessitates, in my opinion, clinical supervision. I think it's more about approach than professional allegiance.

25.In principle this is important to ensure standards etc. However, achieving this, particularly as practitioners become increasingly experienced is difficult to achieve. In order to do so, a form of peer consultation may be most helpful.

26. I consider it essential that supervision continues throughout the career. The requirements will vary depending on nature of work, models used for psychological intervention, stage of career etc. Its important that supervision is still available for senior/experienced people. I am in favour of it being a requirement for registration (if we ever get this).

27. Supervision should be ongoing throughout a person's career but nature and extent might vary. It should always be at least monthly and should cover not only individual work but also intervention in systems/teams/planning/research etc. Where there is no-one locally working within the specialism then this supervision should be arranged externally. There should be a requirement for ongoing CPD activities. Depending on stage of career, these may involve training and/or contribution/attendance at professional/specialist conferences etc. & continuing acquaintance with research literature.

28.Continued supervision is essential to help one develop one's skills & reflect on one's practice.

29.Good idea to continue in some form of supervision/consultation for the duration of one's career.

30. I feel supervision should continue throughout one's career.

31. Supervision is not only a major training and employment component in pre-qualification years, but throughout the professional career. The nature of the supervision changes depending on the level of training input required for each Psychologist or Therapist. However, it should be noted that even though those at the highest levels are Grade B and for Consultants they also require time for discussion of their cases. It is not also solely with casework. The ongoing CPD, administration, budgeting, auditing, personnel matters, also need to be taken into account on a regular basis. At senior levels this may well be at a peer debrief level, but where there is greater discrepancy between supervisor and supervisee, it may be that sometimes attendance at client and management interviews is necessary. I know this last has caused particular problems with those who believe that something special happens in the therapeutic interview, which cannot be interrupted by another member. This is fraught with difficulties because there are more things happening in an interview than are going to be passed on in supervision. Furthermore many patients and clients are used to the idea if a third person, as student or Trainee, sitting in on the interview to preserve quality. Unfortunately, I sometimes think that secrecy about the actual interactions in the interviews is preserved under the guise of it being 'confidential'. Good practice requires openness where possible without jeopardising the rights of the family involved.

32. It all depends on what you mean by supervision. Everyone should check out their thinking with peers. Managers have to keep in touch b/o their responsibilities on behalf of employers.

33. Probably OK. Many of us go overboard. We are in danger of becoming like social workers.

34. I view good supervision as essential therefore would support it being a condition of registration

Clinical supervision and management

1. With appropriate negotiation, I think clinical psychologists can be managed by their psychologist line-manager. However, managers may not have the same or greater level of psychotherapeutic expertise as their managees. Feedback from my speech therapy supervisees suggests that, especially for those with a management role within their own department, an external supervisor is far preferable. My conclusions would be:
a)There should always be the option of not having your manager as your supervisor.
b)More senior or specialised staff will need personally tailored supervision arrangements.
c)Within clinical psychology, the manager is rarely equipped to offer clinical supervision to all his/her specialised managees.

2.The distinction is not as simple as 'clinical' versus 'managerial'. Anyway, what is clinical supervision? – there is no accepted model. Is it about case management, personal development, quality assurance... A manger can (& should) supervise some aspects of clinical activity but should not be the one to provide a safe place where difficult feelings & dilemmas are shared unless the supervisee so chooses. I think, in some ways, it would help to abandon the word supervision (which covers everything from telling a new trainee what to do, up to helping a colleague to reflect on their feelings about a client) and talk about functions:

a) case discussion
b) skills development
c) emotional support
d) clinical governance etc.

They may all happen through supervision, but all can happen in other ways too.

3. In my view, managers do not possess the appropriate skills & competence of professional monitoring activity and clinical supervision. Managers are there to manage & ensure that appropriate & adequate systems of quality supervision time is available to the people they manage!

4. Depends on the situation & the people involved – Flexibility could be useful.

5.Ideally clinical supervision is completely separate & with someone other than the line manager.

6. I think clinical supervision is best provided by someone other than a line manager. I have had supervision from a manager which has been 'good enough' although I still felt burdened by the need I felt to make a good impression, appear competent etc. I have heard endless horror stories (especially from other professions) where clinical supervision from a line manager who often has no training in supervision has not been worthy of the name. Even the best supervision from a line manager is always open to abuse in terms of boundary violations which would be far less likely to occur in the same way if the supervision was provided from elsewhere. I can't think of a good reason for having supervision from a line manager – usually saving money is part of the reason why it does happen.

7.Definitely not managerial supervision it should be external and non-threatening! Managers can add to supervision with their own clinical experience but shouldn't be a sole supervisor. Managers should have sufficient information to know a safe and effective service is being provided but this could come through case audit.

8. Again, I think that this is going to depend on size & organisation of the dept. Where choice is available, I think supervision by a more experienced psychologist is highly desirable. However, if possible this shouldn't be a manager as I think this makes or could make it harder to disclose personal difficulties with clients or other issues that might (or you might perceive) affect career development. Supervision needs to take place within safe boundaries and a manager may not be able to provide these because of a potential conflict of interest between supervisory role & managerial role.

9. Ideally I would like to separate the managerial function from the clinical supervisory function. However I do not practice what I preach. We have a small service and I have quite a lot of experience of both managerial & clinical supervision and this can result in rapid implementation of supervisee needs. However there are dangers and it is important to ensure that clinical supervision is available from non line managers.

10. As a manger I also supervise various of my staff who have requested it. We explore briefly the power/trust issues. I don't offer this supervision unless requested. In other parts of the Trust managers claim to be supervising staff work. This seems more like case management.

11. In general I feel that clinical supervision should NOT be offered within a managerial relationship because the additional power differential must inevitably inhibit free and open communication on the part of the supervisee. Having said that, I do personally receive supervision from my manager for one particular circumstance. He supervises me specifically for my supervision of clinical psychology trainees. This was at my request and, I felt, appropriate due to the parallels in the power relations. I've found this invaluable, and also use some of my time in other supervision arrangements to receive supervision for my supervision of other mental health workers.

12. Depends on the manager! My manager supervises me & I'm quite happy with this, but I feel it could be problematic with a lesser manager.

13. I am strongly of the view that management and supervision can and should be separate. While the manager may be appropriate to some personal development and suchlike I think there needs to be a separate and independent source.

14. I don't think we can adopt an either/or position on this. it's more like an 'and' position. Some clinical psychologists because of the way departments, services, are organised will have to do both or receive supervision from their manager. What's important is that a clinical psychologist is in a position to develop as a result of being in a good supervisory relationship. When clinical supervision's offered within a managerial relationship the 'contract' around that piece of the work and the relationship must be explicit.

15. I think that this is dependent upon many things and that it is hard to have clear rules about it however I think that it is to deny the power imbalance in the supervisory relationship to suggest that supervision does not include management. It seems crucial to me that supervision has some management functions (monitoring professional practice, the well-being of the client, etc.) This needs to happen whether the supervisor is the manager or not. However supervision is about much more than management. It seems to me that the 'personal style' of a manager is important – if they are able to address the management functions of supervision sensitively – allowing space to think and reflect etc...etc... I see no problem with them supervising the people they manage. I can see more of a problem in a supervisor who is unable to address the monitoring issues raised by supervision.

16. In the ideal world I think managers should avoid providing clinical supervision, but practically in the NHS this is necessary. I provide both to junior staff because I have no competent senior staff to supervise. I pay for external clinical supervision for some 'difficult' senior staff.

17.I think it should be flexible. We have identified 3 kinds of supervision.
a) technical/casework
b) managerial
c) personal (including personal therapy)
Not all may come from the same person or even within the same service.

18. Yes clinical supervision should be separated from managerial accountability (whether or not the latter occurs via supervision meetings).

19.There should be an option to have clinical psychology supervision outside of the managerial relationship. It is, of course, already an option if you wish to pay for it, but there are risks/complications with such an arrangement.

20.Dual relationships are problematic. Generally speaking I think that clinical supervision should be provided independently but clear contracting should identify differential responsibilities.

21. My perspective on this varies. I have felt able to consider the tasks of management and clinical supervision as separate when undertaking these tasks with 'junior' colleagues. Maybe I have been fortunate in that there have not been great conflicts in this, and in some ways it has been beneficial. Knowledge of someone's clinical work, style, and intervention can impact on their caseload management etc., and is also helpful in addressing aspects of professional development. From my experience of being 'managed' I have rarely felt well supported/challenged, but usually found that 'supervision' was simply an opportunity for me to update and feedback what had been happening in my area of responsibility. For the past ten years, I have rarely used (or been offered) clinical supervision by the person in this position – I have therefore chosen to seek this from people I have felt had the necessary level of skill and experience to help me with complex and difficult cases/situations, or had particular training that I wanted to draw on. However, had my manager been able to offer this, I am sure I would have wanted to avail myself of their expertise.

22.I think there is a difference between supervision of clinical work + management supervision of a person's job. This distinction becomes more acute, I think, as one progresses from trainee to experienced clinician. Supervision may involve: personal reflection on a case; the need to develop specific skills; space to consider personal difficulties; opportunities to reflect on the work within an organisational framework; + sometimes the chance to 'moan + groan' + say how awful/how good/ how exhausted one feels. Management should be just that: time management; target setting; goal setting; objective assessment of role.
PROBLEMS WITH 2 PERSON SPLIT – 1 TO MANAGE, 1 TO SUPERVISE?
However, the split does invite an automatic conflict: what if clinically a person's practice is dreadful but they 'shine' in front of a manager? Or what if a clinical supervisor gains personal knowledge known to be affecting practice? Or learns about abusive issues? To whom are they accountable? Particularly if supervising someone outside of their profession. Are they being set up to collude with poor practice??? Also what if the clinical supervisor and manager don't get on?
PROBLEMS WITH 1 PERSON 'MANAGING' AND 'SUPERVISING'
Power imbalances. How 'truthful' would we be in sharing our weaknesses if we know that person is responsible for our promotion? It takes a WELL-SKILLED + SENSITIVE PERSON to be able to manage such a role. Do we need training in managing DUAL RELATIONSHIPS?

23.In small departments or geographically isolated settings where a range of supervisory options is not available, it is v. wasteful to 'outlaw' line mangers offering supervision from their juniors. There may of course be tensions that stem from this 'dual relationship' but there are other ways to manage potential difficulties (ground rules; alternatives when necessary; candid negotiation) without employing a blanket ban.

24. I have had excellent supervision from supervisors who have also line managed me. I think the conflict which might arise is something to be 'processed' rather than avoided. That said, I feel a supervisee should have some say in who supervises them, it should be someone they are 'clinically compatible with', their manager may not be the most appropriate clinician in the team.

25. Neither of the above are cut & dried. Depends on needs of supervisee and abilities of the manager. As someone who, until recently, managed a child psychology service, when clinical skills of another senior member of staff were more appropriate, then they provided clinical supervision. Similarly on rare occasions supervision & advice re: appraisals were sought from outside e.g. neuropsychology. However, so long as the 2 relns were clear and discussed both appeared possible with same staff. For more senior staff clinical supervision focussed on general principles and was generally a twoway learning experience.

26. I have mixed feelings about this one. For small professions such as clinical psychology, it may be that the most relevant clinical supervisor is also in a managerial role. Ideally, managerial roles & clinical supervision would be kept separate.

27.In clinical psychology I believe supervision can and should be offered within a managerial context. Clinical governance requires that we are all accountable for everything we do – this is a good thing. I find the idea of supervision divorced from the managerial relationship is a rather precious notion. However, the supervision must be provided by a clinical psychologist. If the manager is not a clinical psychologist then separate supervision should be organised.

28.This will often depend on the profession's hierarchical structure. In psychology the structure is fairly 'flat', & thus I do not see any conflict of interest wrt to this issue.

29. I think there are (at least!) two kinds of supervision: a) managerial and b) external/clinical.

30. I think it depends on the situation. Clearly managers need to be aware of the activities of people they line manage. Sometimes they will also be the appropriate person to offer clinical supervision. It should also be open to a clinical psych. to choose an alternative clinical supervisor, but contractural & financial considerations may be a limiting factor.

31. The huge variation in terms of contract, work circumstances, professional links, because the psychological and related disciplines are huge there does seem any reason why there should be simply one model, which must apply to all of these relationships. Accountability and professional monitoring are of course necessary in order to give the public some confidence, and to justify our profession and service delivery. I am sure we would all hope that this would lead to improved standards of patient care and quality as well as cost effectiveness. Heads of Department and Consultants are usually not provided with supervision by their own profession, but by managers who are within the hierarchical line. At all other levels, it seems appropriate that their own profession does the supervision and I am not averse to the person providing the supervision being the Line Manager. Clearly there will be some departments which will prefer to have a non-line management line of supervision, but this should not be seen to be an excuse for collusion or secrecy. The standards of supervision must be maintained and they need to be open to scrutiny by Line managers and the public agencies, and if necessary the clients and public involved.

32. Given such small groups of staff, it would be a luxury to separate the two even if it is desirable.

33. Makes no odds unless you don't trust your manager.

34. There should be a clear distinction between the managerial relationship and the supervisory relationship. I do not believe they can be carried out by the same person.

Models of clinical supervision and psychotherapy

1. I would follow Hawkins & Shohet's argument that issues may be brought to supervision for a range of reasons, from lack of technical knowhow to 'I hate this patient'. I believe the focus of each supervision episode should be negotiated and that a range of models are likely to be helpful. However, to muddy the water, that's also what I think about therapy! In terms of supervision focused on the trainee's 'stuff':

a) This can be abusive, especially if you also have an ordinary relationship (eg eat lunch or sit in meetings with) your supervisor
b) It can be helpful if i) negotiated ii) brought back to direct clinical relevance before ending
c) Other roles eg examiner will impact on this.
d) There is an issue about whether you see the emotional issues raised by the work as psychopathological, ie requiring therapy, or as illuminating the case in an educative way, or as normal stresses requiring validation, self-disclosure from the supervisor & support.

2. The main focus should be on the client, but I follow Shohet & Hawkins' idea of needing to work at different levels (client, client/therapist, therapist/supervisor etc) at different times. Ideally, the supervision should use similar methods to the therapy, though I've found that a 'mis-match' of orientation in supervisor & supervisee can be stimulating sometimes.

3. So, what's in a name? Problem solving is the key in an objective fashion. Important not to make any party feel belittled, or to thrust on him/her a view with no proven basis. Open honest appraisal is good, which is nonthreatening & not punitive.

4. Often enough for it to be an issue, supervisees bring stories about their clinical work which are full of their own feelings and personal issues. When I feel these personal issues are significantly interfering with their clinical effectiveness, I suggest they explore them with their personal therapist – not with me. My only function is in naming them – identifying them as personal issues which should be explored in their own therapy. It's akin to running a flag up a flagpole, and it is then up to the supervisee to take appropriate action.

5. I see supervision as distinct from therapy in that in supervision the client is at the centre of the work while in therapy it would be the self/worker. However I see no problem with exploring the impact of the client on the therapist in supervision – but would understand this in terms of countertransference. Where someone wanted to explore their countertransference beyond acknowledging it and relating it back to the client I would indicate a boundary. If countertransference (which sometimes is not the client impacting on the worker but maybe the worker's own issues intruding) were not explored in supervision I feel an extremely valuable source of information would be lost.

6. Much of my supervision takes in client focussed issues but personal ones do come in as relevant where they may enlighten the process.

7. I do not see supervision and therapy as identical processes. However, I do think that the supervisory process needs to take into account interpersonal issues in therapy. The main focus of supervision should be on the client within a particular model but then one needs to pay attention & analyse personal reactions or feelings. Ideally, a good formulation should be able to predict, or at least explain the interpersonal issues. I have recently become much more aware of the importance of addressing interpersonal issues in therapy during supervision, as a result of attending a workshop last summer on interpersonal issues in CBT.

8. I am concerned about potential power imbalances when the supervisee is seen as the recipient of therapy. I am more comfortable with an educational model where supervision is seen as consisting of a range of skills, competencies, knowledge based on good quality evidence. Essentially supervision should be seen as an integral component of the curriculum of training.

9. Semantics dear, all semantics.

10. My influences are psychodynamic and Gestalt. For me the supervisory focus is on the space connecting the client and worker and, thus, on both parties. However, when I feel that the worker has a substantial 'unresolved issue' I don't feel it's my role as supervisor to resolve it for them. In that circumstance I will suggest to the worker that they take that issue to their therapist. In the past I have recommended to workers to seek personal therapy if they don't already have a therapist, and I've found this works well. Having said all that, I definitely don't see the distinction between supervision and therapy as black-and-white, but rather as flexible and flowing in a considered and careful way.

11. Should be notionally separate, but inevitably some overlap

12. I see supervision as broader activity than some of the therapy-specific ones.

13. There is a relationship, it depends on emphasis ie I don't think you can dismiss the client or the worker. I'm more along the lines of integrating the process issues with the theory with the people concerned in the work. A more social constructionist view would be looking at the meaning of the dialogue between all parts of the system.

14. I consider that supervision and therapy are two separate activities but that supervision does have some functions that are common to therapy – such as offering support and the chance to begin to think about personal issues raised by the work. it seems important that supervision begins with the work – rather than with the personal issues of the therapist. It also seems important that it is limited and, that if the personal issues, raised by the work are thought about only for the supervisee – rather than to feed back into the work, then a boundary has been stepped over. I think that it is a particularly difficult issue for a profession that has no requirements for personal therapy. I feel that ideally supervision should be able to highlight issues that need to be taken away and worked on elsewhere, and to offer support through this process. This is difficult if the supervisee has nowhere else to take these issues.

15. I am aware of supervision/therapy interface + if concerned would suggest the person gets therapy. The area is difficult, but can be managed sensitively. people are concerned if their supervisor is their manager + this can cause problems, + issues are not raised, or denied.

16.The more 'technique' based a therapy, the more technical supervision can be. There is a need for more personally supportive supervision, especially where the dynamics of therapist/client interactions are the main vehicle for intervention. Also people need general support for the stresses and vagaries of both working and personal life.

17. Supervision should be client-focused – feedback (n.b. not therapy) is sometimes central to highlighting the therapist/client interface + whether or not this is enabling the client. Practices which are technically inefficient or unethical will disable the client thus clinical supervision is a check on these problems.

18. I see supervision as focusing on the relationship between therapist + client, though in earlier phases of supervisee development, and in certain areas of work, there is more of a client focus. Whatever, the purpose of supervision is client focused. It can be therapy like, supportive etc., especially if focused on projective identification or transference/countertransference, but is distinguishable from therapy.

19. In supervision the focus is on the work but can address self in work (and should). If a 'block' is identified the supervisor should help the supervisee to decide on an approach to handling it in a more appropriate relationship. Supervision is about

- ❑ client welfare
- ❑ learning + development
- ❑ restoration

20. I see these as quite different. In clinical supervision the supervisor has to be sensitive to relevant personal issues, emotional aspects that are raised by the work and the supervisee's use of self, the main focus is on the client/family. Clinical supervision also includes skills development, and suggesting reading. As a systemic therapist, I am also very keen on live supervision as a way of working, and helping people develop skills. reviewing videotaped sessions is also valuable in facilitating discussion of therapist/ client interaction that the supervisee wants to reflect on – whether it be something that they felt went well, or part of a session that was difficult. As manger/supervisor I hope to be aware of personal issues that might affect people's clinical work (eg recent bereavement, separation of a partnership) – and think with them about how such sensitivities can be dealt with. I see myself as offering support – but not psychotherapy. If I felt that therapy was indicated, I would discuss this with the individual, and offer any help I could in connecting them with a therapist outside the workplace.

21. I think that all of the above can be true, or partly true, + that it depends on the therapeutic + personal preferences of both supervisor + practitioner as to which is the 'best fit' for making them feel comfortable with the work. I don't think this is just a cop-out. We all hold strong personal reasons as to why we choose to hold certain therapeutic models as a way of working – whether it's based on life experience or 'research' findings – so why shouldn't the supervision process be the same. I like to think of the path to supervision as similar to the path to finding therapeutic integrity. In the early days, we need essential bread + butter skills, concrete things that work, but within a culture that values self-reflèction + honest + open criticism. Some of us may choose to stop there – to remain skills focused. Sometimes life deals a blow, or you find yourself working with someone who challenges the essence of your therapeutic skills. That's the time when you need more reflection + that's when the psychotherapy models seeing therapy + supervision as similar do come into their own. The most important factor would be a supervisor who knows how they work + comes across with supervisory integrity!

22.The tasks of therapy and supervision are very different. However there are evidently a number of transferable therapy skills (eg. alliance-building, assessment of competence etc) that are transferable from the therapeutic context into the supervision role. If you are clear you are conducting supervision not therapy, then using all your available skills + experience to achieve that task seems fine. Although there is something healthy about therapists applying their chosen psychological model of personal change to their fellow psychologists I much prefer to look for generic, educational models of the supervisory process to therapy-specific theories. Especially as the scientific basis for folks commitment to their therapy-specific beliefs (eg the need for personal therapy) is generally zilch!!

23.I think supervision, like therapy, has to monitor & shift its focus according to need (Hawkins & Shohet process model). Sometimes the focus needs to be practical, technique-based, other times it needs to look at process & other times at content (either for the client, the supervisee or the supervisor). I feel that there is an important, if blurred distinction between supervision & therapy. I think the process model of supervision may apply to any therapy – although the focus may partly reflect the therapeutic approach chosen.

24. As a systemic therapist I am always interested in

- ❑ effect of therapist/consultant/teacher on the process they are trying to affect, whatever the context, and will focus on this in supervision for some of the time
- ❑ feedback & how this affects therapists' learning and how they can use it most effectively
- ❑ feedback between therapist and client/group/organisation.

In this sense this model of supervision can be applied to any endeavour.

25. I consider the focus in clinical supervision is the client and the relationship between client & clinician. If these raise significant personal issues then this may signal the need for therapy, but this should be undertaken separately from the supervision.

26.The nature of supervision should depend on the nature of the therapy practiced. Cognitive & behavioural interventions have a different supervisory focus to psychodynamic supervision. However, supervision of other activities of a clinical psychologist must not be forgotten. Supervision of planning, team work, teaching, service development, research, consultancy work etc. all require supervision that is of a different nature to therapeutic supervision. Supervision should always be specific to the nature of the work conducted.

27. It depends on clinical model. I use & supervise within a CT framework. I find a great deal of overlap wrt the process features. Here are the features I use in both clinical work and supervision.

- ❑ goal setting
- ❑ use of feedback
- ❑ collaboration
- ❑ interpersonal features
- ❑ checking out emotions
- ❑ use of behavioural methodologies
- ❑ socialising to an appropriate & consistent conceptual framework
- ❑ homework & learning assignment

28.Psychotherapy is <u>not</u> the supervisors task. Personal issues may interrelate with professional issues and need to be dealt with in an integrative way. Different models suit different purposes.

29. I share Peter Hawkins + Robin Shohet's view that the important factor is the frame within which the work is done. As long as it is relevant to the supervisee's work with the client, supervision may comprise therapy, instruction, education, and/or facilitation.

30. I have strong views about the ethical relationship between supervision and so-called therapy. The supervisory relationship is professional between people of same or similar disciplines and is subject to all ethical guidelines. Patients are in deep distress and have gone out of their way to ask for help and for supervisees to ask for 'therapy' seems to me to be belittling the needs of our patients. If supervisees need therapy, they should not come to anyone in their professional line either of supervision or of management. They should seek individual help to preserve their anonymity, credibility, and confidentiality. Supervisors should refuse to be therapists to those they know in any professional capacity as is clearly underlined in most ethical guidelines. Patients require independent therapists, and I feel this should apply to professional colleagues as well. If the person undergoing supervision does not need therapy in the 'patient sense', they should not be seeking it as it belittles the often desperate needs of patients. They are not patients or clients in the therapy sense and may be solely undertaking it for passing the necessary accreditation criteria. This seems extremely unethical as they do not have, at face value, the same need of therapeutic intervention. Supervisors should not be encouraged to be both supervisors and therapists; it is a conflict of interest and professionalism. The cost (BAC says £1,200) may also suggest potential motivation problems and concomitant elitism.

31. I'm a registered CBT therapist. I use CBT in my supervision but I don't therapise supervisees.

32. Tenuous at most. Personally none. On reflection, it's impossible not to use your personal therapeutic skills during supervision. Maybe it's slightly stronger than tenuous.

33. Supervision can mirror the process of therapy. This can be useful to make overt. therapy techniques can also be very very useful in supervision eg identifying negative thoughts, assumptions and beliefs - Good supervision can model good therapy.

Ethics and clinical supervision

1. I think this is crucial. This may relate to the emphasis in modern family Therapy/Systemic Practice training on power & hierarchy issues.

2. Because supervision is indirect (ie you rarely observe the therapist & client directly) you may have no way of knowing about unethical behavior, so it is hard to take responsibility for it in a typical supervisee (who is qualified). In trainees the relationship is more formal & hierarchical & supervision can & should cover ethics.

3. Agree totally with the above views. I do not believe that supervisors give the necessary amount of time to trainees or offer adequate teaching in this area. The ethics as well as the politics of clinical supervision needs to be highlighted very clearly.

4. important. But depends on how it's done. I don't especially like it when people see themselves, personally, as 'moral guardians'.

5. To fail to monitor ethical matters is to be an ineffective supervisor. These issues cannot be shirked because they are difficult – they have to be faced.

6. I think that ethical practice is always a concern when one is supervising. However, when supervising a trainee I might feel more comfortable addressing such issues as they would be more explicitly on the agenda as part of the learning process. With a more experienced practitioner, it would be harder to address these issues. Actually I'm not sure about this; if someone's practice was deeply unethical they would probably avoid supervision or not mention the issue. if someone was inviting comment on their practice by seeking supervision on an ethical matter then I would expect myself to give them a response even if being honest involved being quite challenging.

7. the gate-keeping function is a problem in supervision and needs a lot of trust (which isn't always maintained) between supervisor & trainee. I don't see a lot of routes around it except to have access to additional non-gatekeeping supervision.

8. This question seems to be asking two different things – the ethics of how to practice, pass/fail issues but also presumably dealing with ethical issues in therapy. I don't see a problem over passing/failing provided you offer good, high quality supervision, monitor closely & give the trainee clear & explicit feedback with plenty of opportunities to rectify problems if there are any. Nor do I see a problem with supervisors working with a particular model (as long as it's empirically based) & expecting the trainee to work within this framework. For eg, I wouldn't expect a trainee of mine to work psychodynamically because the evidence base is poor and I am not competent to practice in this way so would not feel I could give adequate supervision. I do think we have a responsibility to challenge unethical practice.

9.Ethical issues are part of the broader training curriculum. As part of that, I would personally expect to, as a supervisor, and expect our supervisors to address ethical issues in practice where appropriate. We require feedback from trainees on the extent to which their supervisors address ethical issues.

10. can you name an 'unethical' matter. Supervisors need to be aware that all human conduct, be it therapy or child-rearing, has an ethical component. Clinical psychology is generally not very good here – 'ethics' seems to be a term wheeled out only when the Peter Slades of this world hit the headlines.

11. For me ethical issues should obviously be an integral part of the supervisory process, as should gender issues, power issues & so forth. They are just THERE! I feel VERY strongly that ethical matters are given far too little attention on training course.

12. This is <u>essential</u> but clearly often inadequate probably because of poor supervision training (or even non-existent!)

13. I think that it is impossible not to have an ethical dimension to <u>everything</u> we do! We must develop a more systematic approach to teaching + training in ethics generally.

14. I think we should have been paying explicit attention to this issue for years. Now in the age of clinical governance, audit and the like we really have to get our act together. Michael Carroll's (1994) Functions and Tasks model of supervision is one model that flags up monitoring, ethics and the gate-keeping function of supervision. As does Watkins Jnr (1997). I don't think the profession gives this enough thought so it's not surprising that supervisors and trainees don't either. A lack of clear perspective around the issue of ethics leads to many a dilemma within the supervisory relationship.

15. I feel that the monitoring of ethical issues is a crucial part of supervision. For many cases however it may be unnecessary to give a particular time to this, as supervisees, by and large monitor their own ethical practice. However what seems important is that this issue is addressed within the relationship and the implications for the power imbalance discussed.

16. I believe more time should be allowed in supervisor training to address this. In practice I do try to be aware of problems + challenge + report any problems.

17. Clear ethical standards must be the basic underpinning of competence and thus ethical issues should never be ducked. That is not to say that all issues are so clear cut that there is no room for a degree of debate or disagreement.

18.Let's not too carried away with the political potential of supervision. Unethical practice is multi-determined. Supervision is only one check on unethical practice. (For example, re sexual abuse, it might be more efficient to separate female clients from male heterosexual therapists than to rely on supervision to lower the probability of abuse).

19. Ethical issues should inform
- ❑ the supervisory process
- ❑ the therapeutic issues raised routinely in supervision and
- ❑ be a focal point of some supervision sessions

This is about patient care/ monitoring but also about professional development of trainees. There are good academic papers on this topic and research into the risks/dangers of unethical supervision.

20. This is important – needs careful handling. Also there are ethics specific to the supervisor-supervisee relationship.

21. Ethical issues around ?child abuse are reasonably frequent in the child & family context, and so feature regularly in supervision. I always try and include discussions about these with trainees. With qualified supervisees I believe I address ethical issues as and when they arise, and I think this is entirely appropriate. I endeavour to set up a sufficiently safe supervisory environment, where colleagues feel they can bring dilemmas and queries for discussion.

22. I think this is <u>essential</u>; part of what we try to give the people we supervise ought to be the ability to step back + reflect on the whys + wherefores of doing what they/we are doing. Otherwise, we might as well just be blindly applying leeches to bleed out badness; plunging people into cold baths or inducing shocks; or indeed burning people at the stake for that matter! Psychotherapy holds no more rights to virtue or omnipotence than any other hocus pocus that has been applied to the treatment of mental unhappiness + disturbance of the years. For that we <u>must</u> remain truly humble + as supervisors maintain a stance that allows us to look deeply into what we are trying to do.

23.A strong recent move in supervisor training workshops locally has been to put much greater emphasis on a range of ethical issues (informed consent, due process, improper professional relationships etc). Much better to develop trainees' awareness of these important matters in discussion of real-life dilemmas involving actual cases as opposed to writing essays on the topic. Much more likely to shape future practice. Most powerful influence is the supervisor as ethical role model in my opinion. However, slight problem is that previous generations of clinical psychologists may well not have been sensitised to relevant issues by their own training. Mind you a continuing commitment to your own CPD is just the sort of sound practice in senior practitioners with a sense of moral integrity?

24. I think it should be ever present & unethical practice always explored or challenged.

25. Probably is a neglected area. I do try to incorporate racial/cultural and ethics generally into supervision. Also professional conduct features highly, particularly with pre-qualifying students or trainees.

26.Its hard to generalise here. Ethical practice in forensic settings will be fairly key in supervision of trainee clinical psychologists. Clinical supervision with other experienced colleagues may not require such focus on ethical issues. These would be dealt with as they arise out of the material brought to supervision.

27.Current national policy requires professionals to be accountable for their professional endeavours and clinical governance requires professionals to be responsible for the work of their colleagues. Supervisors have a responsibility to challenge and , if necessary, report unethical practice in their supervisees (and vice versa). Ethical issues should always be a focus of supervision and should be seen as a central feature of teaching. Similarly the political consequences/implications of a psychologists work should receive attention both in training and in supervision. At present such issues receive too little attention.

28. This is a key feature, because part of the supervisor's role is as 'model' of ethical practice. Another important function is to act as a gatekeeper, ensuring good practice is routine. As such, it is essential the careful monitoring is carried out – we routinely employ video recordings to do this.

29. I think this is a problem

30. I agree this is (should be) an important function of supervision.

31. I am not so sure whether clinical supervision is widely seen as having an ethical function; this relationship is just as much subject to unethical problems as other professional interactions. Models of working add a further dimension to this as it assumes that often there is only one method that is acceptable within the supervisory relationship. Clearly this cannot be so, and the patient's needs may well cover more than one aspect. In many aspects of supervision, there has been no generic or integrative training and little debate is given to other methods in which either supervisor or supervisee are qualified. to me, this is unethical as it does not necessarily provide the family of a patient or client with the most appropriate intervention. Professionalism cannot exist without considering ethics, training, and future training. The needs of the patient are always greater than the needs of the supervisor or of the supervisee.

32. Not just an ethical function. A legal function, too, on behalf of the employer.

33. If you think anything has ethical implications, as a supervisor you raise the point – daft not to!

34. Time given on these issues depends on how relevant the issues are.

Continuing professional development (CPD) and clinical supervision

1. I think it has elements of CPD & elements of providing a good routine service. For example, I would see my peer supervision group as part of my routine practice, ie not CPD, and my Family Therapy training as CPD.

2. Supervision has several functions. It may contribute to CPD, but it may also have a function in other areas. If it was seen as only CPD, there would need to be some other form of (managerial) monitoring running alongside.

3. Agree that generic as well as specialist supervision should come under the realm of CPD activities. For too long, senior clinical psychologists have 'got away' with the bare minimum of qualifications of becoming a supervisor. They do not keep up with the changing nature and need of contemporary British society.

4. (panelist has underlined phrase 'clinical supervision within CPD) . seems fine as long as this doesn't mean other aspects of CPD (attending conferences, doing research etc) is left out.

5. I think this is a positive development.

6. I believe clinical supervision and CPD are closely linked. Supervision and other forms of CPD should be career long activities. Clinical supervision should be sought from different people and in different contexts thro' the career according to developmental need and the need for variety. I also believe there should be more recognition within the profession of the need for training in supervision and supervision of supervision. These developments are likely to occur as the profession matures and becomes more sophisticated in relation to supervision.

7. Yes!

8. Supervision & learning about supervision are an important part of professional development so it seems logical enough to locate it in CPD. Unless, of course, supervision becomes relegated or marginalised ie rather than being seen as a central part of everyday routine clinical practice & development. I haven't really given this issue much thought before so my ideas are not well developed.

9. In training, we would expect trainees, in addition to learning from their own experiences of receiving supervision, supplemented by teaching in making good use of supervision, to work indirectly with some clients. To the extent that this might involve consultancy/supervision of other professionals eg care workers or carers, we would see that as an opportunity to address supervision training prequalification. There has to be continuity pre/post qualification. Consequently DCP CPD initiatives should build on training and experiences prequalification.

10. Seems fair enough. Supervision should continue one's professional development after all.

11. No! Clinical supervision should simply be an integrated and accepted part of a worker's job, universally. For me, supervision is core. Obviously, I support CPD, but I see that as far more strongly influenced by individuals' interests, ways of working and learning, preferred styles, etc.. Hence I see CPD and supervision as separate and distinct activities – this I do see as black-and-white!

12. Clinical supervision + training for it should be a compulsory aspect of CPD. No supervision or training, no chartered status.

13. I would support the idea of supervision being integral to CPD.

14. (Not sure which relationship you mean. DCP with supervision and CPD, supervision of CPD or all of them). Anyway, for me supervision is just one way in which clinical psychologists need to be continually professionally developing. DCP, as part of the BPS, for me, should start making stronger noises about both CPD (I know it's doing that already) and supervision.

15. I consider that they are related as supervision is important in learning and development. If you consider this to be something that goes on continuously throughout our lives and work there is no problem about supervision and CPD being considered together. However, if CPD is thought about more narrowly (ie as something you do on discreet courses) it is problematic as supervision could then be seen only to be necessary when you are learning something new. Other important functions of supervision (ongoing support, monitoring etc....) could get lost.

16. I think supervision is only one aspect of CPD. People should not be allowed to see supervision as their only form of professional development.

17. If we define CPD as lifelong learning then supervision is clearly an important component of that process and of the maintenance and re-accreditation of competence. For some people it may also serve a more general personal support/ personal growth function.

18. it is one element. Others include: multi-disciplinary training; evidence-based practice updates; and updates on managing organisational change. An over-reliance on clinical supervision has the danger of experienced clinicians replaying their <u>own</u> custom and practices rooted historically in their own training and treatment ideology. CPD should allow post-qualification exposure to processes <u>not</u> rooted in custom + practice.

19. Supervision should continue not as development but as a requirement of basic good practice. But there is a CPD/supervision link in terms of supervisor training.

20. Appropriate location.

21. While supervision (if good) contributes to development, I see it more as fundamental to ongoing practice. Supervisors are in a position to have clear ideas about areas for CPD, which they may be able to address within supervisory time. I see CPD as a wider, longer term process linked to broadening skills and knowledge and fitting in with progression to higher levels of seniority and responsibility.

22. My first reaction upon reading this was, 'that's outrageous'. The reason is that 'CPD' is largely seen by many as 'optional' or indeed many Trusts may not necessarily hold CPD requirements as highly as we do! Yes of course supervision is part of our continuing professional development, <u>but</u> to lump it in the 'CPD' box is a wee bit dangerous. Clinical supervision is a category in its own right, overlapping but in part quite distinct from 'CPD' as in training courses held, maybe, once a month!

23. I'd like to see us move towards some agreed formal curriculum to prepare people for their supervisory responsibilities and to maintain competence/interest in the role. How about making completion of a supervisor training programme and systematic development of one's supervisory ability a condition of promotion to 'B' grade for all clinical psychologists? More realistically the CTCP criteria regarding supervisor training for basic training courses could be made more specific without becoming unhelpfully prescriptive.

24.I think it is interesting that as we become more experienced we are often increasingly involved in the supervision of others –often without any formal training in supervision. Whilst clinical experience is far more valuable than formal or theoretical knowledge the latter should not be neglected. It therefore seems highly appropriate that clinical supervision be incorporated into CPD.

25.If CPD is a given then perhaps clinical supervision should be located here. However in my view CPD is only one of the ways in which services should ensure quality of standards. Supervision is also a must, is ongoing and more on a routine basis, generally not focussed on a particular development need.

26. Regular clinical supervision is one component of CPD. It has many functions: reflecting, enhancing understanding, destressing, finding inspiration & ideas to keep clinical work alive, developing, planned & effective. CPD requires considerably more in addition. This requires the development of knowledge & skills required for work whose demands change & evolve throughout the career. It helps a person give their best to their service & develop their career opportunities with that job & for other jobs.

27. CPD should be part of IPR and of supervision. Supervisors should keep abreast of developments in their area and ensure supervisees do likewise. This is a requirement of clinical governance. Similarly, given current directives, the evidence base of practice should be explored in supervision.

28. This seems to make a great deal of sense to me. Locally this model is used, and the psychologists are socialised to fact that supervision requires specialist post-qualification training. In addition, in order to ensure that you are eligible to receive a trainee, supervisors know that they must attend regular CPD training sessions in supervision.

29. This question is not clear to me. CPD can include supervision, but surely it means more than supervision only ie. research, lectures etc.

30. I agree that CPD should be mandatory + that the DCP is well placed to create guidelines. I also feel that clinical supervision is an important element of CPD.

31. I am not sure that clinical supervision can, at the moment, be seen as CPD. Clinical supervision is necessary and may form a part of professional development. However, it would be fudging the issue to suggest that all professional development can be done under the heading of supervision. There are new aspects, interest, researches, methods, etc., which cannot be provided by just one person. If the person needs also to work outside their current specialism in order to retain a breadth of knowledge. For this reason the APR is probably the best place for suggesting issues for CPD and a budget and audit should follow in order to protect the CPD of the psychologist or psychotherapist. Supervision should continue unabated.

32. One learns from supervising others.

33. quite happy locating CPD in clinical supervision.

34. Clinical supervision should be separate from CPD. Supervision should be firmly linked to therapy work.

The professionalisation of clinical supervision

1. People should have some training in supervision. However, some people do seem to be naturally good at it – I think this is about attitudes & beliefs rather than just skills. I would not be in favour of specifying the exact kind of training etc required.

2. Would we know what to train people in? For example, what should CBT supervision look like? Is there an ideal form you could teach? Has anybody researched whether supervisors add to the effectiveness of their supervisees, & if so, which supervision interventions are most important?

3. As stated before, neither supervisee nor supervisor may have received training in the politics and power imbalances inherent in the dyad relationship. Professionalism is more than just a set of core skills and knowledge. Academic institutions offering training need to revisit their own value base, their mission and their resulting professional practice with trainees.

4. Not good!

5. Most clinical psychologists learn supervision 'by apprenticeship'. In my experience, a) a good qualification b) a number of years experience in practice, and c) ideally, supervision of the first few years of supervisory practice – should be sufficient.

6. I think that this is a situation that needs to change, and hopefully is changing. In terms of the supervisors this is a big problem in relation to the quality of supervision provided. For supervisees, training might improve what they are able to gain even from an excellent supervisor.

7. More training is needed. I think it's a weakness in clinical psychology.

8. Lamentable! I would very much welcome a more systematic approach & a recognition that supervision isn't something that you learn by osmosis.

9. I feel that supervision is potentially a powerful shaper of clinical practice. Consequently it requires a solid evidence base and systematic training.

10. As most training doesn't change the ability of the therapist to help it's hard to see how training in supervision will help someone to supervise better. Reading a couple of decent books on it might help. Organisationally, training is useful as it establishes 'legitimate' supervisors – they are not necessarily better than untrained mentors, however.

11. I think it's silly! When I was first asked to give lectures, I was aware with alarm that I hadn't a clue as to how to teach, so I contacted my local Faculty of Education to get some kind of training & input. When I first began supervising, I felt very much in the same boat. I think it's farcical to assume that having been supervised (possibly poorly) for 2 or 3 years and 2 years of postqualification experience are sufficient for someone to absorb the skills of supervising by osmosis or whatever! Supervising is a highly complex task, and as such it should be recognised that teaching in supervision is essential. Having had some appalling supervisors in my time, I could almost say it should be mandatory. (I had to seek and fund my own supervision training myself!).

12. Ridiculous, such training should be compulsory.

13. Generally I think that supervision should be taught rather than assumed to be a skill that comes with your Clin. Psy D.

14. It's not a good place to be. A particular therapeutic model or training programme is not synonymous with offering supervision. There needs to be explicit programmes dedicated to supervision per se. We have a relatively decent knowledge base on supervision now (albeit largely American and still tied to psychotherapy and counselling psychology) from which to draw on but it is surprising how little most clinical psychologists know about the area.

15. Its dreadful! Trainees don't know how to use supervision and practitioners don't necessarily know how to supervise. Teaching for supervisors and supervisees is essential. As a very basic starting point supervisees need help to identify what their needs in their practice and of supervision are – and how to communicate and monitor these. Supervisors need help to facilitate this process.

16. It would be good to obtain recognition for supervision. Areas where I have worked have included training for supervising at basic/advanced level for supervisors. I might be lucky!

17. Ideally supervisors should be trained. DCP guidelines already tend in this direction without being specific other than for supervision of trainees. There was also a recommendation that people providing 'supervision' through annual performance review should have received training.

18. We are already too professionalised. CPD (including supervision) is a systemic issue to <u>managed</u> in services it should not become a career in itself.

19.First, this <u>is</u> changing with psychotherapy training formalising supervision training. Generally, I would support the idea of formalising training but I am wary of elaborate accreditation procedures and the benefits they offer. How do you make such a system <u>competence</u> based and not just another elaborate hoop-jumping exercise?

20. Ripe for development. Training + accreditation should be introduced gradually. Cannot yet be mandatory if we wish to increase training numbers.

21. The Institute of Family Therapy runs a training course for therapists wanting to be supervisors. Although currently experience may be sufficient, I expect that, in time, accreditation as a supervisor will be linked to the completion of such courses. Over the years I have learned much about doing supervision from FT sources, and a little from workshops run by Clin. Psych. training schemes. I expect that most people reflect on their own good and bad experiences receiving supervision and base their own efforts on what they found helpful. I think the training and support for new supervisors in psychology is often woefully inadequate, and made worse by the intense pressure to take trainees as soon as they are eligible (this may be especially in child work). In the last few years I have run a consultation group for first time supervisors to provide a space for thinking about the issues and processes of supervising trainees. This was well received and appeared to meet a need.

22.The time has come to seriously question why it is that poor practice continues.....Supervision skills are of course part + parcel of our ongoing therapy experience but more than that it is a forum for

- ❑ reflective practice
- ❑ unpacking ethical dilemmas
- ❑ 'support'
- ❑ skills building/teaching

Just cos you're a 'brilliant' therapist, it doesn't mean you're going to be a 'brilliant' supervisor. So I think we do need space + time to learn.

23.V.little evidence linking supervisor training to educational or clinical outcomes but nonetheless makes sense. Also I have been slow to realise how important it is to induct supervisees into their role and seek to articulate supervisee as well as supervisor competencies – this is a joint enterprise. Relying on haphazard transfer from own past experience is unprofessional and outdated. We do however need to document and evaluate our new arrangements to check out not only consumer satisfaction but educational outcomes.

24. Training courses should address this as should those involved in the provision of CPD in our profession. However – I remain unconvinced of the need for a specific, credited course on supervision as a pre-requisite for providing supervision.

25. Its a shortcoming of the profession. In my view supervision is a particular skill and the apprenticeship model, although having its strengths, is not sufficient.

26. I consider supervisors should have training in giving supervision. Professional training does not usually give this. Supervisors workshops usually available through clinical psychology training courses.

27. I believe training in supervision should be a compulsory part of post-qualification training. Supervisors should always have received training in the necessary range of types of supervision in their area.

28.On the CT course we use specific assessment tools. Therefore all supervisors require specialist training.

29. I don't think this is true. I think all trainee/supervisees and supervisors can benefit from training in/about supervision right from day 1.

30. I would like training + qualification in supervision to be mandatory. We are currently working towards this locally.

31. I agree that is frequently assumed that qualification and experience are a sufficient basis for supervision. I cannot see an immediate change in this position because of the poor additional courses and time available for training supervisors to supervise. As in the medical model, it is expected that you both learn and teach throughout all grades of the profession and there should be no exceptions to this rule. The question is one of monitoring and improvement.

32. Training will become mandatory sooner or later.

33. People should be encouraged to do a minimum amount of training/teaching in supervision – most clin psychs are keen – I don't detect a problem.

34. This does need to be addressed but probably in post-qualification training rather than basic training.

Additional comments on DQ1

Supervision should be researched so it can become evidence-based, effective, teachable, and then mandatory.

Supervision is a demanding but fascinating subject. I've enjoyed filling in this questionnaire because it has made me think a lot about the issues. I was also appalled to realise that I hadn't really done any reading about the supervisory process despite the amount of supervision which I do!

I quite enjoyed doing this – thank you!

V. interesting questions – not easy to answer but important. Good luck.

This has proved very thought-provoking. I have just poured my thoughts onto paper – in part due to time – so I hope my thoughts make sense! Thank you for asking me to take part!

I found this quite tough & laborious to complete!

I think your letter was great - energising, informal & motivating.

Appendix V
Covering letter and reminder of methodology in round two:
DQ1 responders

Dear

Thank you very much for returning the initial questionnaire in my Delphi survey of clinical psychologists on clinical supervision recently. It has been an engaging and highly rewarding task to consider all the material that panelists supplied me with, and I hope that the questionnaire I have devised from that material is adequate to express the range of opinions held.

I have pleasure in enclosing the questionnaire with this letter, as well as a brief summary of the background information collected on the group. The reverse of this letter gives a little more information about the survey so far, and reminds readers of the final stage.

I hope you will be willing to continue as a panelist by completing and returning the questionnaire in the enclosed sae.

PLEASE RETURN IT BY

I look forward to hearing from you again, and I thank you for your willingness to share your knowledge.

Yours sincerely

Brenda Roberts
Chartered Clinical Psychologist

researcher's home address

phone

email

researcher's work address

phone

A reminder of the survey's methodology

I sent out 70 initial questionnaires. A few people returned them explaining why they could not participate (and I found myself grateful that they had bothered, so I hope my own manners will improve as a result). Thirty-four questionnaires containing usable information were returned. At that point I realised I already had enough information for a book or two, but I have tried to capture both the essence and the diversity of the material in the enclosed round two questionnaire. Your comments on the face validity of the items, and their relevance to your own opinions, will of course be welcome.

Many people were willing to share their thoughts, hopes, frustrations, plans and researches, in often quite personal ways. I had hoped very much that the Delphi methodology would make this possible, and feel those hopes were justified by the results. The sense of personal contact has been deeply gratifying, and I really appreciate the time, thought and effort that people have been willing to expend at my request. I hope I do you all justice.

This questionnaire is being sent to three groups: 34 people who completed round one; 34 who did not, but who did not indicate an aversion to further contact; and 32 new contacts.

The answers will be collated, and all participants will be sent information about the group's responses and how their own responses are located within the group.Participants are not given any means of identifying any individual's opinion except their own. You are invited to amplify or amend your responses in any way you see fit as a result of seeing how they relate to the consensus.

If you would like more information about Delphi surveys, there is a good chapter by Linda Stone Fish and Dean M. Busby, called 'The Delphi Method', in Research Methods in Family Therapy, edited by Douglas H. Spreckle and Sidney M Moon, published by Guilford Press, New York, in 1996. Alternatively, you could look on the internet on www.ncbi.nlm.nih.gov/PubMed/, which will give you more information than any reasonable person wants to know.

If you would like more information about this project, or about me, please do contact me – details at the top of this page – or my supervisor, Margie Callanan, at Salomons – details overleaf.

Appendix VI
Example of individualised comments in covering letter:

Panelist comment on DQ1:
I'm not clear about the benefits of this methodology – surely a read through the literature on CPD & supervision would generate a better thought out questionnaire? This pre-questionnaire approach is problematic as respondents are not likely to put their all into discursive answers – if they did, they could become papers in their own right. Still, good luck with the Doctorate, listening to my ramblings must be worth a higher degree.

Researcher response incorporated in covering letter for round two:
I note your reservations about the methodology, but as it happens I am extremely interested in people's ramblings (within limits!) I wanted a way to collect a reasonable number of accounts from a group of people who probably have something useful to say on the topic, and then inform them of each other's views to see what came out. Alternatively I could have asked 50 people to talk to each other about supervision for half a day and then tried to analyse or codify in some way the variety of views expressed. But I doubt I could ever arrange such a meeting, and in any case what comes out of events like that is more often a function of the interplay of the personalities than a function of the group's reflections on the issues. As for the literature, so very little is specific to clinical psychology in the British NHS. Perhaps that doesn't matter, and all the American stuff and all the counselling stuff contain everything we need for our situation. But we shouldn't assume that, I think.

Appendix VII
Covering letter and reminder of methodology in round two:
DQ1 non-responders

Dear

Clinical Psychologists and Clinical Supervision

You may recall receiving some information about a Delphi survey I am currently undertaking on the above topic, some weeks ago. The first round is now complete, and I have generated the enclosed questionnaire from the replies received from 34 clinical psychologists. I have also enclosed a further copy of the background information form which was enclosed with the original survey, in case you would like to join the project now but have discarded the earlier correspondence.

Your participation in the project at this stage would be extremely welcome, and I hope you will find it interesting to read the questionnaire and see what your colleagues have identified as the important issues in the field. Whether you thoroughly agree with them or you cannot believe they have missed the whole point, I'd love to learn of your views. If you would like to join in now, please complete the questionnaire and RETURN IT TO ME BY DATE

As you were unable to participate in the first round, I do hope that this communication is not an unwelcome intrusion. If you do not have the time or the interest to participate in the survey at all, then please accept my apologies for adding yet another unwanted decision to your day! If you do not respond to this invitation, I will not contact you again.

If you are able to respond, I look forward to the pleasure of your contribution. Thank you for your time and attention.

Yours sincerely

Brenda Roberts
Chartered Clinical Psychologist

home address
telephone

email

work address
telephone

A reminder about Delphi methodology

Delphi surveys differ from conventional surveys in a number of ways. Participants are not anonymously or randomly drawn from a target population, but selected either because of their general expertise in the topic under investigation or because they may be able to offer a particular minority view. Participation requires not the more usual one-off form-filling session, up to but three separate and distinct rounds. The survey instrument is not pre-written, but constructed after round one, the initial consultation of the participants.

Round one has been completed and the enclosed questionnaire devised from the replies received. This questionnaire, constituting round two, is being sent to three groups of people – the 34 who took part in round one; 34 of those who, like yourself did not take part but did not indicate an aversion to further contact; and 32 new contacts.

The responses to the questionnaire will be collated, and panelists will be contacted for the final round with information concerning the range of received responses, and how their responses relate to this. Participants are not given any means of identifying any individual's opinion except their own. You are invited to amplify or amend your responses in any way you see fit as a result of seeing how they relate to the consensus.

If you would like more information about Delphi surveys, there is a good chapter by Linda Stone Fish and Dean M. Busby, called 'The Delphi Method', in Research Methods in Family Therapy, edited by Douglas H. Spreckle and Sidney M Moon, published by Guilford Press, New York, in 1996. Alternatively, you could look on the internet on www.ncbi.nlm.nih.gov/PubMed/, which will give you more information than any reasonable person wants to know.

If you would like more information about this project, or about me, please do contact me – details at the top of this page – or my supervisor, Margie Callanan, at Salomons – details overleaf.

Appendix VIII
Covering letter and description of methodology in round two:
new invitees

Dear

Clinical Psychologists and Clinical Supervision

I am writing to most cordially invite you to participate in rounds two and three of a Delphi survey on the above topic. For those of you unfamiliar with Delphi methodology, an account is given overleaf. The survey forms part of a research project I am undertaking on the post-qualification doctoral programme in clinical psychology based at Salomons.

As you know, for a variety of reasons the topic of clinical supervision is one of intense interest within our profession at the moment. There are demands to expand and modify our training schemes, demands to establish procedures to enhance clinical effectiveness, demonstrate evidence-based practice and ensure high-quality services, demands to explore routes of registration as psychotherapists, and demands to encourage a culture of continuing professional development (CPD). Clinical supervision is seen as a key component in all of these areas and I am keen to learn more of how my professional peers are thinking about the whole topic. I hope that you too would enjoy learning what has emerged so far, and taking the opportunity to respond to it. I also hope to publish the findings, so you may have the added pleasure of contributing to the cutting edge of the profession's views!

The enclosed questionnaire was generated from the contents of 34 scripts received from the clinical psychologists who participated in round one. You may feel that the issues identified by them are precisely those you would also identify as important and relevant to the general topic. Or you may feel that the previous participants have missed the whole point of the exercise. Either way, I would love to learn your views. Also enclosed is a background form which seeks general information about your professional position and your experiences of supervision. If you would like to become a panelist at this stage, please complete both parts of the enclosed and RETURN BY DATE

I am very grateful for your time and attention in reading this, and I look forward to the pleasure of working with you.

Yours sincerely

Brenda Roberts
Chartered Clinical Psychologist

home address

telephone

email

work address

telephone

Delphi surveys

Delphi surveys differ from conventional surveys in a number of ways. Participants are not anonymously or randomly drawn from a target population, but selected either because of their general expertise in the topic under investigation or because they may be able to offer a particular minority view. Panelists participate in up to three separate and distinct rounds.

The survey instrument is not pre-written, but constructed after round one, the initial consultation of participants, which asks for opinions on the topic in a fairly general way. People are encouraged to identify the issues they believe to be important and to comment freely on the issues offered. A questionnaire is devised from this information, and this questionnaire, constituting round two, is sent to previous participants and to new invitees a few weeks later. The present survey is at this stage, and you are warmly invited to join the project.

The responses to the questionnaire are collated, and you are contacted for the final round with information concerning the range of received responses, and how your responses relate to this. Participants are not given any means of identifying any individual's opinion except their own. You are invited to amplify or amend your responses in any way you see fit as a result of seeing how they relate to the consensus.

If you would like more information about Delphi surveys, there is a good chapter by Linda Stone Fish and Dean M. Busby, called 'The Delphi Method', in Research Methods in Family Therapy, edited by Douglas H. Spreckle and Sidney M Moon, published by Guilford Press, New York, in 1996. Alternatively, you could look on the internet on www.ncbi.nlm.nih.gov/PubMed/, which will give you more information than any reasonable person wants to know.

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Appendix IX
Description of round one participants, sent to DQ1 responders with DQ2

N = 34. Women = 18, men = 16.
Age range 31-58, two missing. Mean age 45 ± 6. No gender differences.

Panelists holding doctorates = 17. Panelists with additional therapy qualifications = 9.
Panelists currently engaged in formal study programmes = 8.

Years in practice: mean 17 ± 7. Mode 25.
Spine point: range 35 – 50 +. Number of Grade B's = 22. Four missing.

All the men have full time posts: approximately half the women have part time posts.

There was a significant relationship between years in practice and spine point (which was something of a relief) but none between spine point and gender.

Three panelists indicated they were not at all familiar with the supervision literature, eighteen that they were somewhat familiar with it, and twelve that they were very familiar with it (one missing).
No-one said they had attended no training events on supervision, twenty-one had attended a few, and twelve had attended many events (one missing).
There was a positive relationship between these two variables and no gender diffs.

Seven were not satisfied with their level of preparation for supervision, nine were uncertain and sixteen were satisfied (two missing). There were obvious gender differences: most women were satisfied with their level of preparation (twelve out of 17), most men were uncertain (seven of 15).

Hours per month giving supervision: range 0-36, mean 14 ± 8, mode 20, (two answered 0, two values missing).

There was no relationship between years in practice and hours of supervision given, nor between amount of satisfaction with level of preparation and hours given.

Three practitioners had received no supervision in the previous six months (one missing). They were all providing supervision for others.

Twenty-one were involved in peer supervision, nine of whom checked only this category. Five had supervision with a senior colleague (clinical psychologist), four of whom checked only this category. Seven had supervision with a manager (clinical psychologist) (four checked only this), one with a non-clinical psychologist manager, seven with an external consultant (one checked only this) and one with a training group. The most common combination was peer plus external (six).

Twenty have access to supervision on their supervision (five missing).

None wanted less supervision, nineteen were satisfied with their supervision received and ten would like more (five missing).

round two Delphi

Clinical Psychologists on Clinical Supervision

Please indicate your opinion of the following statements about supervision. These statements have all been derived from material provided by experienced clinical psychologists in the U.K., and not from literature originating from other professions or cultures. **In case of ambivalence or indecision, please feel free to check more than one box: in case of neutrality or indifference please feel free to omit the item.**
A pilot group took 10-20 minutes to complete this questionnaire.

YOUR NAME:

	strongly agree	slightly agree	slightly disagree	strongly disagree
1. All initial training courses should include some teaching in the use of supervision. 100	84	12	2	2
2. It is highly desirable for all supervisors to receive supervision or consultation on their supervision practice. 100	71	27	2	0
3. After a certain amount of training and experience in supervision, it is rarely necessary to seek consultation on one's supervision practice. 100	0	16	25	59
4. Training in supervision needs to be more formalised and accredited. 96	38	46	10	6
5. Until a sound evidence base is established, training in supervision is probably a waste of time. 100	0	8	27	65
6. Once the criteria for registration as a chartered clinical psychologist have been met, people should be able to work without regular supervision. 100	0	4	11	85
7. Clinical supervision is not routinely necessary where clinical psychologists do little or no psychological therapy. 96	6	22	26	46
8. Supervision need not be a routine requirement for highly experienced practitioners. 100	0	8	22	70
9. Clinical psychologists who work with distressed people in any clinical or research setting should have regular supervision for as long as they practise. 100	78	12	8	2
10. A committment to engage in regular supervision of some kind should be a condition for achieving chartered status. 98	67	20	10	2
11. Having personal therapy is as important a component as clinical supervision in the training of competent psychological therapists. 100	23	27	17	33
12. Clinical psychologists as a group are not as familiar as they need to be with the literature on clinical supervision. 92	23	68	6	2
13. Both supervisee and supervisor are likely to benefit from some kind of role induction to clarify expectations and responsibilities. 100	57	35	6	2
14. The profession should work towards making training and qualification in supervision mandatory for those who wish to supervise. 100	35	39	20	6
15. Registration as a chartered clinical psychologist means one has had six years of supervised practice. This is a sufficient basis for offering supervision to others. 94	10	28	38	24
16. Supervision needs to be precisely tailored to the therapy model used by the supervisee. Generic training in supervision is therefore not useful. 100	2	4	41	53
17. Regular supervision is a core requirement for routine clinical practice and should not be considered an optional element of CPD. 100	76	16	8	0
		Appdx	X	2/5

	strongly agree	slightly agree	slightly disagree	strongly disagree
18. If supervision is seen as CPD there is a danger that other forms of CPD will be ignored. 96	10	25	38	27
19. Having supervision contributes to professional development, so it is appropriate to classify it as a CPD activity. 94	45	28	21	6
20. The Division of Clinical Psychology is developing guidelines for CPD, including monitoring procedures, so it is sensible to include supervision within this area. 90	44	44	7	4
21. Including supervision in CPD will persuade both clinicians and managers to take it more seriously. 98	43	39	16	2
22. A committment to one's development as a supervisor should be one of the requirements for all Grade B clinical psychologists. 98	53	33	10	4
23. Clinical supervision has a vital role in monitoring accountability. 94	48	35	15	2
24. Ideally clinical supervision and managerial supervision should be carried out by different people. 98	54	28	14	4
25. Separating supervision and management is often impossible for practical reasons. 98	18	47	18	16
26. Separating supervision and management is undesirable because it makes it harder to identify and rectify bad practice. 96	2	10	52	35
27. Provided the manager is a clinical psychologist, there should be no difficulty in combining the functions of manager and supervisor. 98	2	14	51	33
28. All clinicians should be enabled to seek consultation or supervision from practitioners other than their manager. 100	72	24	4	0
29. Adequate management includes clinical audit, case management and professional development. Separate clinical supervision is an unnecessary addition. 98	0	2	24	73
30. Where supervision and management are separate it is essential that channels of communication between them are established and specified. 98	47	33	16	4
31. Supervisors should never communicate with managers about issues which arise in supervision without first telling the supervisee. 98	59	29	8	4
32. Managers should never seek information about practitioners from supervisors without first informing the supervisee. 98	59	31	8	2
33. The most appropriate relationship between management and supervision cannot be nationally prescribed as local needs, resources and preferences will outweigh general principles. 98	8	51	35	6
34. Supervisors should occasionally observe their supervisees in action. 92	41	43	15	0
35. Supervisors should occasionally meet the clients of their supervisees to get the client's view of the therapy. 96	6	22	43	29
36. A way to reduce abuse in therapy is to empower supervisors to seek information about any aspect of the supervisee's dealings with clients and not simply attend to what the supervisee brings up. 94	28	49	15	9
		Appdx	X	3/5

	strongly agree	slightly agree	slightly disagree	strongly disagree
37. A way to reduce abuse in therapy is to ensure that therapists working with emotionally or sexually traumatized clients are not of the same gender/sexual orientation as their clients' abusers. 98	2	8	28	62
38. Taping or videoing clinical contacts to use in supervision is to be encouraged. 98	54	30	14	2
39. Clinical psychology has ignored the ethical dimension of practice for far too long. 94	33	30	24	13
40. Regular consideration of ethical issues is a crucial component of good supervision. 100	74	22	4	0
41. An emphasis on ethics encourages supervisors to become 'moral guardians', which is inappropriate. 98	2	16	35	47
42. Frequently clinicians lack a clear perspective on ethical issues in routine clinical work, which leads to many difficulties in supervision. 92	9	33	48	11
43. A much greater emphasis on ethics is highly desirable in both initial clinical training and in supervisor training. 100	40	48	10	2
44. All human conduct has an ethical dimension. Clinical psychologists are generally sufficiently aware of this. 98	10	42	38	10
45. It is unwise for clinicians to offer therapy to people they are supervising. 100	96	0	2	2
46. It is unwise for clinicians to offer supervision to their therapy clients who are training or practising as therapists themselves. 96	90	4	4	2
47. Therapy and supervision have several features in common but they can and should always be clearly distinct. 100	90	8	2	0
48. The supervisee's personal feelings about the work with a client are frequently a very useful source of important information about the client and should be explored as such in supervision. 100	70	26	4	0
49. Clinical work often arouses strong personal feelings. These require support and validation in supervision. 98	66	30	4	0
50. Supervisors who feel the supervisee's personal issues are significantly interfering with their clinical effectiveness should suggest the supervisee seeks appropriate, separate therapy. 96	48	38	8	6
51. Applying therapy techniques in supervision is a highly effective way of teaching those techniques to supervisees. 100	13	34	26	26
52. The interpersonal and emotional issues which are most important in a particular therapy can often be present in the supervision, and require exploration as a parallel process. 98	42	48	8	2
53. It can be very stimulating to have supervision with someone whose therapeutic orientation is quite different from your own. 98	42	48	8	2
		Appdx	X	4/5

	strongly agree	slightly agree	slightly disagree	strongly disagree
54. Therapy-specific models of supervision are likely to miss key aspects of a clinical psychologists' work, which makes their value very limited. 98	12	39	37	12
55. Therapy-specific models of supervision are likely to promote closer adherence to the therapeutic model by the supervisee, which is beneficial to the client. 96	18	51	24	6
56. Therapy-specific models of supervision are likely to inhibit creativity and innovation in both supervisor and supervisee. 92	6	40	40	13
57. It is important for supervisor and supervisee to have the same therapeutic orientation. 96	4	26	56	14
58. The quality of the supervisory relationship is probably the most important factor in determining how much the supervisee will gain from supervision. 98	60	34	6	0
59. This questionnaire addresses most of the key issues in clinical supervision. 88	32	57	9	2
60. This questionnaire omits many crucial issues in clinical supervision. 92	2	13	43	41
61. Completing this questionnaire has been an unpleasant or tedious experience. 88	0	18	32	50
62. Completing this questionnaire has been a pleasant or interesting experience. 86	30	51	21	0

Please add any comments you wish, whether on the content, style or presentation of this questionnaire, the methodology of the survey, or any other aspect of your experience of being a panelist.

Thank you for your time and for your willingness to share your knowledge and expertise.Please return the questionnaire in the sae provided.**PLEASE ENSURE YOU HAVE PUT YOUR NAME AT THE TOP OF THE FIRST SHEET.**

Appendix XI
FF

S N

Name:

Delphi round three feedback form

On this form you are invited to expand or amend your original responses to round two in the light of the responses of the rest of the group. In the lefthand column, put the number of the question to which you want to make an addition: use the middle column for comments: in the righthand column indicate if you wish to change your original answer, by putting A for 'strongly agree', B for 'slightly agree', C for 'slightly disagree' or D for 'strongly disagree', or a combination of these.

no	comment	new answer?

Any final comments?

At this point I would like to applaud your stamina, as well as express my final, sincere thanks to you. I will do my best to use all of the information you have so generously shared with me in an accurate, responsible way which will make a genuine contribution to our knowledge of current practice and opinion of this fascinating topic.

Please return this form in the s.a.e. supplied.

Appendix XII
Covering letter and methodological feedback to round three

9 October 99

Dear

I am delighted to tell you that round two of the Delphi survey on Clinical Supervision and Clinical Psychologists is now complete, and I am contacting you for the third and final round. Many, many thanks for your help so far. I do hope you find the last lap interesting and informative.

I enclose two items. The first is your original questionnaire, on which I have written in red the group's responses. In the question boxes I have put the percentage of the group who answered this question: where there is no number, everybody answered the question. In each answer box is the percentage of all the replies to that question which were in that box.

The second is a form containing a table you can use to identify any of your original answers that you wish to amend or expand in the light of this feedback.

You will note in the top right corner of the form the letters S and N. If you have not already done so, you may indicate that you would like a summary (S) of the final report next summer, or that you are willing to be named (N) in the acknowledgements, by marking the appropriate letter in some way.

I would be extremely interested in your responses to this feedback and I look forward to your reply. **Please return the form by 25 October**.

If I do not hear from you, I will assume you do not wish to add anything to your original answers. All of your comments so far have been noted, and have given me much food for thought. Both the topic and the methodology have elicited some very interesting observations, and I am grateful for them all.

Overleaf is some general information regarding the group's questionnaire responses. It has been an enormous pleasure interacting in this way with so many of my peers: I am indebted to your generosity and goodwill.

With very best wishes

Brenda Roberts
Chartered Clinical Psychologist

Appendix X
Scoring copy of DQ2 and details of initial discarded analysis of responses

Initial recording of data and feedback to participants

The scoring copy of DQ2 was held on computer, on Word 97 (1996). As each completed questionnaire was returned to the researcher, panelists' responses were added to this copy, in the appropriate response boxes. Where a panelist had omitted an item, an entry (1) was made in the item box.

Panelists had been invited to choose more than one response category where they wished to indicate that no single category captured their desired response. No panelist selected more than two responses to any item, but where two responses were selected both were entered. Where panelists had indicated only one response category but they had done so in an extremely emphatic manner (e.g. with multiple ticks, plus signs, or comments indicating very strongly held beliefs) two responses were entered for that category. Doubled responses, then, fell into three categories – emphatic (both responses in the same response category), mixed (one 'slightly' and one 'strongly' response in the same valency) and ambivalent (one response in each valency).

The scoring copy therefore recorded how many individuals had and had not responded to each item (expressed as a number in the item box), and how many *responses* had been made in each response category (expressed as a number in each of four response categories), but it did not record how many *individuals* had responded in each category. When all the data had been entered, they were converted to percentages for ease of comparison. Thus, the percentage of the group who made a response to each item was entered into the item box. The number of responses to each item was totalled, and the percentage of this number in each response category was entered into the appropriate response box.

Each item then had five numbers which described the range and strength of the group's responses to it. These five numbers were written on to every completed DQ2 which was then sent back to its originator.

Discarding initial analysis

In round three, no more multiple responses were made. Had panelists at any stage made extensive use of multiple responses, methods of analysis which adequately addressed both their range and type would have been appropriate. In the event, only 1.26 per cent of responses were so classified, whereas more than twice as many (2.77%) were missing (details at appendix XV). It was therefore decided at this stage that doubled responses would be adjusted so that no more than one response per item per panelist was recorded. The six emphatic responses were registered only once. The 11 mixed responses were adjusted to record the more extreme response only, and the 22 ambivalent responses were omitted. The adjusted missing response rate was 3.48 per cent.

There now follows the scoring copy of DQ2, including the information which was sent to panelists, but which was modified by both round three changes (appendix XVIII), and by the adjustment of double responses as described above, before it was subject to the analysis described in the body of the report.

Some final comments on the Delphi methodology

Since the procedure is interactive and iterative, the Delphi methodology gives a rare opportunity for the investigator to learn just how well or badly the research engages or annoys the panelists. This certainly steepens the learning curve of the investigator.

For example, many people commented that responding to negative items can be confusing when you are trying to respond quickly, and they were irritated by the extra thinking time demanded by this task. This was obvious from the answer forms, where people had initially ticked an answer, scrubbed it out and selected its opposite. I wholeheartedly sympathise with this disgruntlement, and I unreservedly apologise for it. However, it did shake my faith utterly in the meaningfulness of the responses to similarly phrased items on standard personality tests. If a bunch of clinical psychologists find negative items irritating and confusing, my feeling is we're on to a loser when we present them to the hapless general public.

Several people expressed their frustration at being forced to respond to rather bald and general statements, without being able to contextualise their answers. I had hoped to accommodate this difficulty by inviting people to select more than one answer if they wished to emphasise that circumstances alter cases; but this had little appeal and fewer than 0.75% of answers were mixed. On the other hand, those questions which were most likely to prompt people to voice their reservations at having to choose an answer (nos 18, 34, 35, 36, 38, 40, 41, and 53-56 inclusive) were not always the questions with the widest range of responses (nos 11, 33, 42, 44, 51, 54 and 56), nor the ones which elicited the most mixed answers (nos 15, 51 and 57). I only wish I knew what it all meant.

Finally, my thanks to all who noted that on the second page (qq 13-27) the extreme right answer box was incorrectly labelled 'slightly disagree' instead of 'strongly disagree'. Naturally, it leaped to my eye ten seconds after I had committed them all to the post, and not before. I also apologise for inadvertantly doubling the period of supervised practice required before registration (q15) from three years to six!

Appendix XIII
Feedback and response: rounds two to three

Panelist comment written on DQ2:
Questions 61 & 62 made me smile – psychologists love talking about themselves – reflexive profession. Some of this stuff makes supervision sound like the most valuable & important thing a clinical psychologist can do. It's not. Delivering a service is the most important thing – sine qua non. If you go private, what pays the mortgage? Why do we employ surgeons? To do operations. I know this argument could be self-defeating, but if they ultimately spend too much time in supervision & debating the nuances of it, no operations get done.

Researcher comment written on back of above questionnaire, returned to respondent in round three:
I've actually been very puzzled by people's responses to the last four questions – not only are we supposed to be a reflexive profession but I thought it was only good manners to include the questions....But people got all coy about it – lots of non-responders, and of the few brave souls who ticked any of the ever-so-slightly critical boxes, several apologised! I really did want to know what people thought of the experience of taking part in this survey....but it was trickier than I'd anticipated. Ho hum. Incidentally, do you know how much surgery is unnecessary? Ask any physician!

Appendix XIV
Feedback from round three

Panelist comments written on FF:

Q 25: I find the responses here worrying – not separating supervision and management is likely to drive any problems underground. If there were problems, e.g. fitness to practice, the manager needs systems in place to pick that up anyway.

Fascinating. Yet more evidence that the appropriate collective noun for psychologists is a 'disagreement'!

It's very reassuring to discover that, for once, many others have agreed with my answers (& the other way round).

I'm not rigid, but I can't change even one of my original responses.

I'm interested that there is such a lot of agreement on the responses & looking forward to reading your final paper.

Contrary to others' views, I have enjoyed undertaking and being part of the sample. One day perhaps I will learn about the Delphi method properly!

Not sure why I ticked disagree here – I agree strongly.

Q 13: I'm surprised to note that I didn't mark this 'strongly agree'to begin with. It's one of the questions that I feel comfortable taking the extreme position – and it's plain common sense!

Q 18: I am really surprised by people's responses – but I do want to stick to mine.

Q 27: I would like to be able to assume that the manager/ supervisor was a good clinical psychologist who took on board the dynamics and difficulties of the joint role. Others maybe have been less optimistic and, on reflection, so am I.

Q 3: Delighted to see so many think consultation might be necessary more than 'rarely' here – I'll strengthen my response.

Nothing to add from before.

Sorry – I misread this question!

Out on a limb eh?

Q 11: Amazing that 51% can be so dreary & wrong. 51%. Wow.

Appendix XV
Multiple and missing responses

Key:
A or 1 = strongly agree
B or 2 = slightly agree
C or 3 = slightly disagree
D or 4 = strongly disagree
99 = missing data

item	round two response	adjustment
2	BC	99
3	CD	D = 4
5	BD	99
6	BD, CD, DD	99, D = 4, D = 4
7	CD, CD	D = 4, D = 4
11	AA, AB	A = 1, A = 1
12	BC	99
13	AB	A = 1
14	BC	99
15	BC, BC, BD	99, 99, 99
16	BC	99
23	AB	A = 1
24	AA	A = 1
35	BC	99
37	BC	99
38	BC	99
43	AA, BC	A = 1, 99
44	BC	99
45	AA	A = 1
46	AA	A = 1
47	AB	A = 1
49	BC	99
51	BC, BC, CD	99, 99, D = 4
52	AB	A = 1
53	BC	99
55	BC	99
56	BC	99
57	BC, BC	99, 99
58	AB	A = 1

Multiple responses and adjustments

This table shows how many responses were missing from the panelists' replies to the questionnaire in rounds two and three. *Empty boxes mean no change occurred.* Note these figures do not include ambivalent responses which were entered as missing for the final analyses (detailed on previous page) .

item no.	number missing round two	round three	item no.	number missing round two	round three
4	2		35	2	
7	2		36	3	
10	1		37	1	
12	4		38	1	
15	3		39	3	
18	2		41	1	
19	3		42	4	
20	5		44	1	
21	1		46	2	
22	1		49	1	
23	3	2	50	2	
24	1		52	1	
25	1		53	1	
26	2		54	1	
27	1		55	2	1
29	1		56	4	3
30	1		57	2	1
31	1		58	1	0
32	1		59	6	5
33	1		60	4	3
34	4		61	6	4
			62	7	5

Appendix XVI
Panelists' comments on methodology and the experience of participation.

Questionnaire is comprehensive.

Questionnaire is comprehensive and balanced.

Slightly tedious.

Too long, too repetetive. Interesting methodology.

If this had not arrived while I was on holiday, I would not have completed it, as it is far too long. I would not be prepared to complete a survey of this length again.

This is a thought-provoking process. The topic 'spirals outwards' naturally reflecting the huge dilemmas for our profession re science vs arts; therapy vs other clinical roles etc etc. It may be the nature of the survey style but the 'imperative' style of question statement made it quite hard to process (ie the 'shoulds' etc)

Some questions difficult to determine meaning. Answers often depend on individual personalities and circumstances.

At times it has been difficult to tick a box because ... the type and style of supervision is impacted by supervisee factors.

I'm sure I've contradicted myself many times. I keep wanting to say yes, but.. or no, but it all depends etc. But I've done my best.

The multiple choice format forces one to respond without being able to qualify or justify.. I felt that I was made to contradict myself.

Thanks for pursuing this. It's an important area.

Appendix XVII
Identity of supervisees

The panelists in this project had offered supervision to the following groups in the previous six months. Numbers in brackets refer to the number of panelists who supervised people from these groups.

1. Trainee CP's (29)
2. Qualified CP's (28)
3. CMHT members (includes CPN's, OT's, SW's: not always specified) (19)
4. Counsellors (17: one person specified trainee counsellors)
5. Assistant psychologists (15)
6. Qualified CoP's (12)
7. SLT's (3)
8. Postgraduate trainees in CBT (3)
9. Psychiatric day services teams (3)
10. Psychiatrists (3: two people specified psychiatrists in training)
11. Psychiatric inpatient teams (2)
12. Qualified CBT practitioners (2)
13. MacMillan nurses (2)
14. Health visitors (2)
15. Trainee educational psychologists (2)
16. Psychiatric rehabilitation teams (1)
17. Cancer nurses (1)
18. Psychotherapists, including trainees (2)
19. Systemic therapists (1)
20. Group therapists (1)
21. Art therapists (1)
22. Child and family psychiatric nurse (1)
23. Midwives (1)
24. HIV infection control nurses (1)
25. Student nurses (1)
26. Facilitators of self-help group for relatives of people with diagnosis of psychosis (1)
27. Masters or Ph. D. students undertaking clinical research (1)
28. Service managers (1)
29. Organisational consultants (1)
30. Research worker (1)
31. Work development worker (1)

Appendix XVIII
Round three changes

item	initial response	final response	direction of change	panelist comment
1	D	A	T	
3	C	D	T	delighted with peer response
3	C	D	T	on reflection
5	C	D	T	on reflection
8	C	D	T	on reflection
9	D	A	T	don't know why I ticked that
12	B	A	N	on reflection
13	B	A	T	surprised not to have done it first
22	B	A	T	if post not just managerial
23	99	A	n/a	don't know why I missed it
24	D	A	T	misread item
25	D	C	T	too extreme
27	B	C	T	less optimistic now, like peers
27	B	C	T	
31	B	A	T	misread item
31	C	A	T	
31	B	A	T	not strong enough
33	D	C	T	hard to acheive within resources
37	C	D	T	on reflection
40	B	A	T	surprised at own first answer
41	A	D	T	
42	A	B	T	too influenced by something at first
44	D	C	T	wording is confusing
45	D	A	T	mistake
46	D	A	T	mistake
48	B	A	T	questionnaire fatigue
49	B	A	T	questionnaire fatigue
49	B	A	T	on reflection
49	B	A	T	not strong enough
49	B	A	T	on reflection
50	C	B	T	on reflection
50	B	A	T	on reflection
51	A	B	T	wording is confusing
52	C	B	T	on reflection
54	A	B	T	
55-62	99	B C D B B D D B	n/a	original page lost
57	A	B	T	more consistent with own other replies
61	99	D	n/a	
62	99	B	n/a	

Key: A: strongly agree. B: slightly agree. C: slightly disagree. D: strongly disagree.
99: response missing.
T: change is towards majority response. N: change is away from majority response.
n/a: not applicable.

Appendix XIX
DQ2 items ranked by Consensus Index (CI), and median responses

item	N	C I	median
2. It is highly desirable for all supervisors to receive supervision or consultation on their supervision practice.	49	98	1
1. All initial training courses should include some teaching in the use of supervision.	50	96	1
45. It is unwise for clinicians to offer therapy to people they are supervising.	50	96	1
47. Therapy and supervision have several features in common but they can and should always be clearly distinct.	50	96	1
6. Once the criteria for registration as a chartered clinical psychologist have been met, people should be able to work without regular supervision.	49	94	4
29. Adequate management includes clinical audit, case management and professional development. Separate clinical supervision is an unnecessary addition.	49	94	4
28. All clinicians should be enabled to seek consultation or supervision from practitioners other than their manager.	50	92	1
40. Regular consideration of ethical issues is a crucial component of good supervision.	50	92	1
48. The supervisee's personal feelings about the work with a client are frequently a very useful source of important information about the client and should be explored as such in supervision.	50	92	1
49. Clinical work often arouses strong personal feelings. These require support and validation in supervision.	48	92	1
16. Supervision needs to be precisely tailored to the therapy model used by the supervisee. Generic training in supervision is therefore not useful.	49	90	4
46. It is unwise for clinicians to offer supervision to their therapy clients who are training or practising as therapists themselves.	48	88	1
58. The quality of the supervisory relationship is probably the most important factor in determining how much the supervisee will gain from supervision.	50	88	1
5. Until a sound evidence base is established, training in supervision is probably a waste of time.	49	86	4
8. Supervision need not be a routine requirement for highly experienced practitioners.	50	84	4
9. Clinical psychologists who work with distressed people in any clinical or research setting should have regular supervision for as long as they practise.	50	84	1
13. Both supervisee and supervisor are likely to benefit from some kind of role induction to clarify expectations and responsibilities.	50	84	1
Appdx	XIX	1/4	

item	*N*	CI	median
17. Regular supervision is a core requirement for routine clinical practice and should not be considered an optional element of CPD.	50	84	1
37. A way to reduce abuse in therapy is to ensure that therapists working with emotionally or sexually traumatized clients are not of the same gender/sexual orientation as their clients' abusers.	48	82	4
52. The interpersonal and emotional issues which are most important in a particular therapy can often be present in the supervision, and require exploration as a parallel process.	49	82	2
53. It can be very stimulating to have supervision with someone whose therapeutic orientation is quite different from your own.	48	80	2
12. Clinical psychologists as a group are not as familiar as they need to be with the literature on clinical supervision.	45	78	2
31. Supervisors should never communicate with managers about issues which arise in supervision without first telling the supervisee.	49	78	1
32. Managers should never seek information about practitioners from supervisors without first informing the supervisee.	49	78	1
43. A much greater emphasis on ethics is highly desirable in both initial clinical training and in supervisor training.	49	78	2
10. A commitment to engage in regular supervision of some kind should be a condition for achieving chartered status.	49	74	1
27. Provided the manager is a clinical psychologist, there should be no difficulty in combining the functions of manager and supervisor.	49	74	3
26. Separating supervision and management is undesirable because it makes it harder to identify and rectify bad practice.	48	72	3
50. Supervisors who feel the supervisee's personal issues are significantly interfering with their clinical effectiveness should suggest the supervisee seeks appropriate, separate therapy.	48	72	1.50
20. The Division of Clinical Psychology is developing guidelines for CPD, including monitoring procedures, so it is sensible to include supervision within this area.	45	70	2
22. A commitment to one's development as a supervisor should be one of the requirements for all Grade B clinical psychologists.	49	70	1
3. After a certain amount of training and experience in supervision, it is rarely necessary to seek consultation on one's supervision practice.	50	68	4
38. Taping or videoing clinical contacts to use in supervision is to be encouraged.	48	68	1
Appdx	XIX	2/4	

item	*N*	CI	median
24. Ideally clinical supervision and managerial supervision should be carried out by different people.	49	66	1
59. This questionnaire addresses most of the key issues in clinical supervision.	45	66	2
60. This questionnaire omits many crucial issues in clinical supervision.	47	66	3
4. Training in supervision needs to be more formalised and accredited.	48	64	2
23. Clinical supervision has a vital role in monitoring accountability.	48	64	2
34. Supervisors should occasionally observe their supervisees in action.	46	64	2
21. Including supervision in CPD will persuade both clinicians and managers to take it more seriously.	49	62	2
61. Completing this questionnaire has been an unpleasant or tedious experience.	46	60	4
30. Where supervision and management are separate it is essential that channels of communication between them are established and specified.	49	58	2
41. An emphasis on ethics encourages supervisors to become 'moral guardians', which is inappropriate.	49	56	3
62. Completing this questionnaire has been a pleasant or interesting experience.	45	54	2
36. A way to reduce abuse in therapy is to empower supervisors to seek information about any aspect of the supervisee's dealings with clients and not simply attend to what the supervisee brings up.	47	50	2
14. The profession should work towards making training and qualification in supervision mandatory for those who wish to supervise.	49	48	2
19. Having supervision contributes to professional development, so it is appropriate to classify it as a CPD activity.	47	42	2
35. Supervisors should occasionally meet the clients of their supervisees to get the client's view of the therapy.	47	42	3
7. Clinical supervision is not routinely necessary where clinical psychologists do little or no psychological therapy.	48	40	3
55. Therapy-specific models of supervision are likely to promote closer adherence to the therapeutic model by the supervisee, which is beneficial to the client.	48	40	2
57. It is important for supervisor and supervisee to have the same therapeutic orientation.	47	38	3
25. Separating supervision and management is often impossible for practical reasons.	49	30	2
18. If supervision is seen as CPD there is a danger that other forms of CPD will be ignored.	48	28	3
39. Clinical psychology has ignored the ethical dimension of practice for far too long.	47	26	2
15. Registration as a chartered clinical psychologist means one has had six years of supervised practice. This is a sufficient basis for offering supervision to others.	44	24	3

item	N	CI	median
33. The most appropriate relationship between management and supervision cannot be nationally prescribed as local needs, resources and preferences will outweigh general principles.	49	18	2
42. Frequently clinicians lack a clear perspective on ethical issues in routine clinical work, which leads to many difficulties in supervision.	46	16	3
56. Therapy-specific models of supervision are likely to inhibit creativity and innovation in both supervisor and supervisee.	46	8	3
11. Having personal therapy is as important a component as clinical supervision in the training of competent psychological therapists.	50	4	3
44. All human conduct has an ethical dimension. Clinical psychologists are generally sufficiently aware of this.	48	4	2
51. Applying therapy techniques in supervision is a highly effective way of teaching those techniques to supervisees.	48	4	3
54. Therapy-specific models of supervision are likely to miss key aspects of a clinical psychologists' work, which makes their value very limited.	49	2	2

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