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School of psychology

JOB SATISFACTION, BURNOUT AND SELF-ESTEEM IN THE MULTI-DISCIPLINARY TEAM: THE IMPACT OF PSYCHOLOGICAL SUPERVISION

By

Sophie Williams

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Abstract

FACULTY OF SOCIAL & HUMAN SCIENCES

School of Psychology

Thesis for the degree of Doctor of Clinical Psychology

**JOB SATISFACTION, BURNOUT AND SELF-ESTEEM IN THE
MULTI-DISCIPLINARY TEAM: THE IMPACT OF
PSYCHOLOGICAL SUPERVISION**

Sophie Williams

Chapter 1- Systematic review

The last review by Wheeler and Richards (2007) suggested that the literature clearly highlights that supervision benefits counsellors and therapists; however, the quality of evidence is influenced by significant methodological limitations. This systematic review aimed to look at how the evidence base for clinical supervision has developed since 2005, and in particular how clinical supervision impacts upon the psychologist/counsellor, their practice and their clients. This article reviews 22 individual published studies, after detailed inclusion and exclusion criteria were agreed. The literature indicates a strong association between positive clinical supervision experiences and reduced burnout, increased job satisfaction, and improved self-efficacy and competency. Different types of supervision are also discussed, and individual supervision is still seen to be the most effective and useful format. More studies looking at the link between clinical supervision and client outcomes emerged within this review, suggesting promising results that supervision has a positive and direct impact on client outcomes. However, sampling and methodological limitations continue to be a hindrance to this growing area of research, so suggestions are made to overcome these difficulties. Finally, the clinical and theoretical implications are discussed.

Chapter 2- Empirical paper

Introduction: Healthcare professionals working within mental health settings have been shown to be at particular risk of burnout and job dissatisfaction. However, evidence has suggested that clinical supervision could be a potential buffer to such stress related difficulties. No research has yet explored how supervision from a Clinical psychologist might impact upon healthcare professionals' level of burnout, job satisfaction or self-esteem. Therefore, adopting a mixed methods design, this study aimed to explore how supervision from a psychologist impacts upon the multi-disciplinary team. **Method:** Using an online survey, 103 healthcare professionals across different mental health settings participated in the study. Quantitative data directly compared the control group with practitioners who receive supervision from a psychologist. Qualitative data used open-ended questions to explore the experience of receiving supervision from a Clinical psychologist, from a healthcare professional's point of view. Triangulation was used to validate and integrate results. **Results:** A significant difference was found between groups in self-esteem, but no significant difference was found between groups in job satisfaction and burnout. Qualitative results provided supporting evidence to suggest that the process of psychological supervision improves confidence and self-esteem in healthcare professionals. **Conclusions:** The present study demonstrates the importance of further investigating the impact of supervision from a Clinical psychologist, on healthcare professionals.

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DECLARATION OF AUTHORSHIP

I, [please print name]

declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

[title of thesis] JOB SATISFACTION, BURNOUT AND SELF-ESTEEM IN THE MULTI-DISCIPLINARY
TEAM: THE IMPACT OF PSYCHOLOGICAL SUPERVISION

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. [Delete as appropriate] None of this work has been published before submission [or] Parts of this work have been published as: [please list references below]:

Signed:

Date:.....

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School of psychology

Volume 1 of 2

**The impact of clinical supervision on Clinical
psychologists and counsellors, their practice and
their clients: A systematic review of the literature
from 2006-2014**

By

Sophie Williams

Word count: 9,265

1.1 Introduction

Qualified Clinical psychologists and counsellors are often faced with the responsibility of working with complex mental health needs and consistently work closely with vulnerable clients and their families. Clinical supervision has always played an important role in ensuring the safety and welfare of clients, and at the same time promotes learning and professional development of the supervisee. For many years within the UK, the British Association for Counselling and Psychotherapy (BACP), the Health and Care Professions Council (HCPC) and the British Psychological Society (BPS) have recognised regular supervision as an essential requirement for any training or practising therapist. However, it is pertinent at this time of change in the National Health Service (NHS) to examine more closely the function and impact of supervision. Alongside expansion and increasing demand for Clinical psychologists across all areas of the NHS, there is growing requirement for scrutiny of clinical practice. This immediately raises the issue of the effectiveness of practice, and whether supervision is an appropriate use of clinical time. Therefore the need in understanding and justifying the use of supervision is more important and relevant than ever.

1.1.1 Definition of clinical supervision

There are many different definitions of clinical supervision available. From a comprehensive search of the literature many of the definitions are somewhat dated, and do not reflect the multiple functions of the supervision process. Milne (2007) conducted a two-stage review to define supervision; by first proposing a detailed classification (see appendix 1) of supervision and testing the criteria against the existing literature (thus providing an evidence based definition). For the purpose of this systematic review, the definition by Milne (2007) is used:

“The formal provision, by approved supervisors, of an intensive relationship-based education and training that is case-focused and which supports, guides, develops and evaluates the work of colleagues.” (p.439)

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Supervision is now established as one of the most effective methods for helping psychologists and counsellors build skills and develop professionally. Therefore, the clinical supervisor is responsible for client work, teaching skills, developing supervisee self-awareness, whilst also evaluating overall clinical practice. It is interesting to note at this stage, that even the definition already implies that clinical supervision has a significant impact upon the clinician, their practice and their work with clients. Historically, clinical supervision has been regarded only in a positive light, suggesting all aspects of supervision are beneficial and positively impact upon the therapist and their clients. However, when the evidence base for this assumption is reviewed, there appears to be significant paucity within the supervision literature.

1.1.2 The wider context of clinical supervision

In recent years the perception of supervision within clinical psychology has significantly changed (Fleming & Hughes, 2015). Supervision is now viewed as a core skill for Clinical psychologists, which has dramatically changed the roles of many clinicians (from direct clinical work to indirect supervisory and consultancy work with other team members). This shift was initiated by changes in policy and has been supported by the Division of clinical Psychology (DCP), the Care Quality Commission (CQC) and HCPC.

The 'New Ways of Working' (NWW) was originally published in 2005 as a guidance for Psychiatrists in reducing their implicit supervisory and clinically responsible role over the rest of the team (Turpin, 2012). NWW was so successful that it was then expanded to other disciplines, becoming one of the driving forces for developing new roles, more flexible working practices and training opportunities (to broaden therapeutic skills) for all staff working within mental health services. The NWW guidance is now part of NHS trust supervision policies and has emphasised the importance of supervision through working collaboratively with other team members and innovating services. An example of this change is evident in the Psychological Therapies (IAPT) service, which was structured to prioritise supervision (Turpin, 2015) and has commissioned work on defining supervision competence frameworks to inform training programmes (Roth & Pilling, 2008).

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In support of policy changes, the CQC have published the '*supporting information and guidance: supporting effective supervision*' (2013) document, and the HCPC have provided a document on '*standards of proficiency for practicing psychologists*' (HCPC, 2011). Both of these documents include standards required for supervision practices within the role of a Clinical psychologist. The 'DCP policy on supervision' (2014) provides an excellent summary of the guidelines for good practice in clinical supervision. The document includes that all clinical psychologists should receive regular supervision, that all supervisors should be trained in providing supervision; specifying supervisors should apply supervision models and should attend carefully to the supervisory relationship. Each of these guidelines then goes into detail about how each specified standard should be met by supervisors and supervisees. These standards were created initially by the Supervision Training and Recognition (STAR)¹ group. The STAR group developed learning outcomes criteria for introductory supervisor training for Clinical psychologists. The learning outcomes are now adopted and implemented by all clinical psychology training programmes (Beinart & Golding, 2015). The BPS developed the Register of Applied Psychology Practice Supervision (RAPPS) which requires clinicians to attend four CPD training courses based upon the STAR learning outcomes. Beinart and Golding (2015) have also described the development of the Clinical Supervision Advisory group (CSAG) which has adapted the original STAR criteria to support the needs of experienced supervisors in continuing their development in supervisory skills.

In conclusion, supervision is now recognised as a critical element of clinical practice and has become much more of a priority to clinicians across mental health settings. Therefore literature reviews which consider how supervision benefits Clinical psychologists and counsellors will continue to inform future training in the supervisory process.

¹ The STAR group consisted of a small working group of clinical psychology trainers. The group developed criteria for introductory supervision training and ensured that all doctoral programmes were meeting these standards (HCPC now ensure these learning outcomes are maintained).

1.1.3 Previous reviews of the literature

There have been seven reviews of the supervision literature in the past, all of which look at different aspects of supervision in a variety of settings, therapeutic orientations and methodologies. For example, Freitas (2002) reviewed two decades of the evidence base for psychotherapy supervision, but focussed purely on client outcomes as a measure of the effectiveness of supervision. In contrast, Milne and James (2000) considered the evidence base for the impact of cognitive behavioural supervision on health professionals. The general conclusions drawn from all seven of the previous reviews were that supervision consistently benefits the supervisee, but little or no research had demonstrated a significant relationship between supervision processes and client outcomes due to lack of methodological rigor. Such methodological limitations may continue to be a problem in this area of research due to limitations in appropriate outcome measures, the lack of evidence base for some theoretical models of supervision and the complexity of processes involved in supervision itself.

The most recent review (Wheeler & Richards, 2007) inspired the current examination of the literature. Wheeler and Richards (2007) were funded by the BACP to examine the evidence for the effectiveness of supervision to both the supervisee and their clients. The review included 18 studies and concluded that supervision is consistently associated with positive impacts upon the supervisee. This included improvements in crucial developmental areas such as self-awareness, therapeutic skills and self-efficacy. However, as acknowledged by the authors, none of the studies provide substantial evidence to support the link between supervision and its impact upon client outcomes. Therefore, clearly highlighting that to gain any new information in this area, research needs to focus more on the impact of supervision on clients in order to gain an understanding of how supervision may benefit therapeutic outcomes.

1.1.4 Aim of the current review

A systematic review is *'a literature review of a clearly formulated question that uses explicit methods to identify, select and critically appraise relevant research, and to collect and*

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analyse data from the studies that are included in the review' (Green & Higgins, 2010). Such reviews help clinicians keep up to date with research findings, and are often used in the development of clinical practice guidelines and planning future research agendas (Wiesler & McGauran, 2010). Conducting regular systematic literature reviews can help to highlight any gaps or unanswered questions within the evidence base, as well as direct future research and develop ideas into answering the identified questions, in a more a methodologically sound manner.

Based on Wheeler and Richards (2007) original review, this particular report aims to replicate the same search, using similar criteria, to review how the literature has developed and evolved since 2006. Many of the literature reviews about clinical supervision have highlighted methodological limitations of the evidence base, and given positive suggestions towards developing research in this area. For example Wheeler and Richards (2007) conclude that researchers need to develop methodology which measures the long term effects of supervision, the benefits of supervision for experienced practitioners (rather than focussing on trainees), and most importantly which takes into account the impact of supervision on client outcome. It is proposed, therefore, that a contemporary literature review will be able to identify any new developments within this often neglected area of research.

The research question was formulated as: '*What impact does clinical supervision have on the counsellor or psychologist, their practice and their clients?*'. Wheeler and Richards (2007) review question was slightly different in that it asks about the impact on counsellors and therapists rather than psychologists. Overall, this literature review aims to consider a wide range of methodologies to ascertain the impact of supervision on the supervisee, their practice and their clients. It will also highlight how research has developed in this area since the last review, as well as offer alternative directions for future research.

1.2 Systematic review

1.2.1 Search strategy

Google Scholar was initially used to identify previous systematic reviews relating to the impact of clinical supervision on psychologists, their practice and their clients. To complete the

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systematic review of the literature, the bibliographic databases PsycInfo, Medline and Web of Science (all databases) were searched. The following search terms were used: ‘Supervision’ OR ‘Professional Supervision’ AND ‘Psychologist’ OR ‘Psychologists’ OR ‘Psychology’ OR ‘Counsellors’ OR ‘Counsellor’². Search term combinations were completed across the following four fields: title, abstract, keywords and subject. Google scholar, citation indexes and references lists were then searched to identify any other appropriate articles which may have been missed from the search of the databases. The search terms were purposely broad to maximise the number of articles identified from this limited area of research.

1.2.2 Defining inclusion and exclusion criteria

All published work written in English was included between the years of 2006-2014. The review sought to find and analyse empirical research, utilising both quantitative and/or qualitative methodologies. Case studies were excluded due to the difficulties related to generalising the results to the general population.

Similar to the previous literature review by Wheeler and Richards (2007), it was important to include studies that had an objective measurement of the impact of supervision on the supervisee. However, much of the research was limited to self-report studies, so the criteria were extended to include these within the search. Yet, studies which did use self-report measures of satisfaction with supervision were only included if coupled with other more reliable measures to quantify the impact of supervision (in the previous review these were excluded).

For this review, it was decided that the supervisees must be counsellors, psychotherapists or psychologists, who have had substantial therapeutic training (or undergoing training) within their role and were specifically engaged in therapeutic work with clients. Therefore, other health professionals such as psychiatrists, various nursing professions, occupational therapists, physiotherapists, educational psychologists and other professionals having supervision were excluded. As Wheeler and Richards (2007) explain, family therapy articles were also excluded due

² ‘Therapist’ was initially included within the original search but produced an unmanageable amount of articles (which were mainly outside of the UK) therefore the term was excluded from the search

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to the substantially different form of supervision utilised within the profession, compared to other psychologically based disciplines. However, peer supervision, group and triadic supervision research were included when it met the rest of the inclusion criteria.

It is important to note that much of the research conducted in this area focuses on supervision of trainees (American studies refer to trainees as interns). Although these studies were not excluded, careful consideration was paid to recording whether the supervision relates to trainees or experienced practitioners, and this will be made explicit throughout the review.

1.2.3 Results

The initial search yielded 693 articles. Results were narrowed by excluding dissertations, publication type (peer-reviewed journal only), language (English) and date (2006-2014). An initial screening process based on the titles of the articles was first made; this resulted in 580 articles not meeting the inclusion/exclusion criteria based on their titles. The majority of these articles were excluded because they made no reference to the impact of supervision ($n = 272$) or they were a book chapter or dissertation ($n = 178$). Eligibility of the remaining 113 articles were then reviewed based on their abstracts, of which 75 articles were excluded. This resulted in 38 articles from the original search being reviewed at full text level. 16 of those articles were excluded because they were too descriptive in nature and made no measure of the impact of supervision. This resulted in a total of 22 articles included in the final analysis. The selection process is shown in figure 1, and table 1 contains details of the articles included within the review.

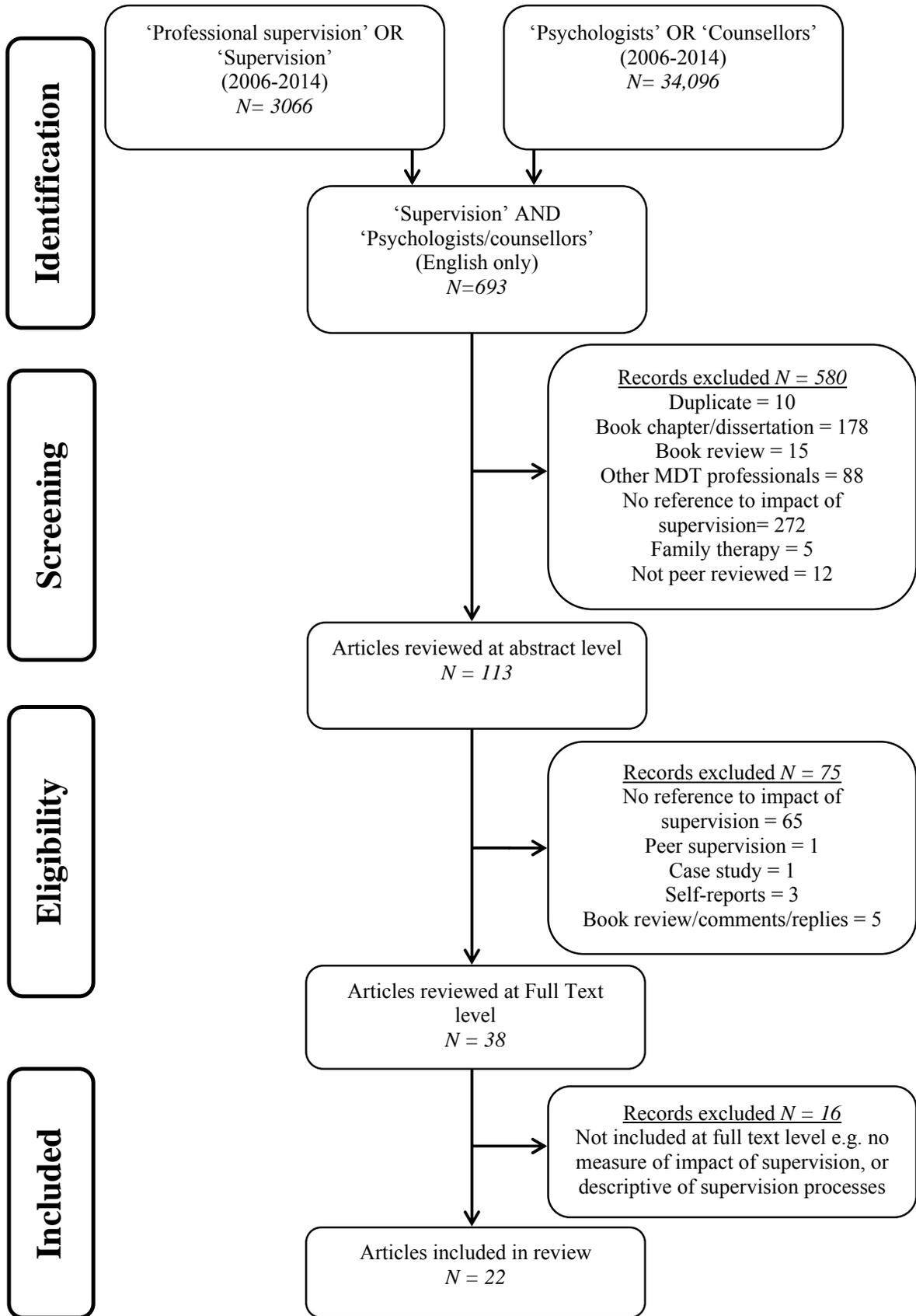


Figure 1: Overview of literature search and retrieval

Table 1: Detailed information for each article

<i>Authors</i>	<i>Aims of study</i>	<i>Sample Size</i>	<i>Design</i>	<i>Measures</i>	<i>Results</i>
Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006)	To explore whether an alliance focussed supervision approach enhances client perception of working alliance, and improve symptoms of client depression. To assess if this impacts upon client retention.	40 supervisors 127 therapists 127 clients	Quantitative-RCT	Beck Depression Inventory (BDI), Social skills inventory (SSI), Working Alliance Inventory (WAI), Treatment evaluation scale, Problem Solving Treatment (PST) adherence scale.	Client rated WAI scores were significantly superior for participants in supervised groups compared with those in unsupervised groups. Clients receiving supervised therapy achieved a significantly greater reduction in BDI scores than those receiving unsupervised therapy. Supervision had a significant effect on client treatment satisfaction and retention.
Borders, L. D., Welfare, L. E., Greason, P. B., Paladino, D. A., Mobley, K., Villalba, J. A., & Wester, K. L. (2012)	To understand the advantages and disadvantages of individual, triadic and group supervision.	31 supervisees 11 supervisors	Qualitative	Individual and group interviews.	Participants reported that individual sessions were more supervisee focussed, individualised and intimate. Triadic sessions were both supervisee and client focussed, yielded quality peer feedback and yet were more time pressured. Group sessions were more client focussed, didactic and less engaging for supervisees.
Gnika, P. B., Chang, C. Y., & Dew, B. J. (2012)	Explore the relationships between perceived stress levels, coping resources, and the supervisory working alliance among counsellor supervisees.	232 supervisees	Quantitative	WAI and supervisory WAI, Perceived stress scale, Coping resources inventory.	Perceived stress was found to be a strong negative predictor of the working alliance and supervisory working alliance. Perceived stress and coping resources influence the quality of the relationships formed with both clients and supervisors

<i>Authors</i>	<i>Aims of study</i>	<i>Sample Size</i>	<i>Design</i>	<i>Measures</i>	<i>Results</i>
Hunt, C. & Sharpe, L. (2008)	Aimed to examine the effect of direct supervision of trainees. Explores patients' perspective on the efficacy of the supervision.	32 Trainees 49 clients	Qualitative	Developed open question surveys.	Trainees had a positive view of their supervisors, and patients had a positive view of trainees regardless of the supervisory practices (call ins or walk ins). Trainees were more positive about supervisors joining the session rather than calling in to the session. Only a few clients commented that this method had a negative effect on their confidence of the therapy.
Knox, S., Burkard, A. W., Edwards, L. M., Smith, J. J., & Schlosser, L. Z. (2008)	To investigate how supervisors view the function of their own self-disclosure within the supervisory relationship.	16 supervisors	Qualitative	Consensual qualitative research led interview protocol.	Supervisors reported that self-disclosure occurs in good supervisory relationships, and is often stimulated by supervisees struggling. Disclosure is often intended to teach or normalise supervisees' experience. Based upon reports, self-disclosure was associated with positive effects on the supervisor, supervisee and the supervisory relationship.
Knox, S., Edwards, L. M., Hess, S. A., & Hill, C. E. (2011)	To explore how supervisees experience supervisor self-disclosure, and how this impacts upon the supervisees' practice	12 supervisees	Qualitative	Interviews	Supervisory relationship is central in supervision. Self-disclosure from a supervisor is beneficial to practice, when it addresses supervisee concerns and thus normalises their clinical anxieties.

<i>Authors</i>	<i>Aims of study</i>	<i>Sample Size</i>	<i>Design</i>	<i>Measures</i>	<i>Results</i>
Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2008)	To investigate whether clinical supervision protects against counsellor turnover.	823 therapists	Exploratory analysis- Quantitative	Maslach burnout inventory (MBI), Turnover intention measure, Clinical supervision- adapted from two separate scales, Job autonomy- also adapted measure.	Clinical supervision is negatively associated with burnout and turnover intention. Perceived quality of supervision is strongly associated with counsellors' perceptions of job autonomy. The study concludes that supervision protects against burnout and turnover.
Knudsen, H. K., Roman, P. M., & Abraham, A. J. (2013)	To replicate the relationship between clinical supervision and emotional exhaustion, and test the hypothesis that occupational commitments acts as a mediator between supervision and emotional exhaustion.	934 therapists	Quantitative	Emotional exhaustion measure (adapted from MBI), Measure of clinical supervision (adapted from multiple sources), Occupational commitment measure.	Clinical supervision is associated with emotional exhaustion (the higher the quality of supervision is associated with lower levels of EE). The quality of supervision was shown to strengthen occupational commitment. Therefore, suggesting supervision plays a role in building ties between the therapist and their employer, which may protect against emotional exhaustion.
Kozlowski, J. M., Pruitt, N. T., Dewalt, T. A., & Knox, S. (2014)	To explore positive boundary crossings (PBC), and their impact on the supervisory relationship.	11 trainees	Qualitative	Interviews	PBC's usually occur in the context of a supportive supervision relationship. Supervisees reported it strengthened the relationship and felt their training had been enhanced.

<i>Authors</i>	<i>Aims of study</i>	<i>Sample Size</i>	<i>Design</i>	<i>Measures</i>	<i>Results</i>
Ladany, N., Mori, Y., & Mehr, K. E. (2013)	Aimed to explore and list the different supervision techniques, behaviours and skills which are considered effective and ineffective.	128 trainees	Mixed methods	Supervisee evaluation of supervisor (qualitative questionnaire), Working alliance inventory (WAI), Supervisory styles inventory, Supervisor self-disclosure index, Trainee disclosure scale, evaluation process within supervision inventory.	Generated a comprehensive list of effective and ineffective behaviours and supervisor competencies. Also identified variables associated with supervision process and outcome.
Lawson, G., Hein, S. F., & Stuart, C. L. (2009)	To examine the experience of supervisees who have participated in triadic supervision.	6 trainees	Literature review & Qualitative	Open ended interview	For triadic supervision to be an effective learning experience for supervisees, the study suggests considering the dynamics between paired supervisees, change in feedback and time for each supervisee. The authors concluded that the addition of a peer provides new forms of learning and support.
Lenz, A. S., Sangganjanavanich, V. F., Blakin, R. S., Oliver, M., & Smith, R. L. (2012)	To compare the wellness model of supervision (WMS) with the integrated developmental model.	32 trainees	Quantitative	Five factor wellness inventory, Counselling skills scale.	The results suggest that focussing on wellness within supervision benefits trainees in resilience and self-development, as well as clinical skills.

<i>Authors</i>	<i>Aims of study</i>	<i>Sample Size</i>	<i>Design</i>	<i>Measures</i>	<i>Results</i>
Lyon, R., Heppler, A., Leavitt, L., & Fisher, L. (2008)	Investigate the relationship between supervisory training and development level. Hypothesised the amount of training hours and experience would predict developmental level.	233 trainees	Quantitative- survey	Demographics, Psychotherapy supervisor developmental scale (PDS), Supervision experience, Training in supervision, Helpfulness of supervision course training.	61% of trainees had not completed any formal training in supervision, and yet 72% had supervised an assistant during their training. Participants that had received training reported higher competence levels. However, number of hours of providing supervision did not predict developmental levels, suggesting providing supervision does not facilitate competency.
McMahon, A., & Errity, D. (2014)	To identify factors associated with satisfaction of supervision. Also to identify factors influencing confidence in providing supervision.	392 psychologists	Mixed methods	Developed own survey which included the Manchester clinical supervision scale.	The study concluded that supervision frequency and quality relates to future confidence in supervising. Also the experience of supervision directly related to predicting confidence in providing supervision.
Mehr, K. E., Ladany, N., & Caskie, G. L. L. (2010)	To examine the content and reason for supervisee non-disclosure in supervision. Also, to examine the association between trainee anxiety non-disclosure and willingness to disclose.	204 trainees	Mixed methods	Supervisee nondisclosure survey, Trainee disclosure scale, WAI, Trainee anxiety scale, Demographics.	A strong supervisory working alliance was related to a lower amount of trainee non-disclosure and higher overall willingness to disclose. The greater the anxiety experienced by the trainee the greater amount of non-disclosure. The study emphasises the importance of process issues that may harm clinical effectiveness in trainees.

<i>Authors</i>	<i>Aims of study</i>	<i>Sample Size</i>	<i>Design</i>	<i>Measures</i>	<i>Results</i>
Nyman, S. J., Nafziger, M. A., & Smith, T. B. (2010)	To evaluate outcome data from a training programme that has implemented a multi-tiered supervision model.	444 clients	Quantitative	College adjustment scale (CAS), Outcome questionnaire- 45 (OQ-45).	The study suggests that counsellor experience does not influence client outcome and that trainee counsellors are just as effective as qualified counsellors in outcomes. The study concludes that a multi-tiered supervision approach is an effective approach to supervision in training.
Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009)	To investigate the use of continuous client outcome data in psychotherapy supervision.	28 supervisees, 9 supervisors, 110 clients.	Literature review & Quantitative	Outcome rating scale (ORS), Session rating scale (SRS), Supervision outcome survey (SOS), Supervision working alliance inventory (SWAI-T), Counselling self-estimate inventory.	Trainees who receive continuous feedback from their clients are twice as effective as those who do not receive feedback. Supervisory working alliance was not significant between groups, despite differing outcomes. It was hypothesised that the outcome data would have led to more specific feedback. However, results indicate that outcome data does not have a negative impact upon perceptions of supervision. The quality of supervisory alliance is related to client outcome.
Schoenwald, S.K., Sheidow, A. J., & Chapman, J.E. (2009)	To investigate the relationship between supervisors adherence to a supervision programme protocol, therapist adherence and changes in client behaviour	1,979 youth and caregivers, 429 therapists, 122 supervisors.	Quantitative	Child behaviour checklist (CBC), Vanderbilt functioning inventory (VFI), Supervisor adherence measure (SAM).	Results suggested that supervision which focussed on the structure and processes of therapy, and clinician development were associated with long term changes in youth behaviour.

<i>Authors</i>	<i>Aims of study</i>	<i>Sample Size</i>	<i>Design</i>	<i>Measures</i>	<i>Results</i>
Sternier, W. R. (2009)	To explore supervisees' perceptions of the quality of supervisory working alliance (SWA), work satisfaction and work related stress for supervisees working in mental health agencies.	71 therapists	Quantitative	Supervisory working alliance inventory (SWAI), Minnesota satisfaction questionnaire, Occupational stress inventory (OSI), Demographics.	The study concluded that supervisees satisfied with their SWA were more satisfied with their work. Positive perceptions of the SWA reduced the experience of work-related stress, and improved personal satisfaction in their work with clients. Preliminary findings suggest that dissatisfaction with clinical supervision might result in higher work related stress.
Tanner, M. A., Grey, J. J., & Haaga, D. A. F. (2012)	To examine whether cotherapy improves clinical outcomes and client retention. Also to assess the effect of cotherapy supervision on trainee performance.	256 clients, 79 therapists, 3 supervisors.	Quantitative (naturalistic)	OQ-45, Drop-out rates.	Client retention and clients symptomatic improvement did not differ significantly between cotherapy clients and control clients. This would suggest that cotherapy does not improve or impact client outcomes.
Wheeler, S., & Richards, K. (2007)	Literature review of the impact of supervision on counsellors, their practice and their clients.	N/A	Literature review	Multiple	The quality of evidence is variable, however the authors conclude that supervision is consistently demonstrated to have some positive impacts on the supervisee.
Worthen, V. E., & Lambert, M. J. (2007)	Review of the literature to justify the need to include outcome monitoring of clients in supervision.	N/A	Literature review	Multiple	Based on the evidence base, the authors propose that monitoring client outcome weekly, and feeding this back to in supervision reduces deterioration rates and induces positive outcomes.

1.2.3.1 Characteristics of identified studies. One of the articles was completed in Ireland, two in Australia, two in the UK and the rest of the 17 articles were undertaken in the USA (one of these being in USA and Canada). The majority of samples are taken from a trainee population; 14 used trainee participants, six used qualified professionals and two did not include a participant population (literature reviews). Participant numbers varied considerably between the articles; overall the numbers ranged from six to 1,979. Only six of the studies included client samples and considered client outcomes as a measure of the impact of supervision.

As anticipated from earlier reviews, limited information was offered about the therapeutic modalities of the supervisors, but where it was disclosed, orientations seem to vary from cognitive-behavioural, solution focused, or psychodynamic perspectives. Nine of the articles include participants from both a counselling and Clinical psychology background, whilst eight articles only used counsellors and three articles only used Clinical psychologists in their samples. Ethnic background of participants varied significantly with location of the study sample. Participants were also recruited from a multitude of different health care settings, only three articles specified that their samples were based in drug and alcohol treatment settings, the rest were taken from general mental health settings. Overall, a multitude of scales were used throughout the studies, some of which formed their own adapted measures, whilst others utilised more standardised measures (this will be discussed throughout the report).

The studies on the impact of supervision on the supervisee have been categorised under the following headings: *'the impact of supervision on the psychologist and their practice'*, and *'beneficial processes of supervision'*. Finally, research which has considered *'the impact of supervision upon the client'* will be discussed and summarised.

1.3 The impact of supervision on the psychologist and their practice

Wheeler and Richards' (2007) previous literature review indicated that self-awareness, skills and self-efficacy are enhanced through supervision. Since then, there is new evidence to suggest that more personal gains and therapeutic skills are developed through supervision processes. The evidence included in this review suggests that clinical supervision appears to be a potential buffer to a variety of negative job experiences; implying that supervision can provide significant support in personal developments as well as encourage growth in therapeutic competencies.

1.3.1 Competency

A central feature of supervision has always been to develop skills and feelings of competency in practice (working therapeutically with clients) but also to cultivate competency in supervisory skills and aid in professional development. With this in mind, research has begun to focus on psychologists' confidence in providing supervision, as an outcome of supervisory processes. Two studies indicate that engaging in supervision and/or receiving training are predictors of improved competency in providing supervision.

McMahon and Errity (2014) conducted the first study to investigate supervision in Irish psychologists. The study had several aims including; measuring the frequency of supervision, investigating factors which affect satisfaction with supervision, and factors affecting the confidence of providing supervision. The results suggested that although 70% of the psychologists who completed the study were providing supervision or had done so in the past, only 40% were confident in doing so. Based on the self-report questionnaire, psychologists named 'experience' as the most important factor contributing to their confidence; both experience as a psychologist and a supervisor were independent predictors of supervisory confidence. Most importantly, having supervisor training was also predictive of confidence in supervisory abilities, and yet only half the participants had attended one day of related training.

A real strength of this article is that over 400 respondents participated in the study, and it involved just over half of all health service psychologists in Ireland (providing a representative sample of the population). However, the study does rely heavily on self-report data; therefore it is difficult to determine how each psychologist's self-reported confidence relates to actual competence in supervisory practice.

Lyon, Heppler, Leavitt and Fisher (2008) considered trainees' perceptions of the supervision training they had received and how this has impacted upon their confidence of being a supervisor. In contrast to McMahon and Errity (2014), the results indicated that having more experience in providing supervision did not facilitate trainee's perceived competence as a supervisor. However, the study indicated that the majority of trainees who participated had received little (61%) or no (11%) formal training in supervision. Trainees with more supervision training reported higher development levels and confidence in being a supervisor, when compared with trainees with less training; supporting the conclusion that training impacts upon confidence in providing supervision. Overall, both studies lack an accurate measure of actual competency in supervision and consequently rely on self-perceived confidence as a measure of competency.

1.3.2 Emotional exhaustion and burnout

Three studies support the notion that receiving frequent supervision reduces levels of emotional exhaustion (EE), burnout and turnover in counsellors. Utilising data from a clinical trial network for drug abuse, Knudsen, Ducharme and Roman (2008) looked for an association between clinical supervision and burnout related factors within a drug abuse clinical trial network. The authors found that supervisees who perceived their supervision positively experienced significantly lower levels of EE and were more likely to remain in post. This would suggest that clinical supervision plays a protective role in counsellor wellbeing, and highlights that the quality of the relationship between the supervisor and their supervisee appears to determine these effects. However, these results are not able to indicate how the supervisory relationship governs this positive impact. A significant limitation of this study is that most of the measures of supervision

are based upon supervisee perception, so more objective measures of supervision performance may change the described relationships between these factors.

Knudsen, Roman and Abraham (2013) used the same data from the drug abuse trial network to understand which aspects of the supervisory relationship impact upon EE and staff turnover. It was hypothesised that supervision works to enrich the counsellor's ongoing experience of their job and connect the counsellor closer to the organisation. Therefore, the authors were particularly interested at looking for an association between commitment to the treatment (occupational commitment) and their commitment to their employer (organisational commitment) as possible mediators of the relationship between supervision and EE. The results suggest that occupational and organisational commitments are directly associated with the quality of supervision; the better the supervision, the more likely counsellors are committed to the treatment programme and to their employer (and wider organisation). This implies that these forms of commitment may be potential mechanisms through which supervision protects against emotional exhaustion. Unfortunately, the relationship observed is based on cross-sectional data; therefore to establish causality between the variables a longitudinal study may be more suitable. Furthermore, the sample is based within a single health care setting which limits the generalizability of the results.

Lenz, Sangganjanavanich, Balkin, Oliver and Smith (2012) considered how supervision may impact specifically on a trainee's development personally and professionally. The authors introduce the Wellness Model of Supervision (WMS) which promotes the inclusion of assessment, planning and intervention of personal wellness goals for the supervisee, throughout weekly supervision sessions (Lenz & Smith, 2010). Wellness goals can fall within six domains of wellness (social, spiritual, physical, intellectual, emotional, and psychological) therefore goals can range from managing work related stress to developing cultural identity and awareness of how this impacts therapeutic work (Lenz & Smith, 2010). By developing such a personally related plan within a supervisory context there is a significant risk of the process mimicking personal therapy.

The model is therefore reliant on the supervisor to clearly define roles and boundaries within the relationship and linking any learning back to clinical work.

A quasi-experimental study was conducted comparing the effectiveness of the WMS with alternative supervision models. The results suggested that trainees in the WMS condition were more likely to report higher overall wellness and significantly greater development in counselling skills. The study suggests that adopting the WMS model develops resiliency in trainees and improves insight into the early warning signs of stress related difficulties, consequently protecting against symptoms of burnout and emotional exhaustion. However, it is important to note that the sample size was small ($N = 32$) and did not reach the threshold for achieving adequate power ($N = 34$) therefore the results of the analysis should be held lightly. The scales adopted to measure overall wellness also have significant limitations; the authors acknowledge that one measure only accounted for 32% of the variance of scores within the normative sample, suggesting a need for more reliable measures of wellness. With that in mind, the preliminary findings propose that providing a focus of personal wellness during training may have more promising implications for confidence in clinical skills and resilience as a clinician in the future.

1.3.3 Self-efficacy

Self-efficacy refers to an individual's belief in their ability to complete tasks and achieve goals, and it has been suggested that supervisory feedback has a direct influence on counsellors' self-efficacy (Daniels & Larson, 2001). Wheeler and Richards (2007) presented five studies which examined the relationship between supervision and self-efficacy. Although the included articles produced some mixed results, the authors were able to conclude that receiving clinical supervision is associated with higher ratings of self-efficacy and improved perceptions of clinical skills.

Reese, Usher, Bowman, Norsworthy, Halstead, Rowlands and Chisholm (2009) have tried to move beyond the scope of supervisory processes improving upon self-efficacy and looked specifically at how including 'client feedback' in supervision influences counsellor self-efficacy during training. Client feedback refers to the use of continuous outcome assessment before and

after each session to track client progress in therapy; it includes written feedback from the client on the therapeutic relationship, and their perception of progress and outcomes in therapy. Trainees were randomly assigned to two different conditions, one group received feedback from clients, and the other group did not. The results suggest that both groups demonstrated improved client outcomes at the end of their work, but those in the feedback condition improved significantly more. Interestingly, both groups showed satisfaction with their supervisory input and rated a good alliance with their supervisor, so there was no difference between groups in terms of how the supervisory alliance was rated. However, those who did receive client feedback demonstrated a higher level of self-efficacy in relation to their client outcomes, suggesting they were making more accurate assessments of their therapeutic abilities, when compared to the group who did not receive client feedback. This not only implies that client feedback does not influence the development of a good supervisory alliance, it also highlights that self-efficacy is not solely developed through supervisory processes but rather depends on a multitude of factors. Monitoring client feedback could help to provide rich information for use in supervision by enabling supervisors to monitor supervisee progress more closely, and also provide appropriate support to trainees who may have received negative feedback from clients. A significant limitation of this study was related to small sample size ($N = 28$); with a larger sample a hierarchical linear model could have been used to assess growth curves across the academic year for both clients and trainees, providing a more detailed and robust analysis of the data.

1.4 Beneficial processes of supervision

It seems that more recently much of the research has focused on understanding how supervision is beneficial to supervisees; specifically looking at different supervisory techniques and how they might impact upon supervision outcome. Landany, Mori and Mehr (2013) looked at the concept broadly by comparing effective and ineffective factors of supervision. A mixed methods design was used to measure individual experiences on the most effective and ineffective supervisor

skills, techniques and behaviours. According to the trainees, supervisors who encouraged autonomy, open discussion, demonstrated good clinical knowledge and offered constructive feedback were associated with effective supervisory techniques. Supervisors who depreciated supervision (were less available and did not treat the time as important), showed a lack of knowledge about the client population, emphasised feedback on negatives and provided inadequate guidance, were associated with ineffective supervisory behaviours. Much of the findings in this study were dependent on participant recall of previous experiences which is open to significant biases, so this must be kept in mind when interpreting the results. However, these findings were consistent with previous implications that the quality and openness of the supervisory relationship determined the overall experience of supervision.

1.4.1 The supervisory working alliance

There is a large body of evidence demonstrating that a strong supervisory relationship is one of the best predictors of supervisee outcomes. For example, Sterner (2009) found significant relationships between perception of the supervisory alliance, work satisfaction and work-related stress, based on findings from an on-line survey. This indicates that when a supervisee is content with their supervisory relationship they are more likely to be satisfied with their work with clients, their work environment and experience less work related stress. Consequently, quality clinical supervision not only contributes to supervisees' professional development and work satisfaction, but also acts as a resource for moderating work-related stressors.

This finding has been replicated by Gnilka, Chang and Dew (2012) who looked at how supervisee stress and perceived coping resources impact upon the therapeutic working alliance with clients as well as within the supervisory working relationship. Their regression models implied that supervisee stress has a negative relationship with the therapeutic working alliance, and that supervisee coping resources had a significant positive relationship with the therapeutic alliance. This suggests that the less stress perceived by the supervisee and the more coping resources they have may predict a better therapeutic working alliance with clients (improved quality of the

therapeutic relationship predicts a significantly better client outcome). In terms of the supervision setting, a similar effect can be observed; supervisees who reported lower levels of stress in their lives and have a greater ability to control their environment reported stronger alliances with their supervisors and clients. This factor would be important to emphasise during the early stages of training clinical psychologists; developing good coping resources, emotional control and mental tension will improve future working alliances, supervisory relationships and protect against stress related difficulties. Also, supervisees who reported a greater sense of control in supervision were more likely to report a stronger supervisory relationship. Supervisors should consider the importance of allowing the supervisee to take control of their own goals from supervision to increase their sense of engagement.

Again, it is important to acknowledge the limitations associated with both the articles mentioned. The studies adopted an on-line survey design which means it is possible that participants with positive experiences of supervision may have been oversampled. Furthermore, the study is a cross-sectional design, so making causal conclusions about the relationships observed is not possible. With this in mind, Gnilka, Chang and Dew (2012) do highlight the importance of supervisors monitoring their supervisees stress levels and coping resources on a regular basis, because it will clearly impact on the quality of the relationships that are formed with both clients and supervisors.

1.4.2 Self-disclosure

Self-disclosure within supervision has long been considered a useful technique for building and maintaining a quality supervisory relationship (Farber, 2006). Much of the previous quantitative research has focussed on the different types of self-disclosure and has found supervisor self-disclosures to have a positive association with supervisory working alliance and supervisory style. More recently, qualitative methods have been utilised to really explore the different uses of self-disclosure and understand its potential impact within the supervisory relationship.

Knox, Burkard, Edwards, Smith and Schlosser (2008) conducted the first qualitative study exploring the supervisor's own perspectives on using self-disclosure. After interviewing 16 supervising clinical and counselling psychologists, the themes suggested that supervisors use self-disclosure to enhance supervisee development and normalise their experiences. Supervisors described using the technique strategically, for example tailoring it to the supervisee's developmental needs, using it more in good quality supervisory relationships, or when the supervisee was particularly struggling. All supervisors reported that self-disclosure yielded positive effects on the supervisee's development and on the supervisory relationship.

Knox, Edwards, Hess and Hill (2011) then went on to explore supervisor self-disclosure from the supervisee's perspective to investigate whether their experiences of the disclosure corresponded with the supervisor's intentions. Using consensual qualitative research methods, the authors interviewed 12 trainees about their supervision experiences. Supervisees typically perceived the intent of the disclosure to normalise their experiences, and were typically used in both personal and clinical contexts. The results suggested that the quality of the supervision relationship was a crucial context for the disclosure; within a positive supervisory alliance the disclosure impacted positively on the supervisee, but within a difficult relationship the disclosure was viewed more negatively by the supervisee. Negative impacts occurred where the intentions of the self-disclosure were unclear to the supervisee. Where a positive impact was reported by supervisees, they felt that the effects persisted into later supervisory relationships and their own clinical work (consistent with previous findings).

Both of the above studies had small sample sizes with limited diversity. As a result it is difficult to know whether the findings would differ with a more diverse and larger sample and thus the representativeness of the findings is questionable. In addition, the interviewing process relies on participants' ability to recall supervisory experiences, which can often be influenced by memory biases.

The limited evidence base would suggest that self-disclosure in supervision is a positive experience which appears to impact upon the supervisee's development. However, Mehr, Ladany

and Caskie (2010) noticed that reasons which prevent disclosure in supervision were somewhat neglected within the literature. The authors explored trainee explanations for non-disclosure in supervision using a mixed-methods design, with direct observation of a supervision session. The results indicated that on average trainees withheld between two and three disclosures in each supervision session, and the most common reason for the non-disclosure was related to a negative supervision experience. Unsurprisingly, the quality of the supervisory relationship was associated with the amount of non-disclosures; the better the relationship the lower the rate of non-disclosures.

1.4.3 Crossing boundaries within supervision

Similar to self-disclosure, the benefits of boundary crossings in supervision has also received attention from researchers in recent years. Boundaries within supervision have been defined as ‘rules of the professional relationship that set it apart from other relationships’ (Knapp & VandeCreek, 2006). Kozlowski, Pruitt, Dewalt and Knox (2014) hoped to explore the potential benefits of boundary crossing in supervision, by interviewing nine trainee psychologists/counsellors. Similarly to the findings with self-disclosure, positive boundary crossings usually occurred in the context of an already supportive supervisory relationship. The most notable positive effects reported by supervisees included a strengthened supervisory working alliance and a perception their training was enhanced. Many trainees described the experience of role confusion after the boundary crossing (such as going out for a drink outside of work, sharing a car journey together etc.) however; in most situations this confusion was never discussed in supervision. A significant limitation of this study is that the interviewers only asked about positive experiences of boundary crossings, which may have prevented supervisees to speak about any negative experiences. Furthermore the perspective of the supervisor was not considered; they may have an alternative view of the function of boundary crossings within the supervisory relationship.

1.4.4 The impact of different types of supervision

Supervision comes in a variety of formats, some of which have a greater evidence base than others. The most traditional format (and with the largest evidence base) is individual supervision, but other forms include triadic, group, peer and within-session supervision. In the past, it has been assumed that the individual supervision format is the most effective arrangement to optimise supervisee learning and development. Now more exploratory research has been conducted to suggest other formats may be just as effective³.

Lawson, Hein and Stuart (2009) completed a review of the literature relevant to triadic supervision. Triadic supervision involves two supervisees receiving supervision together with the same supervisor in the same supervision session. Their reviews revealed that only a small number of studies have focussed on triadic supervision. The most interesting finding from these studies was by Newgent, Davis and Farley (2004) who evaluated the perceptions of 15 supervisors using several standardised questionnaires around the supervisory working alliance. The authors concluded that triadic supervision was rated similarly to individual supervision in terms of the quality of the supervisory relationship, relationship dynamics and satisfaction with supervision. This would suggest that from the supervisor's experience, their working alliance with their supervisees is unaffected by the alternative structure in triadic supervision.

However, Lawson, Hein and Stuart (2009) more recently interviewed six trainees about their experiences of a triadic supervision format. The results indicate a number of benefits to the format but also some potential challenges which will impact upon the supervisee's development and learning. The majority of trainees reported concerns regarding receiving inadequate time and feedback from their supervisors, due to the shared structure of the triadic format. Secondly, a central concern from trainees was supervisee compatibility; a relatively high level of compatibility between supervision peers is necessary to achieve an effective supervision structure. When low levels of compatibility were present, trainees reported negative impacts such as, more guarded

³ Please note: all of the following qualitative studies are subject to similar limitations. In particular, small sample sizes and reduced diversity impact upon representativeness of the sample and generalizability to the population.

communication with their peer, less self-disclosure, reduced learning and generally a struggle to get their needs met through the supervisory process. Yet, in situations where compatibility between supervisees was high, trainees reported significant benefits such as added support and validation of experiences from their peer.

Borders, Welfare, Greason, Paladino, Mobley, Villalba and Western (2012) conducted a qualitative study to explore supervisor and supervisee perceptions of individual, triadic and group supervision sessions. This particular study highlights some of the advantages and disadvantages to each format. Individual sessions were valued for their person-specific attention, undivided time to build on the supervisory relationship and felt that they received a greater depth in feedback. Individual supervision formats did not receive any criticism or negative comments. Triadic supervision also received a lot of positive comments from participants, particularly around having more intimate and comfortable peer interactions, receiving peer feedback and having the opportunity to learn vicariously. However, participants identified similar disadvantages to triadic supervision formats (to previous findings) including, supervisee compatibility and increased time constraints. Finally, group supervision was among the least popular among the three modalities, due to feedback within a group setting being perceived to be less constructive and too generalised. Participants also reported that peer interactions were affected by the group context, resulting in less open interactions when compared to triadic supervision. Despite these limitations participants did report that they benefitted at times from receiving multiple perspectives and theoretical orientations, which often normalised the challenges they might be experiencing.

Hunt and Sharpe (2008) looked at how within-session supervision could be used as an effective technique in training Clinical psychologists. Whilst trainees were conducting therapy with their clients, supervisors were able to telephone into the session to speak with the supervisee (call-ins), or could physically enter the session and provide supervision in the room (walk-ins) with the client present. The authors recorded the reactions of both supervisees and clients to see if the process had been useful or damaging to the therapeutic alliance. Although the study was

naturalistic, there was no random assignment to conditions, therefore characteristics of trainees and supervisors may have influenced the use and frequency of supervision methods.

The results suggest that although a few of the supervisees and clients found the entrance of the supervisor intrusive and unhelpful, the majority of participants reported positive feelings towards within-session supervision. Overall, trainees were more positive about the walk-ins than the call-ins format, and this was the same for clients. The authors had also hypothesised that the use of within-session supervision would alter and affect the supervisory relationship; however ratings of the supervisory style and alliance did not change over time. It must be noted that some supervisees and clients did find the experience disruptive and intrusive. Therefore issues of consent (from both the supervisee and the clients involved) would need to be considered before using this method.

Overall, research still indicates that individual supervision formats are the most favoured by supervisors and supervisees, as it ensures the maximum amount of dedicated time purely focussed on the individual's needs. However, triadic supervision clearly has advantages which individual supervision is unable to provide, including the opportunity for vicarious learning and developing feedback skills. In addition, within-session supervision has also shown to have some advantages for those training in psychology or counselling. More quantitative research is needed to explore the different impacts of these supervisory formats, including objective measures of supervision rather than relying on supervisee self-reports.

1.5 The impact of supervision on the clients

An important role for supervision is to monitor client welfare and to improve client outcomes (Milne, 2009), however, therapy outcomes as a function of supervision has proven difficult to measure. Wheeler and Richards (2007) reported only three studies which had attempted to address and measure how supervision impacted upon client outcomes, all of which are preliminary studies. The studies concluded that the content of supervision has an observable

impact on a supervisee and their client; counsellors perceive that supervision has a positive impact upon client outcomes but there is a distinct lack of evidence to support this relationship.

It is interesting to observe that since the year 2006, only five more studies have measured client outcomes when considering the impact of supervision. The majority of previous studies are characterised by having quite problematic methodological flaws, the most common difficulties are related to the lack of validated measures of supervision and poor measures of client outcomes. Many of the articles use client satisfaction as an outcome, which only provides a measure of their satisfaction of therapy at that time. It does not measure whether their symptoms have reduced or quality of life has improved as a result of supervised treatment. Also, this particular area of the literature is associated with small sample sizes and it often uses trainees (rather than qualified therapists). Therefore it will be interesting to observe whether some of the more recent client outcome studies have attempted to address some of these methodological issues.

The first and only randomised control trial of clinical supervision was conducted by Bambling, King, Raue, Schweitzer and Lambert (2006) who focused on the relationship between supervision, the therapeutic working alliance and symptom reduction in a brief treatment of depression. Participants were qualified therapists who were randomly assigned to two different groups (either receiving supervision or not for their brief therapeutic work). The results showed that client-rated working alliance scores were significantly superior for participants in the supervised group compared with those in the unsupervised group. This suggests that supervisory processes have a clear impact upon the therapist's ability to connect with and maintain a therapeutic relationship with their clients. Bambling et al. (2006) also found that clients receiving treatment from a supervised therapist achieved a significantly greater reduction in depression scale scores when compared to those clients being treated by unsupervised therapists. This would imply that supervision has a substantial impact on improving client outcomes (or in this case reducing depression related symptoms). Clients evaluated supervised treatment much more positively and were significantly more satisfied with treatment when compared to clients who were treated by unsupervised therapists. Finally, supervision appeared to have a significant effect on client

treatment retention, suggesting that supervised treatment assists with ensuring that the client will complete the treatment. This implies that overall client outcome is much improved when the treatment progression is fully supervised, and supervision which focuses on the working alliance can influence the client's perception of the alliance and enhance treatment outcome in a brief treatment for depression.

Despite the methodological strengths of this randomised control trial, participant numbers for each group were only moderately sized ($N = 34$). Therefore the total power of statistical testing was insufficient to ensure that all the parametric assumptions were met. In addition the study was designed to detect total change between groups over time, rather than on a session by session basis. Any tensions that were resolved in therapy as a result of supervision (which could have influenced the working alliance) would not be reflected in the data.

Within an adolescent anti-social behaviour treatment context, Schoenwald, Sheidow and Chapman (2009) examined relationships between clinical supervision, therapist adherence (to treatment programme) and changes in youth behaviour and functioning (measured using pre-, post and one year follow up). Mixed-effect regression models implied that two dimensions of supervision predicted changes in youth behaviour: perceived adherence and control over the structure of supervision and focus on clinician development. This suggests that when supervision was rated as more structured and supervisors adhered to conventional supervision processes then youth behaviour was more likely to improve. The same relationship can also be observed when the supervisee felt that supervision took time to focus on their development (personally and professionally) then youth behaviour was more likely to improve. Although the study initially indicated a large participant sample (429 clinicians and 1979 youths/families) the study later highlights that a lot of the data for different families were missing; out of the 1979 families involved 323 were missing at least one type of data required for analysis. The statistical models adopted for the analysis did account for the missing data, but it is certainly a significant limitation of the study. Another limitation to note is that many of the changes found in youth behaviour were modest differences.

Conversely, there have been studies to indicate that supervision does not have an impact upon client outcomes and retention rates. Tanner, Gray and Haaga (2012) looked specifically at how cotherapy supervision enhanced trainee effectiveness and client outcomes. 'Cotherapy' is a psychotherapy term which refers to therapy provided conjointly by two therapists. Over the years cotherapy has become a common training method; supervisors begin as the primary therapist and the trainee as an active observer. Then gradually over the course of the treatment the trainee takes on more of an active role and eventually becomes the primary therapist (Tanner, Gray & Haaga, 2012). Research has indicated that cotherapy formats allow for immediate feedback and modelling, enabling trainees to correct mistakes more quickly. However, the technique has been criticised for potentially impacting upon the therapeutic working alliance due to the change in therapist dynamic over time (Klitzke & Lombardo, 1991). Tanner, Gray and Haaga (2012) therefore directly compared client outcomes between trainees receiving cotherapy supervision with trainees receiving individual supervision. The results indicated no significant difference between the two groups in either client retention or client symptomatic change. A limitation of this study is that the clients were not randomly assigned to either condition; therefore there is a chance that the more challenging cases were assigned to the cotherapy condition, thus offsetting the format's potential advantages. However, the study does indicate that there is a relationship between supervision and client outcomes, the format of supervision in this particular case did not appear to influence client outcome. In support of this, Nyman, Nafziger and Smith (2010) have shown that client outcomes are not influenced by training level of the counsellor. Therefore trainees receiving the appropriate amount of supervision achieve the same client outcomes as qualified professionals working within that field.

Finally, Worthen and Lambert (2007) conducted a literature review to investigate whether including client tracking and outcome oriented monitoring in supervision enhances outcomes for clients. The authors suggest that tracking client treatment response on a weekly basis and comparing this to an expected treatment response will alert counsellors and supervisors to any clients who are not responding as predicted. Some preliminary research was conducted by

Lambert, Whipple, Hawkins Vermeersch, Nielsen and Smart (2003) who showed that including client feedback in supervision improved progress by 25% and deterioration reduced by 19%. Thus, demonstrating that including this within supervision may highlight cases which need more intensive input, encourage more problem-solving orientated discussion within supervision and improve overall client outcome in the long term⁴.

1.6 Critical review and discussion

1.6.1 Summary of results

Despite Wheeler and Richards (2007) conducting a literature review of the impact on supervision less than a decade ago, this current review highlights several significant progressions within the literature. Overall, supervision has been shown to influence several areas of clinical practice. A relationship between supervisory processes and increased skills in clinical practice has been suggested in previous research (Wheeler & Richards, 2007), but more recently research indicates that supervision cultivates competency in supervisory skills and aids in professional development. For example, having more experience as a therapist and greater experience as a supervisor were both predictors of confidence and self-rated competence in supervisory abilities. However, the majority of working supervisors receive little or no training in providing supervision, and training was also a predictive factor to competence in supervisory ability, and so more effort should be made in training programmes to meet this need.

A negative relationship between supervision and levels of emotional exhaustion, burnout and employee turnover has also been demonstrated consistently within recent research. Therefore, supervisees who attend frequent supervision and are more satisfied with their supervisory input are more likely to feel less exhausted by work, are less vulnerable to burnout and are more likely to stay in their post. This suggests that clinical supervision acts as a potential buffer to a variety of

⁴ A limitation of assessing client outcomes as a measure of effectiveness of supervision is when for example, the goal of work with the client might be to prevent deterioration rather than to return to a 'normal' range of functioning. Therefore it would be important to consider client individual needs and a variety of outcome measures (such as quality of life, skills acquisition and functioning).

negative job experiences, implying that supervision can provide significant support in personal developments as well as encourage growth in therapeutic competencies.

In the past, the relationship between self-efficacy and supervision has received some attention, but also some mixed conclusions. Research has now moved forward to see what other factors might influence trainee self-efficacy; evidence indicated that receiving frequent feedback from clients and discussing this in supervision impacts upon trainee self-efficacy.

There is an increasingly large body of evidence demonstrating that a strong supervisory relationship is one of the best predictors of supervisee outcomes. Those who experience a good supervisory relationship are more likely to experience less work related stress, greater work satisfaction, the more likely supervisees are to self-disclose, learn from supervisor disclosures and respond positively to crossings of boundaries within the relationship. The quality of the supervisory relationship has also been linked to better client outcomes.

There are many different types of supervision, and research has begun to investigate which varieties are the most beneficial for supervisees. Research has shown that triadic supervision has some significant benefits for supervisees, including opportunities for vicarious learning, added support from peers and increased normalisation and validation of experiences. However, triadic supervision did have some reported disadvantages, and was a particularly difficult experience for those who were not compatible with their peers. Group supervision remains to be the least rated among supervisees and within-session supervision is a potentially useful tool during training.

Finally, the impact of supervision on client outcomes was considered. This small but growing body of evidence has now indicated from a randomised control study, that therapists who receive supervision for their therapeutic work achieve better working alliance scores from their clients, have better client retention and observe greater improvements in client symptomology. This suggests that supervision has a direct influence on client outcomes, and a relationship has been demonstrated in two very different clinical settings (brief treatment for depression in adults and challenging behaviour in adolescents in care settings). Including client feedback in supervision may enhance client outcomes.

1.6.2 Methodological issues and research limitations

Within supervision research there are some considerable limitations related to the methodology adopted to investigate this particular area. Most authors seem to comment on these limitations and yet research which has not adjusted for these limitations continues to be conducted. It is important to consider some of the reasons which might limit development of research into clinical supervision. Milne, Leck, James, Wilson, Proctor, Ramm, Wilkinson & Weetman (2012) suggest that the lack of objective measures limits the ability to demonstrate effectiveness. When put into context, developing such measures continues to be difficult because supervision is such a complex process to measure; with diverse functions and subtle reciprocal interactions it would be difficult for a single measure to be able to capture all of these processes. Another limitation related to this is that often outcome measures are developed from the theoretical models of supervision, which lack an evidence base to support the theory. For example the widely used Manchester Clinical Supervision Scale (MCSS; Winstanley, 2000) was developed from the Proctor model (Inskipp & Proctor, 1993). This social role model has not been explicitly tested (Beinart, 2012). However, knowledge of these methodological limitations is assisting in the development of change; Milne et al. (2012) are considering the use of the 'fidelity framework' to systematically overcome the problem of imprecise measurement.

The majority of populations included by most of the research studies in this review are based on trainees who are mostly white, from western cultures and female. Sample sizes vary significantly but the majority tend to be less than 100, which not only influences overall statistical power but also makes it difficult to generalise any of the findings to a general clinical population (as it is not nationally representative). A similar problem is that the most influential client outcome studies have been restricted to two different clinical contexts (drug abuse services and brief treatment for major depression), which again restricts generalizability of findings to other clinical contexts.

Much of the research into the effects of supervision is over-reliant on self-report questionnaires and retrospective recall of participants, therefore various biases might influence participant responses. Often the self-report questionnaires are based upon supervisory satisfaction, and supervisee/supervisor experiences which may not necessarily correlate with the development of competence or other benefits of supervision. Therefore much of the data are restricted due to lack of valid and reliable questionnaires, which measure objectively the multiple aspects of supervision. In addition, retrospective recall methods are again vulnerable to various biases; one study which utilised this method acknowledged this limitation, and highlighted that participants were not even asked about negative experiences of boundary crossings in supervision, which would have lead participants to only talking about positive experiences during interviews.

Another important factor in terms of design limitations is that the majority of the studies included in this review are based on cross-sectional data collection. Therefore, the data may only reflect a snapshot of the possible impact of supervision on the supervisee and their clients.

Ellis, Ladany, Krenzel and Schult (1996) conducted a methodological critique of the clinical supervision research between the years of 1981 to 1993. Although beyond the scope of this review, the authors highlighted some significant methodological issues which needed to be altered in order for the evidence base of supervision to progress. Interestingly, the authors recommended that sample sizes are increased, hypotheses are more theoretically driven, more statistical techniques are utilised to account for potential biases on the results and more psychometrically viable measures of clinical supervision are developed. Most of these limitations clearly exist within the literature today and methodological rigour continues to be an issue within supervision research.

It is important to note that a limitation of this review is that it only includes articles written in English so any relevant articles which have not been translated may have been missed from this search. Also, the search criteria only included published articles and 'therapist' was not included within the search terms due to unmanageable article numbers.

1.6.3 Future research considerations

Future research should consider recruiting from, and comparing between more professionally orientated populations. Trainees receive and require a greater level of supervision during training, therefore using trainees as a sample does not provide an accurate representation of the supervisory needs of qualified psychologists and counsellors. With larger sample sizes the methodological rigour of the studies may significantly improve.

Research should also consider the development of robust and validated supervision specific measures. At the moment there are no ‘common’ measures which are used specifically to measure aspects of supervision, and there is an over-reliance of self-report questionnaires; so providing improved measures may help to improve reliability and validity of research in this area. Consequently valid, reliable and inexpensive measures of clinical supervision are needed.

A more robust statistical methodology must be adapted to any future supervision research, coupled with qualitative measures, to increase the ‘richness’ of the data. Conducting supervision research that focuses on client outcomes is difficult and challenging; yet such research is important and necessary given the centrality of supervision to a psychologist’s role. Research should include more longitudinal or randomised control trial designs, using large multi-site methodology. For example, to fully understand the relationship between emotional exhaustion and supervision, future research should consider recruiting counsellors into a longitudinal study. This will elucidate the relationships between changes in clinical supervision, commitment, and emotional exhaustion as cross sectional studies at the moment cannot establish causality between these variables.

1.6.4 Clinical implications

This review demonstrates the importance of the supervisory relationship. Supervisors need to be aware that they can have significant influence on how supervisees perceive their workplace, develop skills and competencies as well as learn to adapt to changing environments. Hopefully this paper highlights to supervisors (and future supervisors) the importance of their role and how they might support supervisees in the future.

Consistently, research has suggested that current supervisors and trainees receive little or no training around supervisory skills, and many of the supervisors today lack confidence and feel incompetent about playing this role. Since the research included in this literature, training in supervision is now compulsory for trainees and is now considered a regular topic within continuing professional development. Some studies in this review have suggested specific supervision training around alliance management, as the working alliance is such an important factor in influencing the impact of supervision. To help trainees to become more effective clinicians and supervisors in the future, training should also cover issues of self-disclosure and crossings of boundaries in the supervisory relationship, and highlight the importance of reflecting upon this with the supervisee if it happens. The training now available (directed by the STAR and CSAG learning outcomes) do focus on the supervisory relationship and also include up to date knowledge of supervision models and frameworks.

Psychologists and counsellors should consider the responsibility to convey the importance of clinical supervision within mental health agencies and highlight the benefits for supervisees associated with this relationship. Although the NHS supports staff to prioritise regular supervision, it is common that within pressured services supervision is one of the first things clinicians will sacrifice in order to meet client or service needs. Research suggests that clinical supervision can act as a buffer against work related stresses, therefore supervision should remain a priority to clinicians particularly when under increased work pressures. Research could look into the effects of supervision for other health professionals, or whether receiving supervision from a psychologist could be of benefit.

1.7 Conclusions

This review aimed to identify the impact of clinical supervision on counsellors and psychologists, their practice and client outcomes. Results suggested overall that the most positive impacts of supervision occur when the supervisory working alliance is viewed as satisfactory, supportive and effective. Supervision has a significant association with developments in

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competency as well as buffering against work related stress, emotional exhaustion and turnover.

Preliminary studies also suggest that supervision has a significant association with improved client outcomes. A number of methodological biases were identified, particularly with the focus of trainee populations and small sampling. Further research is needed to better understand the relationship between clinical supervision and client outcomes, particularly in diverse clinical contexts. However, given the tentative findings of this review, it does suggest the importance of supervision, and how it impacts upon a variety of personal and clinical factors. Regular reviews of the literature will continue to contribute to the growing evidence base as well as develop and inform supervision training. Overall, training should continue to be a priority to supervisors to help prepare them for this complex and significant role.

UNIVERSITY OF SOUTHAMPTON

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**Job satisfaction, burnout and self-esteem in the
multi-disciplinary team: The impact of
psychological supervision**

By

Sophie Williams

Word count: 10,414

2.1 Introduction

2.1.1 Experiences of stress in healthcare professionals

In recent decades, the NHS has faced continuous changes; with some periods of growth as well as frequent budget cuts. Not only has this impacted upon clients and the services they can access, but it also affects the staff working in such demanding environments. Research indicates that healthcare professionals are vulnerable to stress related difficulties (burnout, job satisfaction, physical illness and sick leave). For example, Rees and Smith (1991) used a measure of occupational stress with different nursing professions to analyse the levels of experienced stress in health professionals. The results indicated that community mental health nurses were the most stressed group; the next two highly stressed groups were ward-based and general hospital nurses. This finding has been replicated by Butterworth, Carson, Jeacock, White and Clements (1999) and Prosser, Johnson, Kuipers, Szmukler, Bebbington and Thornicroft (1996). This evidence indicates that stress related difficulties are significantly higher in professionals who are based within mental health services, and more specifically community settings.

Onyett, Pillinger and Muijen (1997) argued that all disciplines that are based in community mental health settings are vulnerable to stress related difficulties, not just nursing staff. The study concluded that Psychiatrists, Social Workers, Nurses and Clinical psychologists reported high levels of emotional exhaustion (factor related to burnout) and reduced job satisfaction. No relationship was found between caseload size and job satisfaction, however the results did indicate that those clinicians who were clearer about their role within the team were more likely to report higher job satisfaction. This suggests that different aspects of the working environment influence and impact upon stress related difficulties.

To explore this further, Edwards, Burnard, Coyle, Fothergill and Hannigan (2000) conducted a systematic review of the literature. Of the 17 papers included, many different stressors were identified which have been significantly associated with higher levels of stress and burnout within this population; these included increasing caseloads/workloads and administration, lack of resources, inappropriate referrals and role ambiguity. Reduced time or lack of time altogether for

clinical supervision was repeatedly suggested as a contributing factor to stress related difficulties within the population.

In summary, the evidence clearly suggests that healthcare professionals are at significant risk of stress, burnout and job dissatisfaction, particularly within mental health settings. Therefore it is important for measures and processes to be in place to help support staff in managing these difficulties.

2.1.2 Clinical supervision

Supervision is considered to be one of the most effective methods for helping healthcare professionals build skills as well as develop personally and professionally (Milne & James, 2000). It is thought that supervision provides development in self-awareness, evaluates clinical practice to ensure standards are met, and provides personal support in managing stress and burnout. There are a variety of definitions of clinical supervision; Milne (2007) developed an evidence based definition which encompasses all of the above factors:

'The formal provision, by approved supervisors, of an intensive relationship-based education and training that is case-focused and which supports, guides, develops and evaluates the work of colleagues.' (p.439)

2.1.3 Models of supervision

It is important to acknowledge that there are many theoretical models of supervision available, and that all Clinical psychologists offering supervision will have been formally trained to be supervisors and therefore, will inform their supervisory practice within a theoretical model. Beinart (2012) suggests that there are three types of supervision models: developmental models, social role models and integrative approaches to supervision. Supervision is an exceptionally complex process to explain and understand, therefore it is important to consider the evidence base surrounding the models (Beinart, 2012).

The Process model of supervision (Hawkins & Shohet, 1989, 2000, 2012), sometimes known as the ‘*seven eyed model to supervision*,’ is an integrative approach which is often used for multi-professional supervisor training; therefore is suitable for a variety of healthcare professions. The model is both relational and systemic, in that it looks closely at what happens in both the relationship with the clients and within the supervisory relationship; as well as considering the interplay of the wider systems and contexts surrounding those involved (Hawkins & Shohet, 2012). The model seems to encourage the supervisor to open the supervisee up to choices in their approach towards the client (developing their skills) and supporting the supervisee to reflect on how they are affected by their work. Therefore, suggesting that clinical supervision is helpful in developing knowledge and therapeutic skills, and potentially protects against stress related difficulties.

2.1.4 Clinical supervision within the MDT

A large majority of the research into the benefits of clinical supervision are based on counsellors or psychologist populations. In recent years, a growing body of evidence is developing to support the importance of other healthcare professionals receiving more regular supervision. Reid, Johnson, Morant, Kuipers, Szmukler, Bebbington, Prosser (1999) explored the different strategies mental health professionals adopt to manage their high levels of stress and burnout, using a qualitative research methodology. Professionals reported that their main source of support was individual supervision and staff support groups. Moreover, informal contacts with colleagues and general peer support were also popular coping resources amongst professionals based in hospital or community settings. Overall, this would suggest that healthcare professionals view supervision as a helpful coping strategy for managing high levels of stress.

2.1.5 Clinical supervision, burnout and job satisfaction

It has been suggested that clinical supervision is associated with higher levels of job satisfaction, improved job retention (reduced turnover), reduced burnout and increased staff

effectiveness. Hyrkäs (2005) found that mental health nurses rated higher in job satisfaction and lower in levels of burnout when supervision quality and frequency improved. Inefficient supervision which was poorly structured and did not meet the needs of the nurses was associated with reduced job satisfaction (this has been replicated by Koivu, Saarinen & Hyrkäs (2012); White & Winstanley (2009); White & Winstanley (2010)⁵).

However, Spence, Wilson, Kavanagh, Strong and Worrall (2001) reviewed the literature of the effectiveness of clinical supervision in four mental health professions (Clinical psychologists, Occupational Therapists, Social Workers and Speech Therapists). The authors found contradictory evidence and concluded that not all studies have found positive associations between supervision and job satisfaction. For example, Palsson, Hallberg, Norberg and Björvell (1996) found no impact of intensive clinical supervision upon burnout symptoms among district nurses in Sweden. Similarly, Crutchfield and Borders (1997) found minimal associations between job satisfaction and peer supervision when compared to those healthcare professionals receiving unstructured supervision. Further research is needed in this area to examine which specific aspects of supervision support staff to effectively cope with difficult and stressful aspects of their work; this particular study considers how a different form of supervision may impact upon these factors.

2.1.6 Self-esteem

An exploratory variable within the study has also been included; improved self-esteem could be a possible variable associated with clinical supervision. Self-esteem is a person's reflection of their own worth, or judgement of themselves. Often self-esteem is viewed as a self-schema, therefore is a product of learning about ourselves based on experiences, which become prevalent beliefs that shape how an individual perceives and makes sense of other experiences (Fennell, 1997). Consequently a person's self-esteem is often persistent and enduring overtime but is expressed in different circumstances specific to the individual.

⁵ All studies suggested that healthcare professionals who receive clinical supervision are less vulnerable to burnout and other stress related difficulties, are more likely to be satisfied with their work and have an improved sense of wellbeing.

Fennell (1997) developed the cognitive model of low self-esteem, which assumes that on the basis of past experiences people form conclusions (in the form of beliefs and assumptions) about themselves. In order to cope with these entrenched beliefs, individuals set themselves rules (dysfunctional assumptions) which they must achieve in order to remain relatively comfortable and avoid distress. In certain circumstances (specific to the individual, where they have been unable to meet their assumptions) these beliefs are initiated which gives rise to negative automatic thoughts. A self-maintaining vicious circle is established, where negative thoughts lead to painful feelings, changes in physiological arousal and unhelpful behaviour (e.g. avoidance) and these in turn act to maintain and reinforce the negative thoughts about the self (see figure 1.1).

Within the vicious cycle, there are several process in which the beliefs are maintained; a perceptual bias towards negative information, self-critical thinking, negative predictions and avoidance of challenging situations (Fennell, 2009). The model is useful in explaining temporary activation of low self-esteem beliefs as well as more pervasive presentations. Fennell (1997) suggests that self-esteem falls on a continuum which ranges for mild self-doubt (triggered by specific situations) through to intense and constant self-loathing. Where an individual falls on that continuum is influenced by a number of factors: these include how much they believe their self-schema, how many situations/stimuli trigger it, the personal investment into potential triggers and the availability of 'rescue factors' (such as a supportive spouse or social network).

2.1.6.1 Self-esteem and supervision

In relation to the model described above, supervision could potentially act as a critical incident or context in which self-schemas are triggered. Supervision is a situation in which individual work is being assessed and reviewed in terms of meeting high standards of care. Burton and Hoobler (2006) suggested that self-esteem is more readily influenced by negative experiences, and explored the relationship between abusive supervisory processes and self-esteem. The authors found that within a business context, individuals who experience abusive supervisory relationships report lower levels of self-esteem. Overall, although evidence is limited in the area there seems to

be a potentially significant relationship between supervisory experiences and self-esteem. This factor will therefore be included as an exploratory variable to investigate the possible impact supervision may have on supervisee self-esteem. Fennell's (1997) model provides different cognitive approaches (which have been shown to be helpful in treating low self-esteem) which are included within supervision training packages, for example; directing attention to the supervisees strengths can challenge perceptual biases, and having time to consider time-management and the emotional impact of work can reduce anxiety symptoms (related to vicious cycle) and reduce avoidance behaviours. Therefore, it could be hypothesised that Clinical psychologists have the knowledge, skills and training to improve self-esteem in supervisees.

A great deal of research has demonstrated that self-esteem is related to positive personality characteristics, for example individuals with high self-esteem have been found to take more pride in their work and demonstrate higher motivation towards work (Korman, 1977, & Meyer, 1980). Self-esteem has also been related to having a direct impact on job satisfaction; Judge and Bono (2001) conducted a meta-analysis of the evidence base and concluded that self-esteem is a significant predictor of job satisfaction (the higher an individual's self-esteem, the more satisfied they are with their work). Consequently, should supervision from a Clinical psychologist improve self-esteem, then a subsequent impact on job satisfaction may be observed. However, some caution must be taken when interpreting this relationship as the results do not reflect a definitive causal relationship.

2.1.7 Changes in policy and the response of the BPS

The '*New Horizons*' initiative was published by the Department of Health (DOH, 2009) to transform mental health services within the NHS for the better. This governmental programme aims to improve the mental health and wellbeing of the population by continuing to develop the quality of services, ensuring care is personalised and that specialist mental health care is more accessible. In response to this new policy, the British Psychological Society (BPS) developed the document entitled '*Psychological health and wellbeing: a new ethos for mental health*' which

specifically describes the Clinical psychologists role in implementing the initiative within services (BPS, 2009). Alongside individual client work, this role includes:

‘Psychologists also offer training and support to staff to deliver interventions at a range of levels of expertise. Psychologists should develop and support a supervision structure to develop staff potential and to recognise, acknowledge and address problems with workplace stress, morale and burnout. Psychologists should develop formulation-based care plans with staff and service users.’ (BPS, 2009)

The BPS policy document clearly states that Clinical psychologists have the role of supporting MDT members in developing personally as well as professionally. This includes developing individual staff members’ potential, supervising psychologically informed ways of working with clients, and addressing difficulties related to stress and increased pressure which is often observed in services. This is further supported by the Care Quality Commission (CQC, 2013) which suggests that any healthcare professionals working clinically require frequent supervision to maintain good practice and effective care. It has been suggested that Clinical psychologists have the skill set to provide inter-disciplinary supervision to other healthcare professionals.

2.1.8 Inter-disciplinary supervision

Currently there are no formal studies which have investigated inter-disciplinary supervision (receiving supervision from a different professional discipline). Spence et al. (2001) suggested that inter-disciplinary supervision is ‘likely to be effective in relation to administrative and management activities that are common across mental health professionals within an organisation’. Previously, inter-disciplinary supervision was often avoided due to concerns around differences in practice boundaries, responsibilities and roles. However, as NHS services are subjected to greater financial pressures, staff members are required to expand their skill sets to enable the service to offer more to their clients. In practice, effective mental health services require good communication and

complex interactions in order to function well; therefore naturally services are moving towards the need for inter-disciplinary supervision. Yet, there is no current evidence base to support the potential benefits or impact of inter-disciplinary supervision.

2.1.9 The present study

The current study aims to investigate the impact of inter-disciplinary supervision on supervisees using a mixed methods design. In particular, to examine whether healthcare professionals who receive supervision from a Clinical psychologist experience reduced burnout and increased job satisfaction and self-esteem, when compared to those who do not receive supervision from a Clinical psychologist.

2.1.9.1 Mixed methods design. The concept of ‘mixed methodology’ has a significant history within social sciences research. However, recent debate suggests mixed methods should be considered a third research paradigm, separate from quantitative and qualitative research (Johnson & Onwuegbuzie, 2004). From this debate, the following definition is most widely agreed by researchers:

‘Mixed methods are the type of research in which a researcher or a team of researchers combines elements of qualitative and quantitative research approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration.’

(Johnson, Onwuegbuzie, & Turner, 2007, p. 123).

Mixed method designs face significant philosophical and technical challenges and are often criticised for not making sufficient links between theory (research problem), and research methods (Greene, 2008). It has been suggested by Bishop (2015) that adopting a ‘pragmatist’ approach when using mixed methods will help to overcome the philosophical challenges. Pragmatism

suggests that thought is an instrument or tool for prediction, problem solving and action; therefore knowledge is both grounded and constructed by the world subjectively. As a result, scientific truth is achievable through diverse sources of experience (Bishop, 2015). Flick, Garms-Homolová, Herrmann, Kuck and Röhnsch (2012) addressed the technical issues by suggesting that the ‘triangulation’ of perspectives can provide a methodological framework for using mixed methods. Triangulation assumes that qualitative and quantitative components occur simultaneously and that both components are weighed equally within the interpretation (see figure 2).

2.1.9.2 Triangulation approach. Triangulation is defined as the mixing of data or methods so that diverse standpoints or views cast light upon a topic (Olsen, 2004). Several variants of the triangulation model exist within mixed method designs; for this particular study the qualitative data will be used to support the quantitative findings (see figure 3).

Triangulation will be used to enrich the understanding of the potential benefits to healthcare professionals of receiving supervision from a Clinical psychologist; as well as to provide insight into the subjective experience of supervision from a Clinical psychologist. The quantitative data will provide a description of whether healthcare professionals experience benefits from supervision with a psychologist, but it will not explain whether these differences are a result of causation. The qualitative analysis will illustrate some of the subjective experiences of supervision with a psychologist (supporting quantitative findings and enriching the understanding of the multi-disciplinary supervision process). In addition, a mixed methods design will also address some of the methodological issues highlighted below, by enriching the data and providing stronger evidence through conversion of findings.

2.1.9.3 Addressing methodological concerns. The evidence base for general clinical supervision to date is characterised by a range of methodological inadequacies (Spence, et al. 2001). One indirect aim of the present study is to overcome these methodological limitations so that the data are more reliable and valid. Supervision research has been criticised by its limited sampling

methods, which influences the generalizability of the results. Much supervision research is based upon trainee counsellors or clinical psychologists, who are mainly female, with small sample sizes and lack the comparison of a control group. The current study has attempted to address the majority of these issues by ensuring that the sample size reflects a strong statistical power, avoiding the use of trainees within the sample by excluding them from the study, and including a control group to look for differences between the two supervision approaches.

Much of research into the effects of supervision is over-reliant on self-report questionnaires and retrospective recall of participants, therefore various biases might influence participant responses. Often the self-report questionnaires are based upon supervisory satisfaction, and supervisee/supervisor experiences which may not necessarily correlate with the development of competence or other benefits of supervision. Therefore the present study has avoided inaccurate supervisory satisfaction questionnaires and focussed on measureable factors (job satisfaction, burnout and self-esteem). The measures used within this particular study have been selected based on the basis of their reliability and validity, to ensure results are a more accurate reflection of individual experience.

2.1.10 Aims of research and hypotheses

The present study aims to investigate whether health professionals benefit from supervision from a Clinical psychologist. This will be investigated in two ways: an exploration of whether psychology supervision is associated with reduced levels of burnout, better job satisfaction, and self-esteem in mental health team members, but also, an exploration of what health professionals report they gain from supervision from a Clinical psychologist.

Based on these aims, the following hypotheses have been formulated.

- i. Healthcare professionals receiving supervision from a Clinical psychologist will report higher levels of self-esteem, when compared to those who do not receive supervision from a Clinical psychologist.

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- ii. Healthcare professionals receiving supervision from a Clinical psychologist will report lower levels of burnout, when compared to those who do not receive supervision from a Clinical psychologist.
- iii. Healthcare professionals receiving supervision from a Clinical psychologist will report higher levels of job satisfaction, when compared to those who do not receive supervision from a Clinical psychologist.
- iv. Healthcare professionals receiving supervision from a Clinical psychologist will report positive impacts upon their clinical practice and personal development; such as development of therapeutic skills and knowledge.

2.2. Method

2.2.1. Design

This study uses a mixed methods design to explore and investigate the specified hypotheses. The quantitative part of the study is a between subjects, cross-sectional design using validated self-report questionnaires to assess levels of: *job satisfaction*, *burnout* and *self-esteem* in multi-disciplinary professionals. Professionals who were not supervised by a Clinical psychologist formed the control group, whereas those supervised by a Clinical psychologist formed the experimental group. The qualitative part of the study utilises a content analysis methodology to explore the themes of the written responses to the survey (figure 4 illustrates the analysis process implemented).

2.2.2 Participants

2.2.2.1 Demographics. A total of 103 participants were included within the study (62 in the control condition and 41 in the experimental condition). Only five participants were excluded from the study, one was a Clinical psychologist who had completed the survey without fully reading the exclusion criteria and another participant was excluded because they had completed the survey twice (this was realised by the researcher when the same email address was provided for the prize draw). The remaining three participants did not work in mental health settings (as stated in the survey). It was estimated that the total sample pool was 233 (based on the number of complete and incomplete surveys) giving a recruitment rate of approximately 44%. The majority of participants were female ($N = 83$) and nurses ($N = 35$). Tables 2 and 3 show key participant demographic information. A priori power analysis using G-Power indicated that 35 participants in each condition would be sufficient to detect a large effect size ($P = 0.50$) within this model.

2.2.2.2 Inclusion and exclusion criteria. Any health professionals working in a mental health setting were included in the study. Exclusion criteria included Clinical psychologists, assistant

psychologists, health care professionals not working in mental health settings, individuals who did not read English and who were under the age of 18.

2.2.2.3 Sampling Strategy. Participants were recruited from two different NHS trusts⁶ using an online survey. The study was advertised on the trusts' staff intranet, social media and individual service managers were approached to forward the survey onto their staff teams. When possible, short presentations about the study were also provided to teams to encourage recruitment, and posters were put up across the trust in different team bases. Recruitment took place over the autumn and winter of 2014-2015. Participants were given the opportunity to enter a prize draw to win £50 in vouchers for their participation; the winner was drawn at random once the recruitment period was over.

⁶ Ethical approval was received from each NHS trust involved, see ethics and risk section for more detail.

Table 2: *Demographic characteristics of sample*

<i>Variable</i>	<i>Sub-category</i>	<i>N (%)</i>
Gender	Female	83 (80.6%)
	Male	20 (19.4%)
Age (years)	0-25	4 (3.9%)
	26-35	34 (33.0%)
	36-45	30 (29.1%)
	46-55	24 (23.3%)
	56+	11 (10.7%)
Role	Psychiatrist	1 (1.0%)
	Occupational therapist	14 (13.6%)
	Physiotherapist	4 (3.9 %)
	Nurse	35 (34.0%)
	Speech and language therapist	5 (4.9%)
	Mental health practitioner	26 (25.2%)
	Support worker	12 (11.7%)
	Manager	4 (3.9%)
Other	2 (1.9%)	
Team	Adult mental health	37 (35.9%)
	Learning disabilities	22 (21.4%)
	Child & adolescent mental health	17 (15.5%)
	Older adult mental health	6 (12.6%)
	Inpatient services	9 (10.7%)

Table 3: *Supervision characteristics for all participants*

<i>Variable</i>	<i>Sub-category</i>	<i>N (%)</i>
Frequency	Weekly	8 (7.8%)
	Fortnightly	19 (18.4%)
	Monthly	63 (61.2%)
	Other	13 (12.6%)
Duration (mins/hours)	30 minutes	19 (18.4%)
	1 hour	47 (45.6%)
	1.5 hours	29 (28.2%)
	2 hours	6 (5.8%)
	Other	2 (1.9%)
Format	Peer supervision	14 (13.6%)
	Group supervision	20 (19.4%)
	Individual supervision	52 (50.5%)
	All types	16 (15.5%)
	Other	1 (1.0%)

2.2.3 Measures

Each participant read information about the study and gave their consent to participate before continuing the online survey (see appendix 2). They then completed a demographics questionnaire detailing their age, gender, employment role, hours of supervision per week/month and the types of supervision they receive (see appendix 3). Participants were then asked to complete the following self-report questionnaires: Rosenberg self-esteem scale (RSES), the abridged job in general (aJIG) scale and the abridged job descriptive index (aJDI) as a measure of job satisfaction, and the Maslach burnout inventory (MBI, as a measure of burnout). Finally, experimental participants were given the option of completing open-ended questions about their experiences of clinical supervision with a Clinical psychologist (see appendix 4).

2.2.3.1 Rosenberg self-esteem scale. The RSES is a 10-item scale that measures individual feelings of global self-worth (Rosenberg, 1965), for example: ‘on the whole I am satisfied with myself’. All responses are made on a four point likert scale ranging from one (strongly disagree) to four (strongly agree). It includes five reverse scored items (appendix 5).

The scale has high internal consistency (Cronbach’s alpha = .87) suggesting good internal reliability and validity (Bosson, Swann, & Pennebaker, 2000), and has been widely used within research as a reliable measure for self-esteem. The RSES has significantly strong correlations with measures of personality, psychological health and has previously been used to link self-esteem to specific psychological difficulties such as depression and anxiety (Robins, Hendin & Trzesniewski, 2001).

2.2.3.2 Abridged job in general scale and the abridged job descriptive index. The aJDI and the aJIG are shortened versions of the JDI and JIG scales. The abridged versions of the scale only include the highest correlational factors associated with each subscale; therefore they could be considered more reliable and accurate measures of job satisfaction when compared to the longer versions. The aJIG consists of one scale with eight items; for each item participants are asked to

rate the item on whether they agree (yes), not sure (?) or disagree (no). The aJDI is structured in the same way but has five sub-scales with six items in each (appendix 6).

The internal consistency reliability for the aJIG is (Chronbach's α) .85. Russell, Spitzmüller, Lin, Stanton, Smith and Ironson (2004) used a central approach to estimate the confidence intervals around a reliability coefficient estimate, the obtained 95% confidence interval was [.82, .87]. The aJIG also correlates strongly with organisational commitment ($r = .47, p < .05$) and affective commitment ($r = .48, p < 0.5$), suggesting that feelings of global job satisfaction are related to commitment and identification with the work organisation. This also provides evidence of the scales construct validity.

Stanton et al. (2001) developed the aJDI by using a systematic and statistical method. None of the subscales achieved internal consistency reliability lower than .75 (Chronbach's α), suggesting good internal reliability and validity. Overall the authors concluded that the aJDI preserves the desirable characteristics of the full-length version, whilst reducing item count and administration time considerably.

2.2.3.3 Maslach burnout inventory. The MBI is one of the most frequently used questionnaires for measuring burnout in research; Schaufeli, Bakker, Hoogduin, Schaap and Kladler (2001) suggested that 90% of journal articles assessing burnout used the MBI. The MBI consists of three scales; emotional exhaustion (draining of emotional resources), depersonalisation (negative attitudes towards recipients) and personal accomplishment (the tendency to evaluate oneself positively, particularly in work ability). The whole scale consists of 22 items, and all responses consist of a six point likert scale; participants are asked to rate how often they feel in different ways about their job, responses range from 'Never' to 'Everyday' (see appendix 7).

High levels of emotional exhaustion and depersonalisation, and a low level of personal accomplishment are characteristic of burnout. The MBI is an internally consistent questionnaire with most studies finding Cronbach alpha values of .70 or above (Maslach, Jackson & Leiter, 1996; Schaufeli, Enzmann & Girault, 1993).

2.2.4 Procedure

Participants were recruited across two NHS trusts, through the advertising methods described in the sampling strategy section. To facilitate recruitment, team managers were contacted to clarify the research purpose, introduce measures, confirm procedures and discuss ethical considerations. Posters were also provided to advertise the study (see appendix 8), short presentations were made directly to teams and information was provided about how to access the online survey.

Participants who chose to complete the survey were greeted with brief information about the study, highlighting the advantages and disadvantages of completing the survey. Before continuing the study, participants were asked to provide their consent to completing the questionnaire, and it was clearly explained that they can simply withdraw by cancelling the screen. Upon completing all of the demographic, self-report scales and open-ended questions, participants were given the opportunity to enter into a prize draw by entering an email address in which they could be contacted. Finally, participants were presented with debriefing information (see appendix 9) and signposted to appropriate support services, should they be required.

All of the data were automatically anonymised and saved by the on-line survey. The results were stored on a University laptop, under a secure password and locked away in order to maintain confidentiality and fulfil data protection laws.

2.2.5 Ethical considerations and risks

The content of some of the questions included in the survey may have induced emotional discomfort for participants, as it asks about their satisfaction with their job, pay, the relationship with their co-workers and supervisors, as well as looking at their level of burnout and self-esteem. Therefore this risk was managed by signposting participants to appropriate support services, should they feel affected by the content of the questions (appendix 9).

This study received full ethical approval from the University of Southampton Ethics committee, and research and development approval from two local NHS trusts (see appendix 10). A full risk assessment and protocol was completed prior to recruitment.

2.2.6 Pilot study

A pilot of the procedure was completed with five participants, three of whom were service managers and two were healthcare professionals. After completing the survey successfully, each participant gave feedback on the survey. Some highlighted spelling and grammar mistakes which were immediately corrected, and others provided suggestions on extra alternatives to include in the demographic options. All of the suggestions were considered and appropriate alterations were made before the final survey was launched. These corrections were accepted by the University ethics committee, and then approval was received from the Research and Development departments of both NHS trusts.

2.2.7 Analysis strategy

Prior to analysis, the data were downloaded and automatically transferred into a format appropriate for the chosen statistical software. The Statistical Packages for Social Sciences (SPSS) version 21 was used to complete data analysis and inferential statistics.

For hypotheses i, ii and iii the analysis strategy included the use of an independent t-tests to investigate differences in job satisfaction, burnout and self-esteem between the two groups. This parametric test has several assumptions which ensure the test is valid and reliable; these include normally distributed data, equal variances between populations, the samples are independent and measured at an interval level (Field, 2009). Much of the data did not meet the assumptions of the independent t-test; consequently bootstrap resampling methods were implemented as it is considered more reliable than data transformations (Field, 2014). The bootstrap method does not require normal distribution and has demonstrated superior power when testing for differences between two groups (Efron & Tibshirani, 1994).

For hypothesis iv, the analysis strategy included the qualitative method of content analysis. This was used to explore the themes of the written responses to questions exploring the experiences of receiving supervision from a Clinical psychologist.

Content analysis is a method of analysing written, verbal or visual communication methods (Cole, 1988). Originally content analysis was considered to be the '*quantitative analysis of communication*,' (Krippendorf, 1980) but now includes interpretations of the content. As a result of this transformation, the method has been criticised for being an over-simplistic quantitative technique (Morgan, 1993) and not sufficiently qualitative or interpretative. Despite such criticism, content analysis has been widely accepted in a variety of research disciplines such as psychology, sociology and nursing (Neuendorf, 2002), and has offered these areas several benefits. Content analysis is content-sensitive; therefore, the analysis of communication content allows the researcher to understand and access the thought processes of people. Huff (1990) suggested that in its most basic form, the frequency of words reflects cognitive centrality (or importance of the thought) and consequently groups of words reveal underlying themes of meaning.

Another benefit of using content analysis is that it is analytically flexible; the method can be used in both inductive and deductive research, and can be used at two different levels. For this research, the method will be used to analyse the latent content and interpret the deeper meaning embodied within the responses from the on-line survey. The process of conducting the content analysis was guided by the step-by-step guide published by Elo and Kyngäs (2007) - see figure 4 for a detailed description of this process.

2.3 Results

2.3.1 Descriptive statistics

The means, standard deviations and ranges of the total scores were calculated for each variable (see table 4). Chronbach's alpha coefficients were calculated for each of the variables, to check the internal consistency of the measures, based on the data collected. The job satisfaction scales ($\alpha = .64$) and self-esteem scale ($\alpha = .69$) all demonstrated moderate reliability. However, the burnout scales had low reliability ($\alpha = .57$) therefore will be considered with caution as this implies the scale has low internal consistency.

Participants were also compared by their levels of job satisfaction and burnout, to see if this varied between different services. Figure 5a demonstrates that job satisfaction fell within the satisfied range across all of the services included in this study. Interestingly, more healthcare professionals working in inpatient mental health settings fell within the high EE range (suggesting higher levels of burnout). However, the majority of healthcare professionals based in all of the other specified services scored within the low EE range (see figure 5b).

Table 4: *Descriptive statistics for variables and subscales*

<i>Variable</i>	<i>Subscale</i>	<i>Mean (M)</i>	<i>Standard Deviation (SD)</i>	<i>Range/cut-offs</i>
Self-esteem (RSES)	SE	20.07	5.52	0 - 30/ low self-esteem < 15
Control group	SE	19.10	5.76	
Experimental group	SE	21.54	4.85	
Burnout (MBI)	Emotional exhaustion (EE)	18.93	11.06	0 - 54/ moderate EE = 17 – 26
	Depersonalisation (DP)	3.97	4.70	0 - 30/ low DP = 0 - 6
	Personal accomplishment (PA)	36.69	7.65	0 - 48/ moderate PA = 32 – 38
Job Description Index (aJDI)	Work itself	14.47	3.90	0 - 15/ satisfaction > 8
	Pay	10.33	5.94	0 - 15/ satisfaction > 8
	Promotion opportunities	5.77	4.83	0 - 15/ dissatisfaction < 7
	Supervision quality	13.75	5.04	0 - 15/ satisfaction > 8
	Co-workers (relations with)	14.91	3.89	0 - 15/ satisfaction > 8
Job In General	<i>aJIG</i>	19.46	5.38	0 - 24/ satisfaction > 14

2.3.2 Self-esteem (hypothesis i)

Some outliers were present in the data, as assessed by inspection of a boxplot, and self-esteem scores for each group were not normally distributed (as assessed by Shapiro-Wilk's ($p > 0.05$). Transformation methods of the data were unsuccessful in altering the distribution of the data; therefore a bootstrapping method was applied. The assumptions of homogeneity were met by both the experimental and control group, as assessed by Levene's test for equality of variances ($p = .828$).

An independent sample t-test helped to determine if there were differences in self-esteem between the two supervisory formats (see table 5). Looking at the means, the group receiving supervision from a Clinical psychologist scored higher in self-esteem ($M = 21.54$, $SD = 4.85$) than those not supervised by a psychologist ($M = 19.10$, $SD = 5.76$). Further analysis where $M = 2.44$, 95% BCa CI [-0.33 to -4.64], found a statistically significant difference between the groups, $t(101) = -2.237$, $p = .029$. This is represented by a medium effect size ($r = .54$). Overall, the results indicate that those who receive supervision from a Clinical psychologist have significantly higher self-esteem than those who receive standard supervision.

Table 5: Independent t-test results for all measures.

<i>Variable</i>	<i>Subscale</i>	<i>Mean (control)</i>	<i>Mean (experimental)</i>	<i>Degrees of freedom (df)</i>	<i>t-score</i>	<i>Significance</i>
Self-esteem	SE	19.0968	21.5366	101	-2.237	.029*
Burnout	Emotional exhaustion	4.2232	4.0395	101	.691	.491
	Depersonalisation	4.1935	3.6341	101	.590	.549
	Personal accomplishment	35.7742	3.6341	101	-1.502	.103
Job in general	JIG	19.3548	19.6098	101	-.234	.792
Job descriptive Index	Work	13.9839	15.1951	101	-1.552	.098
	Pay	10.1613	10.5854	101	-.353	.742
	Promotion	6.1129	5.2439	101	.892	.395
	Supervision	13.8871	13.5366	101	.344	.712
	Co-workers	14.9677	14.8293	101	.176	.865

*p<.05

2.3.3. Burnout (hypothesis ii)

2.3.3.1 Preliminary analysis. Boxplots indicated that outliers existed for all three of the subscales of burnout. This varied from one outlier for emotional exhaustion to six outliers for depersonalisation. The outliers were each carefully reviewed and were all included within the analysis; the outliers were not consistent across measures and seemed to only represent severe cases within the sample.

In addition, all of the subscales for burnout violated the assumption of normality, as assessed by the Shapiro-Wilk's test ($p > .05$). For the depersonalisation and personal accomplishment subscales, applying the standardised transformation methods still demonstrated significant kurtosis (square root, logarithmic or reciprocal transformations); therefore a bootstrapping method was applied. For the emotional exhaustion subscale, a square root transformation met the assumption of normality; therefore the analyses were completed using the transformed data.

2.3.3.2 Emotional exhaustion. The means suggest that the control group scored slightly higher in emotional exhaustion ($M = 4.22$, $SD = 1.32$.) compared to those in the experimental group ($M = 4.04$, $SD = 1.32$). As assessed by Levene's test for equality of variances, homogeneity of emotional exhaustion scores were met ($p = .772$). However, an independent t-test (see table 5) suggests there were no significant differences between the two groups, $t(101) = .691$, $p = .491$, where $M = .184$, 95% CI [-.34 to .71]. It also represented a small-sized effect ($r = .14$), suggesting that the results should be interpreted with caution. A score between 0-16 indicates low emotional exhaustion, therefore both groups scored within this range on average; generally speaking the results indicate that the groups did not show a significant difference in levels of reported emotional exhaustion.

2.3.3.3 Depersonalisation. The means suggest that the control group scored slightly higher in depersonalisation ($M = 4.20$, $SD = 5.24$) compared to those in the experimental group ($M = 3.63$, $SD = 3.76$). Depersonalisation scores demonstrated homogeneity of variances for the experimental

and control group ($p = .180$). However, an independent t-test (see table 5) showed there were no significant differences between the two groups, $t(101) = .590$, $p = .549$, where $M = .56$, 95% BCa CI [-1.13 to 2.24]. It also represented a small-sized effect ($r = .12$) thus the results should be interpreted with caution (due to generalizability to the population). Overall both groups scored very low in depersonalisation (a score between zero and six indicates low depersonalisation), and suggests that the groups did not differ in depersonalisation levels.

2.3.3.4 Personal accomplishment. Based upon the independent t-test (refer to table 5), the means suggest that the experimental group scored slightly higher in PA ($M = 38.07$, $SD = 5.79$) compared to those in the control group ($M = 35.77$, $SD = 8.59$). Equality of variances was not met as assessed by Levene's test ($p = .011$) indicating that the results should be interpreted with caution. There was no significant difference between the two groups, $t(101) = -1.502$, $p = .103$, $M = -2.30$, 95% BCa CI [-5.15 to .31]. Overall both groups scored within the moderate range for personal accomplishment (a score between 32 and 38 indicates moderate personal accomplishment). There was no significant difference in reported personal accomplishment between the two groups.

2.3.4. Job satisfaction (hypothesis iii)

2.3.4.1 Preliminary analysis. Boxplots were used to assess for outliers for each of the subscales. This varied from no outliers present for satisfaction with pay, to seven outliers for satisfaction with job in general. The outliers were each carefully reviewed; the outliers seemed to simply represent severe cases within population and thus still represented the sample. Consequently, all outliers were included within the final analysis.

In addition, all of the subscales for job satisfaction violated the assumption of normality, as assessed by the Shapiro-Wilk's test ($p > .05$). For all of the subscales, applying the standardised transformation methods still demonstrated significant kurtosis (square root, logarithmic or reciprocal transformations); therefore a bootstrapping method was applied.

2.3.4.2 Job in general. The means suggest that the experimental group scored slightly higher in satisfaction with their jobs ($M = 19.61$, $SD = 4.34$) compared to those in the control group ($M = 19.35$, $SD = 6.01$). Equality of variances was met ($p = .090$). However, an independent t-test (refer to table 5) suggests there was no significant difference between the two groups, $t(101) = -.234$, $p = .792$. Overall both groups scored within the high range for satisfaction with their job, and no significant difference was found between the groups in satisfaction with their job in general.

2.3.4.3 Work itself. The means suggest that the experimental group scored slightly higher in satisfaction with their work ($M = 15.2$, $SD = 3.16$) compared to those in the control group ($M = 13.98$, $SD = 4.28$). Equality of variance was not met as assessed by Levene's test ($p = .030$). Also, the independent t-test (see table 5) shows there was no significant difference between the two groups, $M = -1.211$, 95% BCa CI [-2.66 to .120], $t(101) = -1.552$, $p = .098$. In addition, a medium-sized effect ($r = .31$) was found. Overall both groups scored high in satisfaction with their work, but no significant differences were found between the groups.

2.3.4.4 Pay. Examination of the means suggest that the experimental group scored slightly higher in satisfaction with their jobs ($M = 10.56$, $SD = 5.52$) compared to those in the control group ($M = 10.16$, $SD = 6.23$). As a result no significant differences were found between the two groups, $t(101) = -.353$, $p = .742$, where $M = -.424$, 95% BCa CI [-2.62 to 2.07]. Overall both groups scored just above the neutral range in satisfaction with their salary.

2.3.4.5 Opportunities for Promotion. A review of the means (see table 5) suggest that the control group scored slightly higher in satisfaction with their opportunities for promotion ($M = 6.11$, $SD = 5.03$) compared to those in the experimental group ($M = 5.24$, $SD = 4.53$). There was homogeneity of variances for promotion scores for the experimental and control group, as assessed by Levene's test for equality of variances ($p = .160$). Also, there were no significant differences between the two groups, $t(101) = .892$, $p = .395$ and this represented a small-sized effect ($r = .18$).

Overall the groups did not significantly differ from each other, and both groups scored within the ‘dissatisfaction’ range with their opportunities for promotion.

2.3.4.6 Satisfaction with supervision. The means suggest that the control group scored only very slightly higher in satisfaction with supervision ($M = 13.89$, $SD = 5.16$) compared to those in the experimental group ($M = 13.54$, $SD = 4.91$). Homogeneity of variances were met ($p = .373$), however there were no significant differences between the two groups, $t(101) = .344$, $p = .712$ where $M = .351$, 95% BCa CI [-1.52 to 2.35.]. Overall, participants’ satisfaction with supervision was not significantly different between the two groups.

2.3.4.7 Relationship with co-workers. Finally, the means suggest that the control group scored only very slightly higher in satisfaction with their relationship with co-workers ($M = 14.97$, $SD = 4.23$) compared to those in the experimental group ($M = 14.83$, $SD = 3.37$). As a result, there was no significant difference between the two groups, $M = .138$, 95% BCa CI [-1.32 to 1.62], $t(101) = .176$, $p = .865$. Overall both groups scored relatively the same, and showed high satisfaction with their co-workers.

2.3.5. Qualitative analysis (hypothesis iv)

The process of conducting the content analysis was guided by the step-by step guide (Elo & Kyngas, 2007). Initially, the data is prepared for examination by selecting the unit of analysis. In this review, an inductive approach to the data was used so ‘themes’ were the chosen unit of analysis. Time was then taken to make sense of the data and become familiar with the content. Next is the organising phase which includes several processes; open coding, creating categories and abstraction (flow diagram of the full process can be found in figure 4). The written material is read again, and many headings are written down to describe all aspects of the content (Elo & Kyngas, 2007). Based on these headings (entitled codes within my data), categories are freely generated and grouped under an overall theme, considering any sub-themes within that topic (see table 6 for a summary of the themes and sub themes). A full table of the raw data and content analysis process can be viewed in appendix 11.

Table 6: *summary of themes and sub-themes.*

Theme	Sub-theme
Methods of accessing interdisciplinary supervision	Mandatory
	Voluntary
	MDT supervision groups
Enriched quality of the supervision process	Depth
	Reflective practice
	Different perspectives
Personal development and growth	Confidence
	Emotional coping
Professional development and growth	Knowledge and skills
	Understanding
	Support in managing complexity

2.3.5.1 Theme 1- ‘Methods of accessing inter-disciplinary supervision’. Participants were initially asked how they accessed supervision from a Clinical psychologist; from the qualitative responses, three sub-themes emerged.

a. Mandatory

Some participants described that attending supervision with a Clinical psychologist is mandatory, they therefore had felt forced to attend by management, or higher systems beyond their control.

‘I was forced to attend group supervision by management when I was already having 1:1 supervision which was more effective.’ (Participant 94)

‘No choice, I was informed I had to receive supervision from the Clinical Psychologist (the clinical lead of the team).’ (Participant 42)

b. Voluntary

Other healthcare professionals reported that they had chosen to attend supervision with a Clinical psychologist. However, the methods by which this was initiated seem to vary considerably; from attending consultation clinics to discuss complex cases to having training in specific therapeutic approaches which lead to regular supervision with a psychologist.

‘I have CBT supervision facilitated by a psychologist.’ (Participant 74)

‘I referred a client to psychology but it was felt that I would be able to do this work separately with some support and supervision from psychology.’ (Participant 51)

‘For a more in depth approach... more formal, organised session that will challenge my views and working practices.’ (Participant 67)

c. MDT supervision groups

Separately from voluntary methods, healthcare professionals also accessed supervision from a psychologist because they attended the same supervision group, peer group or reflective practice group.

'Our psychologist is part of our peer supervision group which is multidisciplinary.'

(Participant 58)

'Group supervision and ward reflective practice is held once a month on the ward.'

(Participant 89)

2.3.5.2 Theme 2- 'Enriched quality of the supervision process'. When asked about the benefits of attending supervision from a Clinical Psychologist, many healthcare professionals identified that the supervision is different to their 'usual' supervision. Participants touched on the different supervisory processes which are contained in supervision with a psychologist which they would not normally receive in other forms. Three sub-themes emerged within this theme:

a. Depth

Participants identified that their supervision with a psychologist is a more in-depth approach which results in the healthcare professional learning to be more thorough and detailed in their practice.

'I think you gain from their expertise with multiple approaches and depth of knowledge.'

(Participant 42)

'They are more thorough and help me offer options to the family I'm working with.'

(Participant 66)

b. Reflective practice

Many healthcare professionals expressed how much they value having a space to reflect on their clinical work and the impact it may have upon them as professionals. This process seems to

be unique to the profession of psychology and participants emphasised that this process is of real benefit to them.

'I am more able to explore and reflect on options to address a client's presenting problems. This has been particularly helpful when faced with 'stuck' clients or interventions that may not be proving effective.'

(Participant 68)

'I find supervision has been hugely validating for me allowing me space to reflect on my work with clients.'

(Participant 68)

'Reflective supervision- thinking about my own thoughts and feelings and not just talking about theories, processes and tasks.'

(Participant 95)

c. Different Perspectives

Participants also valued the different perspective that Clinical psychologists can offer in supervision. Healthcare professionals reported that this aided their understanding of clients and gave insight into their needs.

'...supervision with a psychologist can often offer a different perspective and help you to look at a problem/dilemma from another view point.'

(Participant 36)

'It helps me get a better understanding of the subject and think in a different way from how I would normally think.'

(Participant 60)

2.3.5.3 Theme 3- 'Personal development and growth'. Two sub-themes emerged from the data which were related to development of personal attributes, as a result of receiving supervision with a psychologist. This included coping with the emotional demands of working in mental health settings, and personal confidence in their work abilities.

a. Confidence

Professionals connected with the idea that they felt more confident in their abilities as a clinician and in providing psychologically informed interventions.

'Supervision from a psychologist can often give reassurance and clarifications, making me feel like a more confident practitioner.' (Participant 36)

'I am more likely to have the confidence to try new ideas.' (Participant 43)

'Improvement of my skills to be able to be more confident with certain cases where I deliver CBT...' (Participant 74)

b. Emotional coping

Participants expressed that supervision from a psychologist helped them to manage the difficult emotions related to working with complex mental health client groups. Some also acknowledged that it gives them space to reflect on the emotions related to the increased pressures of working within the NHS.

'I think it helps me manage the difficult emotions related to work more than my practice' (Participant 101)

'My supervision with the psychologist is different to my normal supervision as I can use it to talk about how I feel about my work, and I learn more about myself to improve my work when working with more challenging clients.' (Participant 50)

'Psychology supervision is also an important grounding opportunity as workload has been increasing and peer support has proved harder to access.' (Participant 68)

2.3.5.4 Theme 4- ‘Professional development and growth’. An important theme which emerged from the data was a strong sense that healthcare professionals developed in their professional abilities through attending supervision with a psychologist. The following three sub-themes emerged from analysis:

a. Knowledge and skills

Many healthcare professionals reported that they benefit from the psychologist sharing their psychological skills and knowledge with them. Participants reported that they particularly gained from formulation and intervention skills.

‘Increases my knowledge around psychological therapies to work more effectively with clients.

It gives me a plan of the work I will be undertaking.’

(Participant 51)

‘Validation of the skills I already have... I also feel they help me keep very focussed and use

the model to work out formulations and enrich my treatment plans,’ (Participant 74)

‘Enhance skills in area of psychological intervention.’ (Participant 19)

b. Understanding

Another important sub-theme was related to an increased understanding of clients’ needs (through formulation) and also an increased understanding of the role of a Clinical psychologist.

‘I learn more about formulation, and how this helps to understand the client better.’

(Participant 50)

‘Increased understanding of psychological therapies and how they can be implemented at an acute level in the community with service users who are in acute mental health crisis.’

(Participant 23)

c. Support in managing complexity

Finally, several participants felt that supervision from a psychologist was helpful in managing complex needs and chronicity of mental health difficulties.

'... the support has been invaluable when I have got stuck on a case. Supervision with a psychologist has helped me work through the difficulties.' (Participant 60)

'... and support when working with people who requires support with managing their emotions.' (Participant 29)

2.3.6 Associations between methods

The quantitative results indicate a higher level of self-esteem in healthcare professionals receiving supervision from a psychologist. This links with some of the qualitative results, which suggested that professionals gained confidence in their own abilities and reported developing a self-compassionate approach.

Other quantitative results were not significant; therefore levels of burnout and job satisfaction were not statistically different between the two groups. However, the descriptive statistics did indicate that the majority of participants fell within the satisfied range for their work, job in general, relationships with co-workers and supervision. This was also reflected in the qualitative results; professionals expressed multiple factors associated with job satisfaction for example, participants reported supervision with a Clinical psychologist helped them gain psychological skills and knowledge which improved their clinical practice.

2.4 Discussion

2.4.1 Results summary

Quantitative findings suggest that the only significant difference between the participants who have supervision from a Clinical psychologist and those who do not, is their level of self-esteem. There was no statistical difference between the groups in terms of job satisfaction and burnout levels. The quantitative data only indicates whether there was a difference between groups, therefore cannot imply that receiving a different form of supervision improves self-esteem. Qualitative data were also collected to explore the reasons that people access supervision from a psychologist and what they feel they gain from the experience, in order to back-up and strengthen any quantitative findings.

2.4.2 Self-esteem

The qualitative analysis suggests that those who receive supervision from a psychologist report several benefits; including personal and professional development (improved skills and knowledge, increased confidence in clinical practice and emotional coping skills), and access to improved quality of supervisory processes (reflective practice and a more in-depth perspective). In combination, the qualitative data supports the finding that self-esteem differs between groups; and provides preliminary evidence for why this difference between the groups exists.

Research suggests a significant link between self-confidence and self-esteem. Kohn and Schooler (1983) initially suggested that global self-esteem consists of two major components; self-confidence and self-deprecation. Thereby, suggesting that an individual's internal view of themselves is determined by negative and positive attributes; thoughts of personal ability competence and efficacy are all related to self-confidence. Owens (1993) provided further evidence for this view that global self-esteem is a construct of two components, and found a particularly strong correlation between self-confidence and self-esteem (.88). This is further supported by Scheff, Retzinger and Ryan (1989), who associated reduced self-esteem with feeling foolish, ashamed and inadequate, whereas increased self-esteem was associated with feelings of

pride, self-satisfaction and confidence. Overall, research suggests that high self-esteem is directly associated with higher levels of self-confidence.

The combination of the qualitative and quantitative results could suggest that psychology supervision for healthcare professionals improves individuals' confidence in their abilities, which could have a positive impact on self-esteem. This would provide further evidence to Burton and Hoobler (2006) who linked different supervisory experiences with self-esteem, suggesting that positive experiences of supervision can also improve global self-esteem.

As mentioned within the introduction, all Clinical psychologists are required to complete official training in supervision and engage in continual professional development in this area. Therefore when providing supervision it is likely they will be adopting evidence based models and have knowledge of cognitive approaches. Based upon the cognitive model of self-esteem (Fennell, 1997), supervision could be viewed as a potential critical incident, which challenges core negative self-schemas. Should this happen within a supervisory context (with a Clinical psychologist as the supervisor), it can be hypothesised that there are several ways in which the supervisors response might alter the vicious cycle associated with maintaining self-esteem. One possibility is that the supervisor utilises cognitive approaches; for example being open and paying attention to the supervisee's strengths may challenge perceptual biases and assist the supervisee in accessing their more positive self-image. In addition, having time to reflect on the emotional impact of the client work may help to reduce the physical feelings of stress, encourage supervisees to improve their work life balance and gently challenge any self-critical thinking. Related to this, another hypothesis could be that the supervisory relationship acts as a 'rescue factor' by providing additional support networks to the supervisee. Clearly the cognitive model provides some insightful possibilities in explaining the relationship observed within this study. However, further research is still needed to strengthen these tenuous hypotheses, as there is still the possibility that healthcare professionals with higher self-esteem are more likely to access supervision from a psychologist, rather than being a direct effect of the process.

2.4.3 Burnout

The descriptive statistical results suggest that burnout levels did not differ between the two groups. When broken down into the subscales, both groups scored within the low range for both emotional exhaustion and depersonalisation and within the moderate range for personal accomplishment.

Although a positive result, as it indicates that the healthcare professionals who took part in the study are not currently at risk of burnout, it is an unexpected result. Previous research has suggested that stress related difficulties (such as burnout) are significantly higher in healthcare professionals who are based in mental health settings (Rees & Smith, 1991). In addition, due to recent budget cuts within the NHS there are fewer staff available to run services. Consequently caseloads for all practitioners are significantly higher, which puts greater pressure and stress on staff to provide a good level of care to more clients. Working under such demanding conditions can make staff vulnerable to burnout. Therefore the results could reflect several explanations; NHS staff are using helpful strategies to manage the effects of burnout successfully, thus staff score lower in burnout levels; or staff who were suffering with burnout were less likely to participate in the study, as this will have been an added pressure to their already high work load.

An interesting finding within the descriptive statistics was that the majority of healthcare professionals working in inpatient services scored within the high range for emotional exhaustion. This result contrasts previous evidence which suggests healthcare professionals working in community settings are more vulnerable to burnout (Rees & Smith, 1991). However, this result should be taken lightly as only an observable difference is evident within the data; no further formal analysis could be completed as participant numbers were too low.

There was a slight observable difference in means (between the two groups) in personal accomplishment levels, although it did not reach significance. With more data in both groups significance may have been found. The qualitative data implies that those who are supervised by a Clinical psychologist reported more factors associated with personal accomplishment, such as confidence to try new interventions, the feeling that they are helping their clients and providing the

best possible care. Therefore, the qualitative data seems to supplement as well as support the quantitative data; where the strength of the statistical analysis may be lacking, the qualitative data illustrates what the professionals themselves feel they gain from attending a different form of supervision. Consequently, the qualitative data has enriched the quantitative findings, and helped to develop some of the possible benefits that supervision from a psychologist may have to offer to healthcare professionals in mental health settings.

2.4.4 Job satisfaction

The results suggest that the groups did not differ in their overall satisfaction with work. Again, when broken down into subscales, both groups scored within the high satisfaction range for supervision, relationship with co-workers, opportunities for promotion, work itself and job in general, and within the dissatisfied range for pay.

Although another positive result, as it indicates that the healthcare professionals who took part in the study are currently reporting that they feel satisfied with several aspects of their job (other than pay), it is an unexpected finding. As discussed above, the increased pressure on resources can often impact upon staff morale and satisfaction with working conditions, which inevitably causes job satisfaction to reduce significantly. The result within this study does not reflect this, and is suggesting that healthcare professionals within mental health settings are currently satisfied with their jobs.

A similar effect to personal accomplishment can be observed in the 'work itself' subscale of job satisfaction; when means are compared, those who were supervised by a psychologist scored slightly higher in satisfaction with their work. With more participants a significant difference may have emerged. The qualitative data suggests that psychology supervision encourages professional and personal development, which may impact upon satisfaction with work and clinical practice. This again demonstrates how qualitative findings can enrich and help to explain what the quantitative results could not.

An interesting result is that the majority of participants reported dissatisfaction with their pay; and that both groups were equally dissatisfied. However, this is no revelation when put into the context of the NHS restructure which has occurred over the last five years. This included a global review of the roles and responsibilities of different disciplines and resulted in changes in banding (bands represent a salary range). Some disciplines stayed within the same band, others went up or down depending on the result of the review. Particularly within nursing, and some other disciplines (OT and Physiotherapy) the banding reduced, which resulted in healthcare professionals having the same amount of responsibility and continuing to hold large caseloads but being paid less. However, further quantitative and qualitative evidence is needed to investigate the link between satisfaction with pay, level of responsibility and NHS restructuring.

2.4.5 Qualitative results

The qualitative data provide an insight into what healthcare professionals within mental health settings value from psychology supervision, and describe a variety of methods in which it is accessed. Interestingly, the majority of participants described choosing to attend supervision with a psychologist, but a small minority described that it was mandatory. It would be interesting to know more about these circumstances and investigate further how this impacted upon overall experience of the supervisory process. Comparing and contrasting experiences of those who chose and those who were made to attend supervision with a psychologist, could enrich our understanding of this area and inform future supervisors how to prevent imposing psychology supervision upon practitioners.

An important theme which emerged from the data, was that participants felt that the quality of the supervision processes were beneficial; this included having time to go into more depth about cases, having a space to reflect on clients and gain a different perspective. This feedback would suggest that such processes do not happen in their usual supervision, and could be important to incorporate in training for future supervisors.

As noted within the introduction, the BPS document ‘Psychological health and wellbeing: a new ethos for mental health’ clearly states that Clinical psychologists have a duty of supporting the MDT in developing personally and professionally. This includes developing individual staff members’ potential, supervising psychologically informed ways of working with clients, and addressing difficulties related to stress and increased pressure which is often observed in services. Notably, most of these factors were mentioned by the healthcare professionals within this study, who were receiving supervision from a psychologist. The qualitative themes drawn from this study were around personal and professional growth and development, providing evidence that psychologists are responding to this change in their role positively (by providing the best possible support for team members).

2.4.6 Limitations

The online survey methodology has several limitations which may have influenced the data obtained within the study. Although all healthcare professionals within the NHS have access to the internet, those who are less confident with computers may have been less likely to participate in this study as paper copies of the survey were unavailable. It is important to mention again that practitioners experiencing burnout may have been less likely to complete the survey, so the results may be under-representative of the population. Factors which were less controllable could be related to personal experiences; individuals who chose not to respond to the survey may have disregarded it because of frustrations with their supervisor, and those that did take part may be more willing to share their positive supervisory experiences. An alternative possibility could be that recent positive or negative events with a clinical supervisor could have distorted how participants evaluated their overall experiences of supervision, again impacting upon their responses.

Another limitation of the study is that ethnicity was not included in the demographic information. Therefore it is difficult to conclude whether the sample obtained is at all ethnically diverse; with the representation of the sample in question this reduces generalizability of the

results. Upon reflection, it may have been helpful to establish whether participants had previously been supervised by a psychologist; this may have indicated whether the observed effects in this study are maintained and whether the experience of psychological supervision has helped clinicians in the longer term. Also, the demographic questionnaire did not include the length of time participants had worked in their post or the NHS, which may have been an indication of the level of experience of each participant.

Another improvement to the study would have been to ask all participants (including the control group) the qualitative questions about their experiences of supervision, and establish what they feel they gained from supervision. It would have been helpful to compare experiences between groups, clarify any similarities and highlight what might be different about supervision with a psychologist compared to normal supervision formats. Finally, a larger sample size and collecting the qualitative data via an interview (rather than written form) may have improved statistical power and gained more detailed qualitative information.

It is important to acknowledge some of the content of the aJDI and the aJIG. The aJIG consists of one question as a measure of satisfaction with work, therefore used on its own would not provide an accurate reflection of all the different aspects of work (such as opportunities for promotion, pay etc.). Also, many of the options available in the aJDI which describe aspects of an individual's job are quite limiting, therefore may not provide an accurate reflection of satisfaction with aspects of their job. For example, when asking about relationships with colleagues, participants were asked to decide how well each of the following phrases describe their colleagues; boring, slow, responsible, smart (clever), lazy and frustrating. The majority of these options are quite negative towards colleagues and the format of the questionnaire does not allow participants to elaborate on their answer, therefore factors influencing individual decision would be missed. This is a significant limitation of the measure. Overall, job satisfaction is a notoriously difficult concept to measure, as it consists of a multitude of complex factors. Therefore, although measures try to capture of all these concepts, providing a singular 'score' or reliable measure is very difficult. Although the aJDI and aJIG are used throughout research, there are other job satisfaction measures

such as the Minnesota satisfaction scale. A scale which may have been more appropriate for this particular study is the Brief Index of Affective Job Satisfaction (BIAJS), because it considers the affective or emotional aspect of job satisfaction, which the aJDI and aJIG seems to lack. As the qualitative results highlighted, healthcare professionals working in mental health settings are exposed to a variety of difficult emotions, so it would have been interesting to see if the groups differed in affective job satisfaction.

2.4.7 Clinical and research implications

As highlighted by the limitations, the results must be viewed with some caution. However, there are significant implications for the whole sample; given the current climate of the NHS, the majority of the sample scored within the low range for burnout and moderate ranges for job satisfaction. Suggesting that despite the enormous pressure on services, support networks that are available to staff seem to be maintaining job satisfaction and managing burnout sufficiently.

The results also pose an interesting debate for Clinical psychologists, particularly related to how much time they should dedicate to offering supervision to healthcare professionals. Results suggest that practitioners report some benefit from the process, however, psychological skills and knowledge can be shared through other means (not just through individual supervision). Providing supervision to the wider team takes up a significant amount of clinical time and with greater pressures on services other means of broadening psychological awareness to the MDT could be explored. Further research will be needed to assess the effectiveness of these alternative methods, but Clinical psychologists could consider providing frequent training in psychological skills, group supervision and consultation instead of individual supervision sessions.

The qualitative findings of this study could be of particular interest to managers of services to help improve the quality of general supervision. Training could be beneficial to other healthcare disciplines in improving the content and quality of supervision, so that more depth and sharing of skills/knowledge take place in other supervision formats. The qualitative results indicate which

supervisory processes are most valuable to supervisees and could help to shape supervisory processes in the future.

Finally, another indirect aim of this study was to overcome some of the methodological limitations associated with clinical supervision research. Firstly, trainees and students were excluded from the study to ensure the sample represented qualified clinicians working within mental health settings, and were therefore generalizable. Statistical power was also met by the sample size, and a control group was included. Most importantly, the study adopted a triangulation methodology to combine qualitative and quantitative data together. This study demonstrates the benefits of triangulation for methodological plurality and how it enriches the evidence base; future research should consider more mixed methods approaches to this complex area.

2.4.8 Future research

No previous research has been made into this particular area of supervision. Therefore, it is likely that findings will need to be replicated using a larger and more representative sample across multiple sites. This may include more detailed measures of supervision, self-esteem and other factors identified within the current study. In an ideal world, a randomised control trial measuring change over time will provide a more realistic picture of the effects supervision from psychologists may have on healthcare professionals.

Future studies could also include client outcomes, to investigate whether the type of supervision received impacts on clinical practice and client experience. Although this would be a challenging study to carry out, it would be fascinating to explore whether supervision from a psychologist provides better outcomes for clients, in terms of service experience as well as symptom reduction.

The results of this study imply that clinical supervision from a psychologist could increase self-esteem in health care professionals; clearly more investigation is necessary to further explore this possible relationship. A longitudinal method may assist in this process; by measuring supervisees' baseline self-esteem prior to starting supervision with a psychologist and then tracking

this over a period of time may shed some light upon this observed relationship. Another alternative, more related to the cognitive model of self-esteem, would be to explore the processes and approaches used within supervision which are most likely to impact upon self-esteem. This could be investigated through observational or qualitative methods.

Finally, more qualitative research into this area would also be beneficial in enriching the understanding of why clinicians continue to access voluntary psychological supervision. An in-depth interview format with participants could provide this information. In addition, exploring the reasons behind healthcare professionals choosing not to attend supervision with a psychologist could also be interesting to further investigate using qualitative methods. It could provide vital information about engaging professionals who are more reluctant to work psychologically.

2.5 Conclusions

The present study demonstrates the importance of further investigating the impact of supervision from a psychologist, on healthcare professionals. Analysis found no significant difference between groups in burnout or job satisfaction levels. However, the results did show that healthcare professionals who receive supervision from a psychologist score significantly higher in self-esteem, report significant benefits in quality of supervision, and experience professional and personal development and growth. There is some evidence to suggest that self-esteem increases as a result of attending supervision with a psychologist, through processes such as improving self-compassion and confidence in clinical abilities; links with the model of self-esteem have been made to help explain this result, however further research is required to replicate and generalise these findings. Overall, triangulation of qualitative and quantitative research has been demonstrated as a useful tool in investigating supervision processes and should be considered for future research.

References

- Balzer, W. K., Kihm, J. A., Smith, P. C., Irwin, J. L., Bachiochi, P. D., Robie, C., Sinar, E. F., & Parra, L. F. (2000). User's manual for the Job Descriptive Index (JDI: 1997 Revision) and the Job in General (JIG) Scales. In J. M. Stanton, & C. D. Crossley (Eds.), *Electronic resources for the JDI and JIG*. Bowling Green, OH: Bowling Green State University.
- Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16*(03), 317-331. doi: 10.1080/10503300500268524
- Beinart, H. (2012). Models of supervision and the supervisory relationship. In I. Fleming & L. Steen, (Eds), *Supervision and clinical psychology: theory, practice and perspectives* (2nd edn), (pp. 47-62). Hove: Routledge.
- Beinart, H. & Golding, L. (2015). Group of trainers in clinical psychology supervisor training and recognition (STAR) guidance on learning outcomes for advanced supervisor training: the desired characteristics of experienced and effective clinical psychology supervisors. *Clinical psychology forum, 266*, 30-35.
- Bishop, F. (2015) Using mixed methods research designs in health psychology: An illustrated discussion from a pragmatist perspective. *British journal of health psychology, 20*(1), 5-20. doi: 10.1111/bjhp.12122
- Borders, L. D., Welfare, L. E., Greason, P. B., Paladino, D. A., Mobley, A. K., Villalba, J. A., & Wester, K. L. (2012). Individual and Triadic and Group: Supervisee and Supervisor Perceptions of Each Modality. *Counselor Education and Supervision, 51*(4), 281-295. doi: 10.1002/j.1556-6978.2012.00021.x
- Bosson, J. K., Swann Jr, W. B., & Pennebaker, J. W. (2000). Stalking the perfect measure of implicit self-esteem: The blind men and the elephant revisited?. *Journal of personality and social psychology, 79*(4), 631. doi: 10.1037/0022-3514.79.4.631

- British Psychological Society (2009). *Psychological health and wellbeing: a new ethos for mental health*. Leicester. Author.
- Burton, J. P., & Hoobler, J. M. (2006). Subordinate self-esteem and abusive supervision. *Journal of Managerial Issues*, 18 (3), 340-355.
- Butterworth, T., Carson, J., Jeacock, J., White, E., & Clements, A. (1999). Stress, coping, burnout and job satisfaction in British nurses: findings from the clinical supervision evaluation project. *Stress medicine*, 15(1), 27-33. doi: 10.1002/(SICI)1099-1700(199901)15:1<27::AID-SMI782>3.0.CO;2-U
- Care Quality Commission (2013). *Supporting information and guidance: supporting effective clinical supervision*. London: CQC.
- Cole F.L. (1988). Content analysis: process and application. *Clinical Nurse Specialist* 2(1), 53–57. PubMed: 3349413
- Crutchfield, L. B., & Borders, L. D. (1997). Impact of two clinical peer supervision models on practicing school counselors. *Journal of Counseling & Development*, 75(3), 219- 230. doi: 10.1002/j.1556-6676.1997.tb02336.x
- Daniels, J. A., & Larson, L. M. (2001). The Impact of Performance Feedback on Counseling Self-Efficacy and Counselor Anxiety. *Counselor Education and Supervision*, 41(2), 120-130. doi: 10.1002/j.1556-6978.2001.tb01276.x
- Department of Health (2005). *New ways of working for psychiatrists: enhancing effective, person-centred services through new ways of working in multi-disciplinary and multiagency contexts*. London: Department of Health.
- Department of Health (2009). *New Horizons: Towards a shared vision for mental health: Consultation*. London: Department of Health.
- Division of clinical psychology (DCP) British psychological society (BPS) (2014) *DCP policy on supervision*, Leicester, BPS.

- Edwards, D., Burnard, P., Coyle, D., Fothergill, A., & Hannigan, B. (2000). Stress and burnout in community mental health nursing: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 7(1), 7-14. doi: 10.1046/j.1365-2850.2000.00258.x
- Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T. & Coyle, D. (2006). Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing*, 15(8), 1007-1015. doi: 10.1111/j.1365-2702.2006.01370.x
- Efron, B., & Tibshirani, R. J. (1994). More complicated data structures: the two sample problem. In Efron, B., & Tibshirani, R. J., *An introduction to the bootstrap*. CRC press, 86-103. ISBN: 9780412042317
- Ellis, M. V., Ladany, N., Kregel, M., & Schult, D. (1996). Clinical supervision research from 1981 to 1993: A methodological critique. *Journal of Counseling Psychology*, 43(1), 35. doi: 10.1037/0022-0167.43.1.35
- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of advanced nursing*, 62(1), 107-115. doi: 10.1111/j.1365-2648.2007.04569.x
- Farber, B. A. (2006). Supervisee and supervisor disclosure. In B. Farber, (Eds), *Self-disclosure in psychotherapy* (pp. 180-197). New York: Guilford Press.
- Fennell, M. (1997). Low self-esteem: a cognitive perspective. *Behavioural and cognitive therapy*, 25, 1-25. doi: 10.1017/S1352465800015368
- Fennell, M. (2009). *Overcoming low self-esteem: A self-help guide using cognitive behavioural techniques*. Hachette UK.
- Field, A. (2009). *Discovering Statistics using SPSS (and sex and drugs and rock 'n' roll)* (3rd ed). London: Sage. ISBN: 9781847879073
- Field, A. (2014). *Discovering statistics using SPSS (and sex and drugs and rock 'n' roll)* (4th ed). London: Sage. ISBN: 9781446249178
- Fleming, I. & Hughes, J. (2015). Supervisor training: recent updates. *Clinical psychology forum*, 266, 36- 39.

- Flick, U., Garms-Homolová, V., Herrmann, W. J., Kuck, J., & Röhnsch, G. (2012). ‘‘I Can’t Prescribe Something Just Because Someone Asks for It...’’: Using Mixed Methods in the Framework of Triangulation. *Journal of Mixed Methods Research, 17*, 1-14. doi: 10.1177/1558689812437183
- Freitas, G. J. (2002). The impact of psychotherapy supervision on client outcome: A critical examination of two decades of research. *Psychotherapy: Theory, Research, Practice, Training, 39*(4), 354-367. doi: 10.1037/0033-3204.39.4.354
- Gnilka, P. B., Chang, C. Y., & Dew, B. J. (2012). The relationship between supervisee stress, coping resources, the working alliance, and the supervisory working alliance. *Journal of Counseling & Development, 90*(1), 63-70. doi: 10.1111/j.1556-6676.2012.00009.x
- Green, S. & Higgins, J. P. T. (2011) In, *The Cochrane collaboration*. Version 5.1.0, <http://www.cochrane.org/resources/glossary.htm>. Accessed December 19, 2014.
- Greene, J. C. (2008). Is mixed methods social inquiry a distinctive methodology?. *Journal of mixed methods research, 2*(1), 7-22. doi: 10.1177/1558689807309969
- Hawkins, P. & Shohet, R. (1989). *Supervision in the helping professions*, Buckingham: Open University press.
- Hawkins, P. & Shohet, R. (2000). *Supervision in the helping professions: an individual group and organisational approach* (2nd edn), Milton Keynes: Open University press.
- Hawkins, P. & Shohet, R. (2012). *Supervision in the helping professions* (4th edn), Maidenhead: Open University press.
- Health and care professions council (HCPC) (2011). *Standards of proficiency: practitioner psychologists*. London, HCPC.
- Huff, A. S. (1990). *Mapping strategic thought*. Chichester, NY: John Wiley and Sons.
- Hunt, C., & Sharpe, L. (2008). Within-session supervision communication in the training of clinical psychologists. *Australian Psychologist, 43*(2), 121-126. doi: 10.1080/00050060801933402

- Hyrkäs, K. (2005). Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in Finland. *Issues in Mental Health Nursing*, 26(5), 531-556. doi: doi:10.1080/01612840590931975
- Inskipp, F., Proctor, B., & CASCADE, Twickenham (United Kingdom);. (1993). *The art, craft & tasks of counselling supervision Part 1-making the most of supervision; professional development for counsellors, psychotherapists, supervisors and trainees*. Twickenham: Cascade publications
- Ironson GH, Smith PC, Brannick MT, Gibson WM, Paul KB. (1989). Construction of a Job in General Scale: a comparison of global, composite, and specific measures. *Journal of Applied Psychology* 74, 193–200. doi: 10.1037/0021-9010.74.2.193
- Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational researcher*, 33(7), 14-26. doi: 10.3102/0013189X033007014
- Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of mixed methods research*, 1(2), 112-133. doi: 10.1177/1558689806298224
- Judge, T. A., & Bono, J. E. (2001). Relationship of core self-evaluations traits—self-esteem, generalized self-efficacy, locus of control, and emotional stability—with job satisfaction and job performance: A meta-analysis. *Journal of applied Psychology*, 86(1), 80. doi: 10.1037/0021-9010.86.1.80
- Klitzke, M. J., & Lombardo, T. W. (1991). A " Bug-in-the-Eye" Can Be Better Than a " Bug-in-the-Ear" A Teleprompter Technique for On-Line Therapy Skills Training. *Behaviour modification*, 15(1), 113-117. doi: 10.1177/01454455910151007
- Knapp, S. J., & VandeCreek, L. D. (2006). *Practical ethics for psychologists: A positive approach*. American Psychological Association. Washington, DC.

- Knox, S., Burkard, A. W., Edwards, L. M., Smith, J. J., & Schlosser, L. Z. (2008). Supervisors' reports of the effects of supervisor self-disclosure on supervisees. *Psychotherapy Research, 18*(5), 543-559. doi: 10.1080/10503300801982781
- Knox, S., Edwards, L. M., Hess, S. A., & Hill, C. E. (2011). Supervisor self-disclosure: Supervisees' experiences and perspectives. *Psychotherapy, 48*(4), 336-341. doi: 10.1037/a0022067
- Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2008). Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse. *Journal of Substance Abuse Treatment, 35*(4), 387-395. doi: 10.1016/j.jsat.2008.02.003
- Knudsen, H. K., Roman, P. M. & Abraham, A.J. (2013). Quality of clinical supervision and counsellor emotional exhaustion: The potential mediating roles of organizational and occupational commitment. *Journal of substance abuse treatment, 44*, 528-533. doi: doi:10.1016/j.jsat.2012.12.003
- Kohn, M. L., & Schooler, C. (1983). *Work and personality: An inquiry into the impact of social stratification*. Norwood, NJ: Ablex Pub.
- Koivu, A., Saarinen, P. I., & Hyrkäs, K. (2012). Who benefits from clinical supervision and how? The association between clinical supervision and the work related wellbeing of female hospital nurses. *Journal of clinical nursing, 21*(17-18), 2567-2578. doi: 10.1111/j.1365-2702.2011.04041.x
- Korman, A. (1977). *Organization behaviour*. Prentic Hall Regents, Englewood New Jersey.
- Kozlowski, J. M., Pruitt, N. T., DeWalt, T. A., & Knox, S. (2014). Can boundary crossings in clinical supervision be beneficial?. *Counselling Psychology Quarterly, 27*(2), 109-126. doi: 10.1080/09515070.2013.870123
- Krippendorff K. (1980). *Content Analysis: An Introduction to its Methodology*. Sage Publications, Newbury Park.

- Ladany, N., Mori, Y., & Mehr, K. E. (2013). Effective and ineffective supervision. *The Counseling Psychologist, 41*(1), 28-47. doi: 10.1177/0011000012442648
- Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it Time for Clinicians to Routinely Track Patient Outcome? A Meta-Analysis. *Clinical Psychology: Science and Practice, 10*(3), 288-301. doi: 10.1093/clipsy.bpg025
- Lawson, G., Hein, S. F., & Stuart, C. L. (2009). A qualitative investigation of supervisees' experiences of triadic supervision. *Journal of Counseling & Development, 87*(4), 449-457. doi: 10.1002/j.1556-6678.2009.tb00129.x
- Lenz, A. S., Sangganjanavanich, V. F., Balkin, R. S., Oliver, M., & Smith, R. L. (2012). Wellness model of supervision: A comparative analysis. *Counselor Education and Supervision, 51*(3), 207-221. doi: 10.1002/j.1556-6978.2012.00015.x
- Lenz, A. S., & Smith, R. L. (2010). Integrating wellness concepts within a clinical supervision model. *The Clinical Supervisor, 29*(2), 228-245. doi: 10.1080/07325223.2010.518511
- Lyon, R. C., Heppler, A., Leavitt, L., & Fisher, L. (2008). Supervisory training experiences and overall supervisory development in predoctoral interns. *The Clinical Supervisor, 27*(2), 268-284. doi: 10.1080/07325220802490877
- Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach Burnout Inventory* (3rd ed.) Palo Alto, CA: Consulting psychologists press.
- McMahon, A., & Errity, D. (2014). From New Vistas to Life Lines: Psychologists' Satisfaction with Supervision and Confidence in Supervising. *Clinical psychology & psychotherapy, 21*(3), 264-275. doi: 10.1002/cpp.1835
- Mehr, K. E., Ladany, N., & Caskie, G. I. (2010). Trainee nondisclosure in supervision: What are they not telling you?. *Counselling and Psychotherapy research, 10*(2), 103-113. doi: 10.1080/14733141003712301
- Meyer, H. H. (1980). Self-appraisal of job performance. *Personnel Psychology, 33*(2), 291-295. doi: 10.1111/j.1744-6570.1980.tb02351.x
- Milne, D. (2009). *Evidence-based clinical supervision*. Chichester: BPS Blackwell.

- Milne, D. (2007). An empirical definition of clinical supervision. *British Journal of Clinical Psychology, 46*(4), 437-447. doi: 10.1348/014466507X197415
- Milne, D., & James, I. (2000). A systematic review of effective cognitive behavioural supervision. *British Journal of Clinical Psychology, 39*(2), 111-127. doi: 10.1348/014466500163149
- Milne, D., Leck, C., James, I., Wilson, M., Proctor, R., Ramm, L., Wilkinson, J. & Weetman, J. (2012). In I. Fleming & L. Steen, (Eds), *Supervision and clinical psychology: theory, practice and perspectives* (2nd edn), (pp. 142- 158). Hove: Routledge.
- Morgan D.L. (1993). Qualitative content analysis: a guide to paths not taken. *Qualitative Health Research, 1*, 112–121. PubMed: 8457790
- Neundorf, K. (2002). *The Content Analysis Guidebook*. Sage Publications Inc., Thousand Oaks, CA.
- Newgent, R. A., Davis Jr, H., & Farley, R. C. (2004). Perceptions of individual, triadic, and group models of supervision: A pilot study. *The Clinical Supervisor, 23*(2), 65-79. doi: 10.1300/J001v23n02_05
- Nyman, S. J., Nafziger, M. A., & Smith, T. B. (2010). Client outcomes across counselor training level within a multitiered supervision model. *Journal of Counseling & Development, 88*(2), 204-209. doi: 10.1002/j.1556-6678.2010.tb00010.x
- Olsen, W. (2004). Triangulation in social research: qualitative and quantitative methods can really be mixed. *Developments in sociology, 20*, 103-118. doi: 1902796829
- Onyett, S., Pillinger, T. & Muijen, M. (1997). Job satisfaction and burnout among members of community mental health teams. *Journal of Mental Health, 6*(1), 55-66. doi: 10.1080/09638239719049
- Owens, T. J. (1993). Accentuate the positive-and the negative: Rethinking the use of self-esteem, self-deprecation, and self-confidence. *Social Psychology Quarterly, 56*, 288-299.
- Palsson, M. B., Hallberg, I., Norberg, A., & Björvell, H. (1996). Burnout, empathy and sense of coherence among Swedish district nurses before and after systematic clinical supervision.

Scandinavian Journal of Caring Sciences, 10(1), 19-26. doi: 10.1111/j.1471-6712.1996.tb00305.x

Prosser, D., Johnson, S., Kuipers, E., Szmukler, G., Bebbington, P., & Thornicroft, G. (1996).

Mental health," burnout' and job satisfaction among hospital and community-based mental health staff. *The British Journal of Psychiatry*, 169(3), 334-337. doi: 10.1192/bjp.169.3.334

Rees, D. W., & Smith, S. D. (1991). Work stress in occupational therapists assessed by the occupational stress indicator. *The British Journal of Occupational Therapy*, 54(8), 289-294. doi: 10.1177/030802269105400805

Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology*, 3(3), 157. doi: 10.1037/a0015673

Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., Bebbington, P. & Prosser, D. (1999). Improving support for mental health staff: a qualitative study. *Social Psychiatry and Psychiatric Epidemiology*, 34(6), 309-315. doi: 10.1007/s001270050149

Robins, R. W., Hendin, H. M., & Trzesniewski, K. H. (2001). Measuring global self-esteem: Construct validation of a single-item measure and the Rosenberg Self-Esteem Scale. *Personality and social psychology bulletin*, 27(2), 151-161. doi: 10.1177/0146167201272002

Rosenberg, M. (1965). The measurement of self-esteem. *Society and the adolescent self - image*, 297, V307.

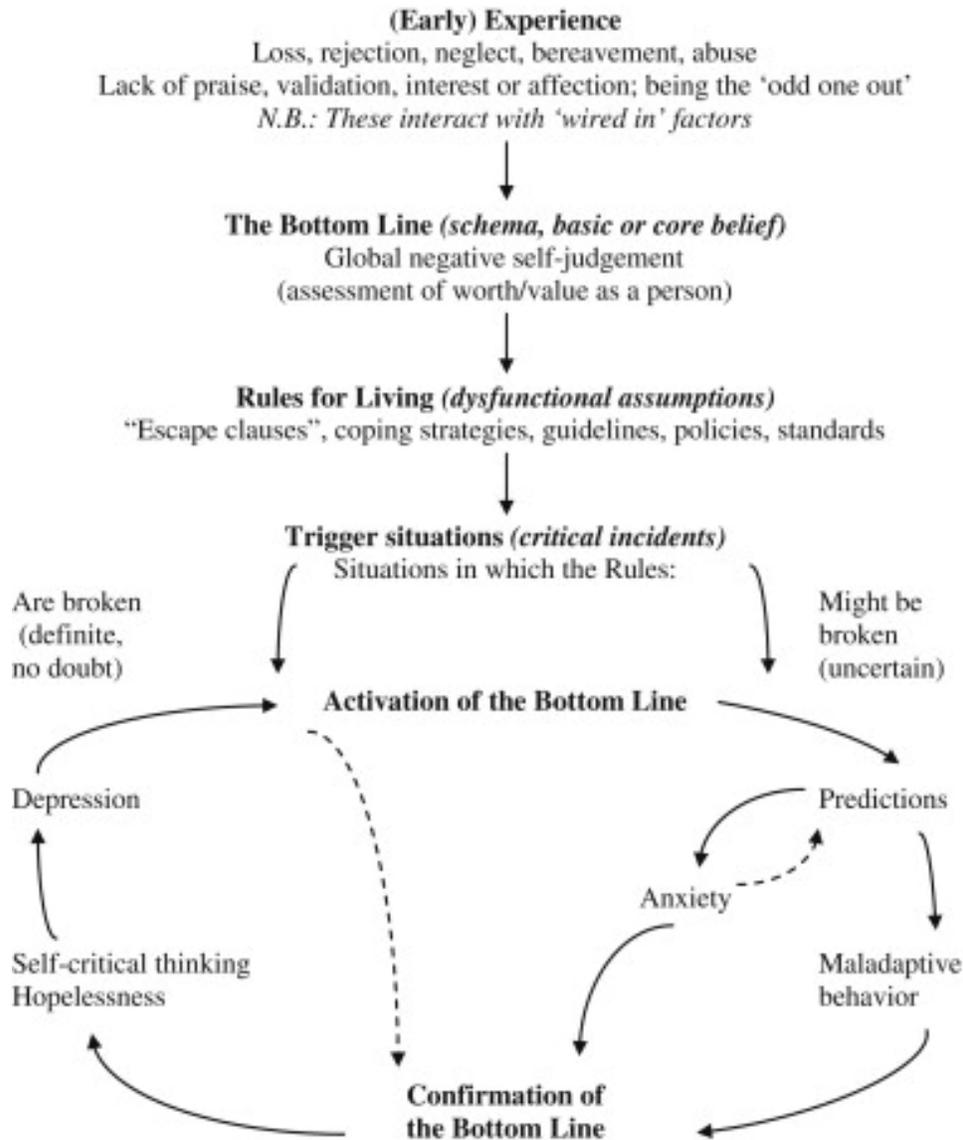
Roth, A. D., & Pilling, S. (2008). *A competence framework for the supervision of psychological therapies*. (www.ucl.ac.uk/clinical-psychology/CORE/competence_framework.htm; accessed 17/08/2015).

- Russell, S. S., Spitzmüller, C., Lin, L. F., Stanton, J. M., Smith, P. C., & Ironson, G. H. (2004). Shorter can also be better: The abridged job in general scale. *Educational and Psychological Measurement, 64*(5), 878-893. doi: 10.1177/0013164404264841
- Saane, N., Sluiter, J. K., Verbeek, J. H. A. M., & Frings-Dresen, M. H. W. (2003). Reliability and validity of instruments measuring job satisfaction—a systematic review. *Occupational Medicine, 53*(3), 191-200. doi: 10.1093/occmed/kqg038
- Schaufeli, W. B., Bakker, A. B., Hoogduin, K., Schaap, C., & Kladler, A. (2001). On the clinical validity of the Maslach Burnout Inventory and the Burnout Measure. *Psychology & Health, 16*(5), 565-582. doi: 10.1080/08870440108405527
- Schaufeli, W. B., Enzmann, D. & Girault, N. (1993). Measurement of burnout: a review. In W. B. Schaufeli, C. Maslach, & T. Merck (Eds), *Professional burnout: recent developments in theory and research* (pp. 199-215). Washington, DC: Taylor and Francis.
- Scheff, T. J., Retzinger, S. M. & Ryan, M. T. (1989). Crime, violence, and self-esteem: Review and proposals. In A. M. Mecca, N. J. Smelser, & J. Vasconcellos (Eds), *The social importance of self-esteem* (pp. 165-199), Berkeley: University of California Press.
- Schoenwald, S. K., Sheidow, A. J., & Chapman, J. E. (2009). Clinical supervision in treatment transport: Effects on adherence and outcomes. *Journal of Consulting and Clinical Psychology, 77*(3), 410. doi: 10.1037/a0013788
- Spence, S. H., Wilson, J., Kavanagh, D., Strong, J., & Worrall, L. (2001). Clinical supervision in four mental health professions: A review of the evidence. *Behaviour Change, 18*(03), 135-155. doi: 10.1375/bech.18.3.135
- Stanton, J. M., Sinar, E. F., Balzer, W. K., Julian, A. L., Thoresen, P., Aziz, S., Fisher, G. G. & Smith, P. C. (2002). Development of a compact measure of job satisfaction: The abridged Job Descriptive Index. *Educational and Psychological Measurement, 61* (6), 1104-1122.
- Sterner, W. R. (2009). Influence of the supervisory working alliance on supervisee work satisfaction and work-related stress. *Journal of Mental Health Counseling, 31*(3), 249-263.

- Tanner, M. A., Gray, J. J., & Haaga, D. A. (2012). Association of cotherapy supervision with client outcomes, attrition, and trainee effectiveness in a psychotherapy training clinic. *Journal of clinical psychology, 68*(12), 1241-1252. doi: 10.1002/jclp.21902
- Turpin, G. (2012). The impact of recent NHS policy on supervision in clinical psychology. In I. Fleming & L. Steen, (Eds), *Supervision and clinical psychology: theory, practice and perspectives* (2nd edn), (pp. 23- 46). Hove: Routledge.
- Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research, 7*(1), 54-65. doi: 10.1080/14733140601185274
- White, E., & Winstanley, J. (2009). Implementation of clinical supervision: educational preparation and subsequent diary accounts of the practicalities involved, from an Australian mental health nursing innovation. *Journal of psychiatric and mental health nursing, 16*(10), 895-903. doi: 10.1111/j.1365-2850.2009.01466.x
- White, E., & Winstanley, J. (2010). A randomised controlled trial of clinical supervision: selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *Journal of Research in Nursing, 15*(2), 151-167. doi: 10.1177/1744987109357816
- Wieseler, B., & McGauran, N. (2010). Reporting a systematic review. *CHEST Journal, 137*(5), 1240-1246. doi: 10.1378/chest.09-2625
- Winstanley, J. (2000). Manchester clinical supervision scale. *Nursing Standard, 14*(19), 31.
- Worthen, V. E., & Lambert, M. J. (2007). Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations. *Counselling and Psychotherapy Research, 7*(1), 48-53. doi: 10.1080/14733140601140873

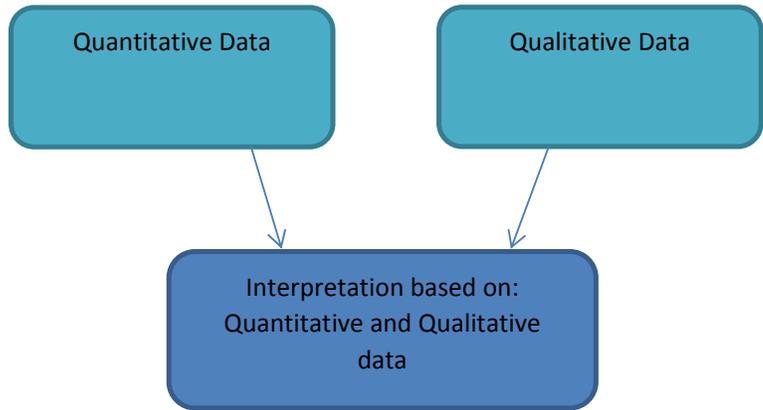
Figures

Figure 1.1: The cognitive model of self-esteem



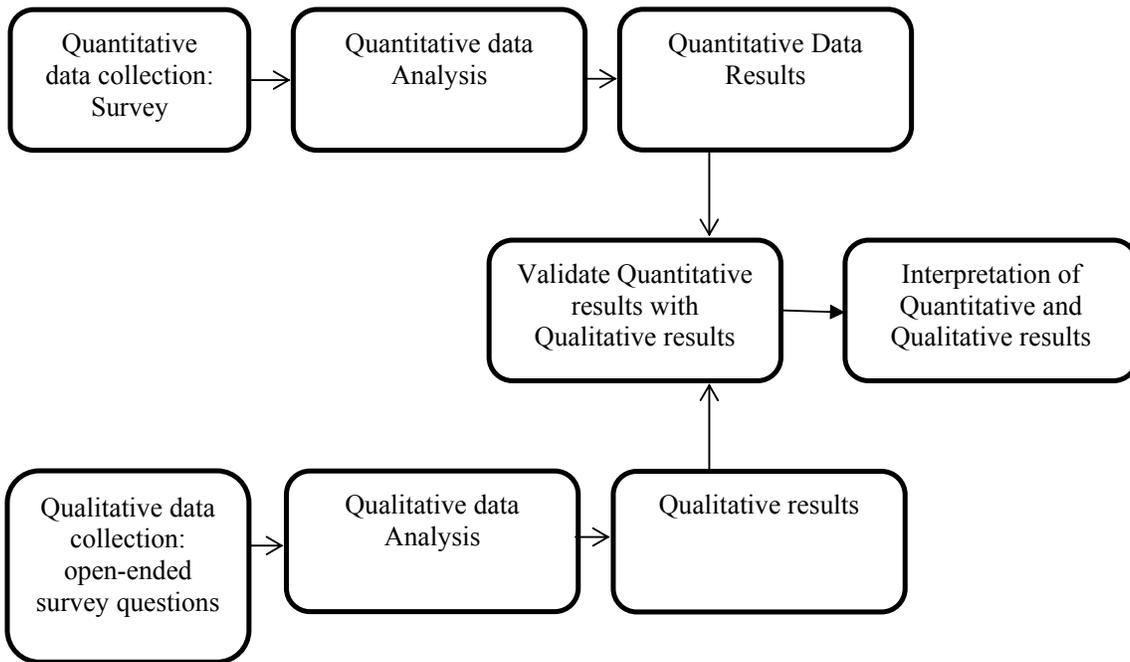
Taken from Fennell (1997)

Figure 2: *Triangulation approach*



Taken from: Bishop (2015)

Figure 3: Breakdown of triangulation design (validating quantitative data model)



Adapted from: Olsen (2004)

Figure 4: *The inductive content analysis process (adapted from Elo & Kyngas, 2007)*

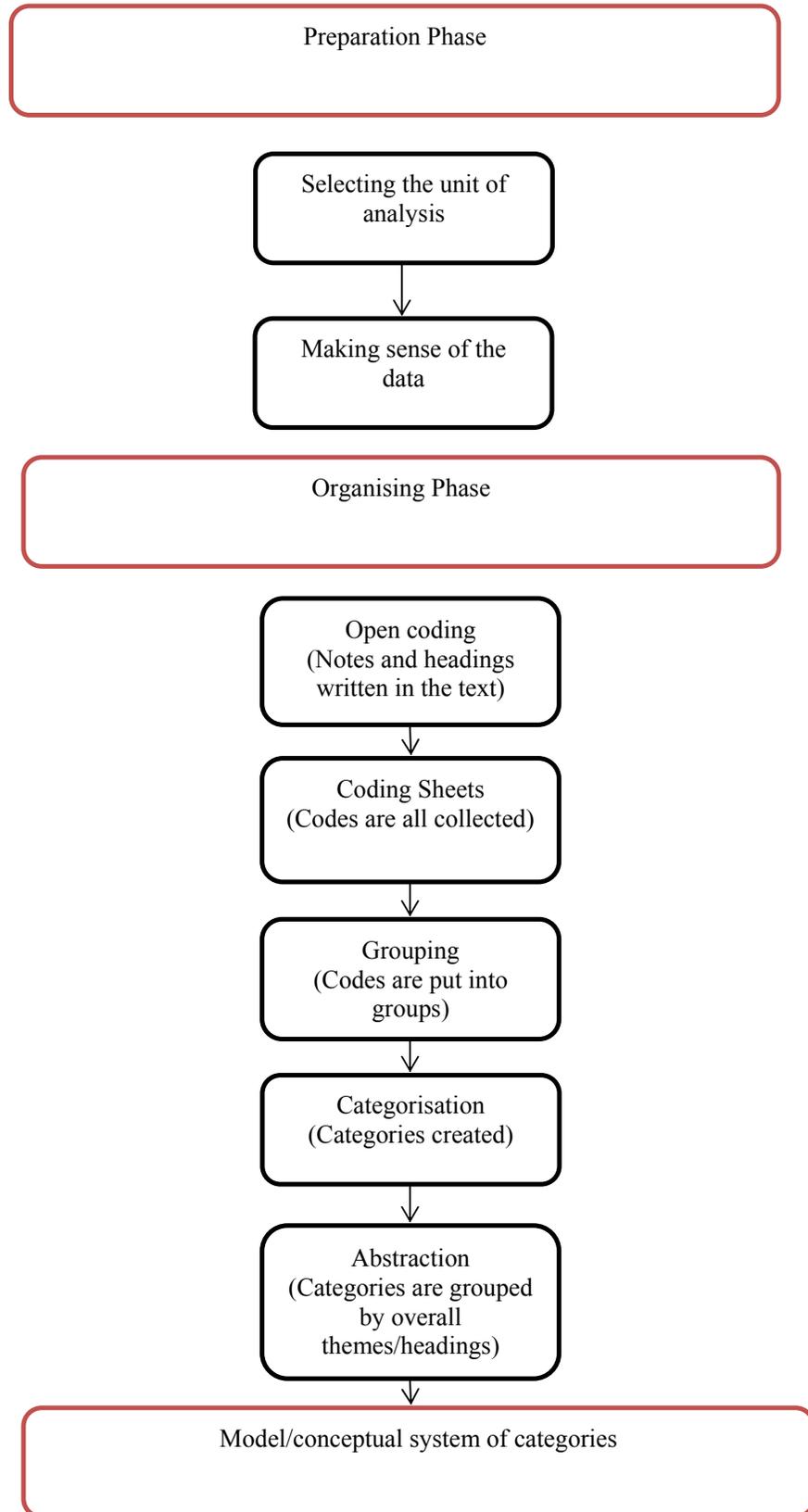
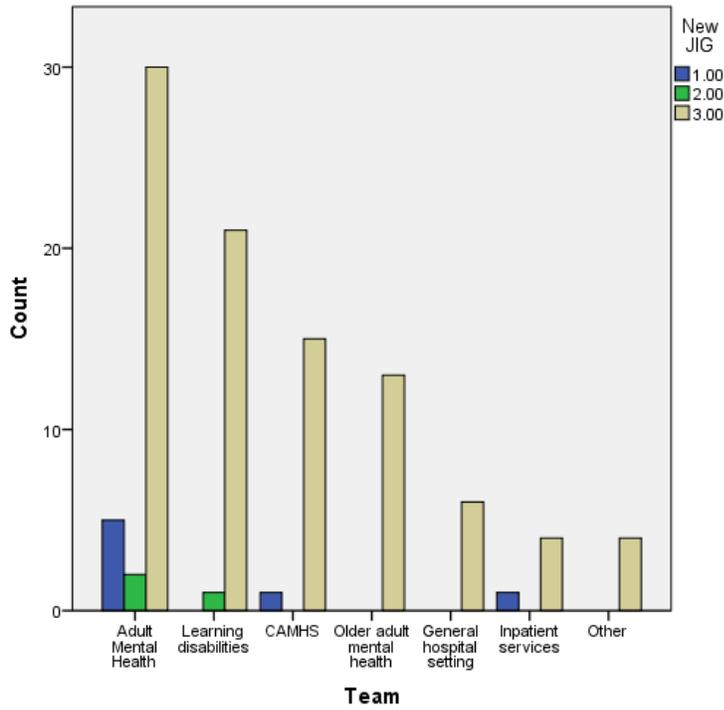
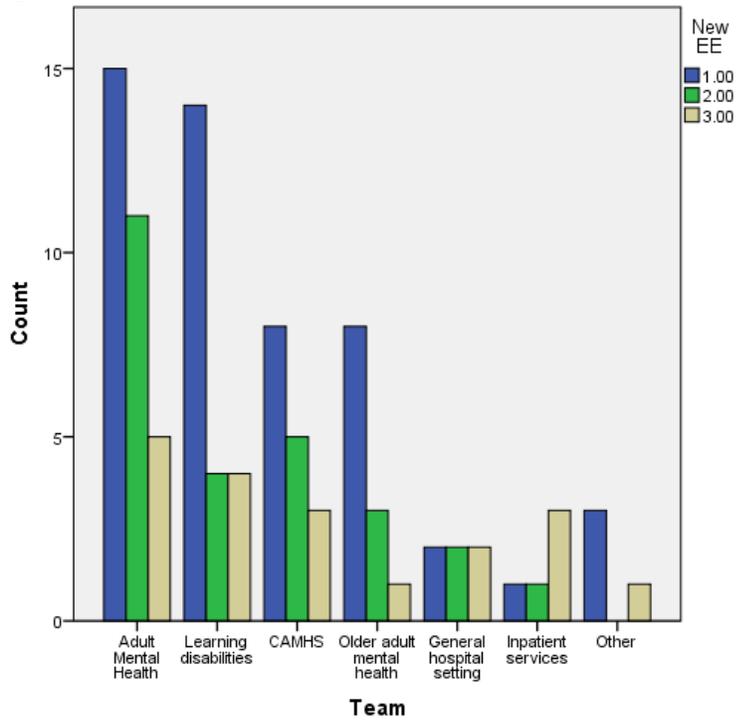


Figure 5a: A bar chart to show job satisfaction levels between teams.



1 = low satisfaction range, 2 = neutral and 3 = high satisfaction range.

Figure 5b: A bar chart to show emotional exhaustion levels between teams.



1 = low EE range, 2 = moderate EE range, 3 = high EE range

Appendices

Appendix 1. *The definition of clinical supervision (with clarifying comments)*

‘FORM’ OF SUPERVISION:

**‘The formal provision (i.e. sanctioned by relevant organization/s);
by senior/qualified health practitioners (or similarly experienced staff)
of an intensive (i.e. typically 1:1 and regular/ongoing, at least, three meetings with protected time,
of at least 3 hours total duration),
relationship-based (inc. confidential and highly collaborative, being founded on a learning alliance
and featuring (e.g.) participative decision making and shared agenda setting; and therapeutic inter-personal qualities, such as empathy and warmth),
education and training (general problem-solving capacity or ‘capability’ aspect, not just competence enhancement)
that is case-focused (supervisee guides topics and tables material and supervisor typically overlays professional and organizational considerations/standards)
and which supports, directs and guides (inc. also ‘restorative and normative’ topics, addressed
by means of professional methods, inc. objective monitoring, feedback and evaluation; and by reference to the empirical and theoretical knowledge-base)
the work of colleagues (supervisees) (inc. CPD/post-qualification colleagues)**

‘FUNCTIONS’ OF SUPERVISION:

**(1) quality control (inc. ‘gatekeeping’ and safe, ethical practice);
(2) maintaining and facilitating the supervisees’ competence and capability; and
(3) helping supervisees’ to work effectively (inc. promoting quality control and preserving client safety; accepting responsibility and mostly working independently; developing own professional identity; enhancing self-awareness and resilience/effective personal coping with the job;
critical reflection and lifelong learning skills)**

(Milne, 2007)



Welcome to the Supervision Online survey!

Participant Information Sheet

Date: Version 2

Title: 'An investigation into the experience of multi-disciplinary clinical supervision'

Researcher: Sophie Williams Ethics number: 12964

Please read this information carefully before deciding to take part in this research. If you consent to participating in this study please select the option below and press the link to continue

What is the research about?

I am Sophie Williams, a Trainee Clinical Psychologist at the University of Southampton. I am interested in gaining information about how supervision is helpful to healthcare professionals. In particular to investigate whether certain types of supervision may be more beneficial to healthcare professionals than others, and understanding what professionals feel they gain from supervision.

Who can participate?

Any health care professional (who works in inpatient/community settings or with mental health/learning disability) who requires regular supervision, from either someone who is in the same discipline as them or receives supervision from another discipline (e.g. a Clinical Psychologist). This includes nursing, occupational therapists, physiotherapists, support workers etc. Unfortunately, Clinical Psychologists, Trainee Clinical Psychologists and Assistant Psychologists cannot participate in this study.

What will happen to me if I take part?

You will complete an online survey which will take approximately 15-20 minutes.

Are there any benefits in my taking part?

You will be contributing to the growing body of knowledge we have on the potential benefits of supervision

Are there any risks involved?

There are no known risks to participating in this study.

Will my participation be confidential?

Storage of data will comply with the Data protection act and NHS policy. All your responses are completely anonymous, so your identity is completely protected. You will be given the opportunity to enter a prize draw for **£50 worth of Amazon vouchers**, for participating in the study. If you would like to be entered into the draw simply enter your email address where required. Email addresses will be stored separately from the survey responses to ensure anonymity.

What happens if I change my mind?

You have the right to withdraw at any time during the survey, simply click the cancel button in the top right of the screen.

Where can I get more information?

If you would like any further information or have any concerns regarding this study, please contact:

Academic supervisor: [REDACTED]

Clinical Supervisor: [REDACTED]

Or you can contact the researcher directly [REDACTED]

If you have questions about your rights as a participant in this research, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: [REDACTED], email [REDACTED]

Please tick (check) this box to indicate that you consent to taking part in this survey

Appendix 3: Demographics questionnaire

Please indicate your gender

Male Female Prefer not to state

Please indicate your current age

0-25 26-35 36-45 46-55 56-65 66+

Role within the service

Psychiatrist Occupational Therapist Nurse Manager

Mental Health Practitioner Speech and Language therapist

Support worker Physiotherapist Art therapist

Other

What team do you currently work in?

Adult mental health Older adult mental health

Learning disabilities Inpatient

Child and Adolescent mental health Other

How frequently do you receive supervision?

Weekly Fortnightly Monthly Other

What is the average duration of your supervision meetings?

Half an hour an hour 1 ½ hours 2 hours +

What types of supervision do you receive?

Peer individual group All of the above

Do you receive separate supervision from a psychologist?

Yes No

Appendix 4: *Open-ended questions for experimental participants*

Qualitative questions for the survey

What made you choose to attend supervision with a Psychologist?

What do you feel you gain from attending supervision with a Psychologist?

How do you feel supervision with a Psychologist influences your practice?

Appendix 5: Measure of self-esteem (RSES)

Below is a list of statements dealing with your general feelings about yourself. Please indicate how much you agree with each statement by selecting the appropriate response.

	Strongly Agree	Agree	Disagree	Strongly disagree
On the whole, I am satisfied with myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At times I think I am no good at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I have a number of good qualities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am able to do things as well as most other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel I do not have much to be proud of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I certainly feel useless at times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I am a person of worth, at least on an equal plane with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wish I could have more respect for myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All in all, I am inclined to feel that I am a failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take a positive attitude toward myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 6: Job satisfaction measures (aJIG and then aJDI)

Question 1: Think of your job in general, all in all, what is it like most of the time?

For each word or phrase below please indicate 'Yes' whether it describes your job, 'No' if it does not describe it or '?' if you can't decide.

	Yes	No	?
Good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undesirable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Better than most	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disagreeable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Makes me content	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoyable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 2: Think of the majority of people with whom you work or meet in connection with your work. How well does each of the following words or phrases describe these people?

Please select one of the following, 'Yes' if it describes the people with whom you work, 'No' if it does not describe them or '?' if you can't decide.

	Yes	No	?
Boring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responsible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smart (clever)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frustrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 3: Think of the work you do at present. How well does each of the following words or phrases describe your work?

Please select one of the following, 'Yes' if it describes your work, 'No' if it does not describe it or '?' if you cannot decide.

	Yes	No	?
Fascinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Satisfying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exciting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rewarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uninteresting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 4: Think of the pay you get now. How well does each of the following words or phrases describe your present pay?

Please select one of the following, 'Yes' if it describes your pay, 'No' if it does not describe your pay or '?' if you cannot decide.

	Yes	No	?
Barely live on income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Well paid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Underpaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comfortable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enough to live on	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 5: Think of the opportunities for promotion that you have now. How well does each of the following words or phrases describe these?

Please select one of the following, 'Yes' if it describes your opportunities for promotion, 'No' if it does not describe your opportunity for promotion, or '?' if you cannot decide.

	Yes	No	?
Good opportunities for promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opportunities somewhat limited	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dead-end job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good chance for promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular promotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fairly good chance for promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 6: Think of the kind of supervision that you get on your job. How well does each of the following words or phrases describe this?

Please select one of the following, 'Yes' if it describes the supervision you get on your job, 'No' if it does not describe it or '?' if you cannot decide.

	Yes	No	?
Praises good work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tactful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Up to date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annoying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knows job well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 7: Measure of burnout (MBI)

You will now be presented with 22 statements of job related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have never had this feeling, select the number '0' (zero) after the statement. If you have had this feeling please indicate how often you feel it by selecting the number (from 1 to 6) that best describes how frequently you feel that way.

⊕

	1) A few times a year or less	2) Once a month or less	3) A few times a month	4) Once a week	5) A few times a week	6) Everyday
I feel emotionally drained from my work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel used up at the end of the work day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel fatigued when I get up in the morning and have to face another day on the job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can easily understand how my recipients (clients) feel about things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel I treat some recipients (clients) as if they were impersonal objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working with people all day is really a strain for me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I deal very effectively with the problems of my recipients (clients)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel burned out from my work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel I am positively influencing people's lives with my work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've become more callous to people since taking this job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I worry that this job is hardening me emotionally	☺	☺	☺	☺	☺	☺	☺	☺	☺
I feel very energetic	☺	☺	☺	☺	☺	☺	☺	☺	☺
I feel frustrated by my job	☺	☺	☺	☺	☺	☺	☺	☺	☺
I feel I'm working too hard on my job	☺	☺	☺	☺	☺	☺	☺	☺	☺
I don't really care what happens to some recipients (clients)	☺	☺	☺	☺	☺	☺	☺	☺	☺
Working with people directly puts too much stress on me	☺	☺	☺	☺	☺	☺	☺	☺	☺
I can easily create a relaxed atmosphere with my recipients (clients)	☺	☺	☺	☺	☺	☺	☺	☺	☺
I feel exhilarated after working closely with my recipients (clients)	☺	☺	☺	☺	☺	☺	☺	☺	☺
I have accomplished many worthwhile things in this job	☺	☺	☺	☺	☺	☺	☺	☺	☺
I feel like I'm at the end of my rope	☺	☺	☺	☺	☺	☺	☺	☺	☺
In my work I deal with emotional problems very calmly	☺	☺	☺	☺	☺	☺	☺	☺	☺
I feel recipients (clients) blame me for some of their problems	☺	☺	☺	☺	☺	☺	☺	☺	☺



TO ALL **HEALTHCARE PROFESSIONALS** WORKING WITHIN
MENTAL HEALTH SETTINGS: IT IS **YOUR** CHANCE TO HAVE
YOUR SAY IN A
**RESEARCH STUDY EXPLORING YOUR
EXPERIENCES OF CLINICAL
SUPERVISION**

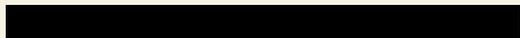
If you are a healthcare professional working within a mental health setting and receive supervision from the same discipline or a different discipline then you are eligible to participate in this study.

You will be asked to complete an online survey of short standardized questionnaires, and you may be asked to comment on some of your experiences of supervision. The survey will take approximately 15-20 minutes of your time to complete. All participants will be given the chance to be entered into a prize draw, with the chance to win £50 Amazon vouchers.

If you would like to participate, please click on the link below:



FOR MORE INFORMATION CONTACT:



ETHICS NUMBER: 12964

Appendix 9: Debrief Information

Debriefing Form
10/06/2014: Version 1
Ethics Number: 12964

Thank you very much for taking part in this study.

The main aim of this study is to gain more understanding of how people experience multi-disciplinary supervision, and how this impacts on self-esteem, job satisfaction and burnout. Little research so far has explored how supervision from a Clinical psychologist may benefit other mental health professionals in terms of their clinical work and experience of supervision. This study hopes to explore whether such supervision has a positive impact.

You may have found that some of the questions included in the questionnaires bring up difficult emotions. If you feel you would like further support with this, you are advised to contact your GP, your Occupational Health department or a Clinical psychologist in the team you work in. In addition there are several community services who may be able to assist you; Samaritans or Mind

If you have any further concerns or queries regarding this research study please contact:

Academic supervisor: [REDACTED]
Clinical Supervisor: [REDACTED]
Or you can contact the researcher directly [REDACTED]

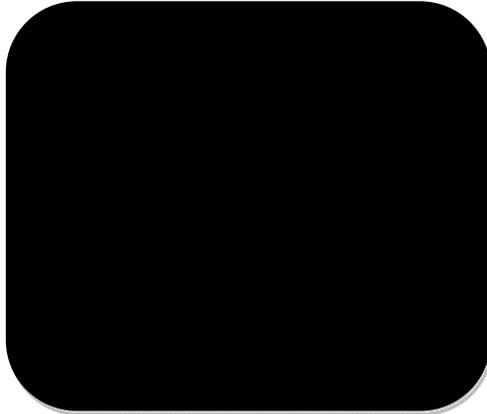
If you have questions about your rights as a participant in this research, you may contact the Chair of the Ethics Committee, Psychology, [REDACTED].

If you have any further comments or queries please do not hesitate to contact me.

Kind regards,

[REDACTED] Trainee Clinical Psychologist.

Appendix 10: Ethical approval letters



1 December 2014



Psychology Supervision for the Multi-disciplinary Team

I am writing formally to confirm that the R&D Committee Chair granted management permission ("R&D approval") to your project on the 24 November.

We note that, under the harmonised Governance Arrangements for Research Ethics Committees (GAfREC), your research is GAfREC exempt as it involves NHS staff recruited as research participants by virtue of their professional role and therefore does not require REC review.

One of the local governance checks relates to the issue of Honorary Research Contracts or Letters of Access where required. We note that our staff may be involved in completing online survey questionnaires and that you will have access to **identifiable** staff data as a result. As you will not be accessing this data in our NHS facilities, I confirm that a Letter of Access will not be required.

This management permission is conditional upon the following:

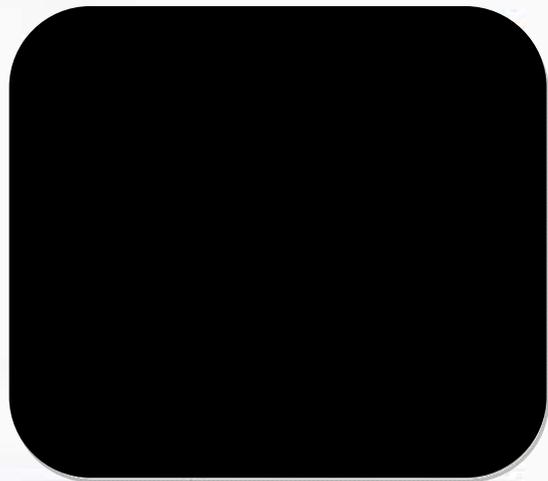
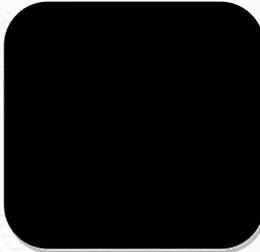
- Submission of a progress report 12 months from today's date. Annual progress reports should be submitted thereafter until the end of the study. If the study has not started within 12 months of this management permission, you should give an explanation for the delay in the first progress report
- If you plan to extend the duration of the study beyond the period specified in your initial R&D application, you should notify the R&D Office in writing, giving reasons for the extra time needed to complete the research
- You should notify the R&D Office in writing of the conclusion or early termination of the study and send a summary of the final research report within 12 months of the end of the study. As a minimum, you should state whether the study achieved its objectives, the main findings, and arrangements for publication or dissemination of the research, including any feedback to participants

I wish you every success with your study.



Research Management and Governance Manager

12 August 2014



Study Title	Psychology Supervision for multi-disciplinary Teams		
REC Reference	N/a	Trust Project N ^o	SHT139
Protocol N ^o	N/a		

This letter provides the formal [redacted] NHS approval required for your project to commence. Your project is now registered on the R&D database with identification number SHT139. It would be helpful if you could use this number on all correspondence with the R & D Office.

Please note that this Trust approval (and your ethics approval) only applies to the current protocol. Any changes to the protocol can only be initiated following further approval from the REC via a protocol amendment; the R&D office should be informed of these changes.

This approval is conditional on members of the research team being substantively employed by the Trust or having appropriate Honorary Research contracts in place before they start data collection. Please contact the R&D office to confirm requirements for any new members of the research team.

This letter notes that the University of Southampton will act as Research Sponsor and will provide indemnity under arrangements for potential liability of harm to participants arising from the design and management of the research.

In the event that you have applied to have this study adopted to the UKCRN Clinical Research Portfolio, may we take this opportunity to remind you of your responsibility for uploading accrual data for the research site. If you have any difficulty with this process please let us know.

We would like to remind you that as Principal Investigator you are responsible to ensure that the study is conducted within the Research Governance Framework (RGF) and we encourage you to become fully conversant with the RGFHealth and Social Care document. Any breaches of the RGF constitute non-compliance with the RGF and as a result Trust approval may be withdrawn and the project suspended until such issues are resolved.

Please do not hesitate to contact us should you require any additional information or support. May I also take this opportunity to wish you every success with your research.

Yours sincerely



Director of R&D



Appendix 11: Content analysis process of all survey responses.

Meaning unit	Condensed meaning unit	Code	Sub-theme	Theme
<p>‘No Choice I was informed I had to receive supervision from the Clinical Psychologist (the clinical lead of the team).’ (p42)</p> <p>‘Forced to by management.’ (p81)</p> <p>‘It is mandatory.’ (p85)</p> <p>‘I was forced to attend group supervision by management when I was already having 1:1 supervision which was more effective.’ (p94)</p>	<p>I was told I had to, because they are lead of the team (no choice).</p> <p>Forced by management. It is mandatory.</p> <p>Forced to attend group supervision when I did not want to.</p>	<p>No Choice</p> <p>Forced</p> <p>Mandatory</p>	<p>Mandatory</p>	<p>Methods of accessing interdisciplinary supervision</p>
<p>‘To discuss complex patients within the chronic pain service.’ (p49)</p> <p>‘It was offered as a regular thing when I worked jointly with a psychologist several times.’ (p50)</p> <p>‘I referred a client to psychology but it was felt that I would be able to do this work separately with some support and supervision from psychology.’ (p51)</p> <p>‘Recommendation from others.’ (p63)</p> <p>‘For a more in depth approach... more formal, organised session that will challenge my views and working practices.’ (p67)</p> <p>‘Our nurse practitioners... have requested clinical supervision from the psychologist in order to meet the need for clinical supervision.’ (p69)</p> <p>‘I have CBT supervision facilitated by a psychologist.’ (p74)</p> <p>‘She (psychologist) also runs consultation slots each week which I have done a couple of times when I had difficult cases.’ (p103)</p>	<p>Discuss complex cases.</p> <p>Offered as a regular arrangement.</p> <p>Guided through a specific piece of work.</p> <p>Recommendation. For a more in depth approach which is formal and structured.</p> <p>The team requested supervision from a psychologist.</p> <p>Received regularly after CBT course.</p> <p>Discuss specific/complex cases.</p>	<p>Discuss specific clients</p> <p>(Consultation)</p> <p>Offered regularly</p> <p>Discuss specific clients</p> <p>(consultation)</p> <p>Recommendation</p> <p>More in depth approach?</p> <p>Requested</p> <p>Requested</p> <p>CBT specific supervision</p> <p>Consultation</p>	<p>Voluntary</p>	

<i>Meaning unit</i>	<i>Condensed meaning unit</i>	<i>Code</i>	<i>Sub-theme</i>	<i>Theme</i>
<p>'We get group supervision that is led by our ward clinical psychologist.' (p16)</p> <p>'I work in a holistic MDT team' (p43)</p> <p>'Our psychologist is part of our peer supervision group which is multidisciplinary.' (p58)</p> <p>'Group supervision and ward reflective practice is held once a month on the ward.' (p89)</p> <p>'The psychologist facilitates the supervision, it's for those in the team who carry out CBT with their patients.' (p95)</p>	<p>Group supervision led by psychologist. Holistic MDT team. MDT peer supervision group.</p> <p>Group supervision and reflective practice. Psychologist facilitates supervision for CBT trained supervision in a group.</p>	<p>Group supervision</p> <p>Holistic MDT</p> <p>Peer supervision group</p> <p>Group supervision</p> <p>Reflective practice groups</p> <p>CBT group supervision</p>	<p>MDT supervision groups</p>	<p>Methods of accessing interdisciplinary supervision</p>
<p>'I think you gain from their expertise with multiple approaches and depth of knowledge.' (p42)</p> <p>'They are more thorough and help me offer options to the family I'm working with.' (p66)</p> <p>'She considers aspects of delivering patient care that I may not of considered.' (p67)</p> <p>'A more in-depth approach, considering a range of skills to use. More formal, organised sessions... This hopefully improves my practice.' (p67)</p>	<p>Gain expertise and depth of knowledge. More thorough perspective which benefits families. Considers more aspects. More in-depth approach which is formal and considers a range of skills.</p>	<p>In-depth approach</p> <p>Thoroughness</p> <p>Broad knowledge</p> <p>In-depth approach</p>	<p>Depth</p>	<p>Enriched quality of supervision processes</p>
<p>'I am more able to explore and reflect on options to address a client's presenting problems. This has been particularly helpful when faced with 'stuck' clients or interventions that may not be proving effective.' (p68)</p> <p>'I find supervision has been hugely validating for me allowing me space to reflect on my work with clients.' (p68)</p> <p>'Space to reflect on my own personal thoughts and feelings about difficult members in the group...'. (p73)</p>	<p>More able to reflect on client's presenting problems. Allows me space to reflect on my work with clients. Allows space to reflect on personal thoughts/feelings</p>	<p>Reflect on client work</p> <p>Reflect on client work</p> <p>Reflect on own thoughts/feelings</p>	<p>Reflective practice</p>	

<i>Meaning unit</i>	<i>Condensed meaning unit</i>	<i>Code</i>	<i>Sub-theme</i>	<i>Theme</i>
	Structured reflection.			
'It gives the team an opportunity to reflect in a structured manner.' (p89)				
'Reflective supervision- thinking about my own thoughts and feelings and not just talking about theories, processes and tasks.' (p95)	Thinking about my own thoughts/feelings.	Reflect on own thoughts/feelings		Enriched quality of supervision processes
'Clinical supervision affords protected time to formally reflect on my practice and hear thoughts from my peers.' (p69)	Protected time to reflect on practice/hear thoughts from peers.	Reflect on practice		
'Insight into another profession' (p29)	Insight into another profession.	Insight	Different perspectives	
'...supervision with a psychologist can often offer a different perspective and help you to look at a problem/dilemma from another view point.' (p36)	Helps you look at a problem/dilemma from another view point.	Different perspective		
'Different outlook than a nurse.' (p43)	Different outlook.	Different perspective		
'Their different view, perspective and skill set.' (p69)	Different view/perspective.	Awareness of choice		
'Awareness of different treatment options and diagnostic support' (p85)	Awareness of different options.	Different perspective		
'Helps me get a psychological formulation about the client- instead of strictly thinking on the line of the biomedical model.' (p52)	Formulation useful to think outside of biomedical model.	Different perspective		
'It helps me get a better understanding of the subject and think in a different way from how I would normally think.' (p60)	Helps me think in a different way.	Different way of thinking		
'It gives me a chance to see another angle of the patient.' (p89)	Consider other angles.	Awareness of choice		
'Problem solving.' (p63)		Problem solving	Problem solving	
'...and how we might work together to manage difficult behaviour in the future.' (p73)	Working out ways of working together.	Developing ways of working		
'Problem solving, looking at behaviours of myself and others.' (p78)	Problem solving.	Problem solving.		
	Formulation of problems.			

<i>Meaning unit</i>	<i>Condensed meaning unit</i>	<i>Code</i>	<i>Sub-theme</i>	<i>Theme</i>
'It has enabled me to use a framework with clients and formulate their problems and identify recovery focussed goals.' (p68)		Understanding problems		
'I also gain confidence as the supervision is not didactic but helps me to come up with my own experiments and thoughts for treatment programmes.' (p61)	I gain confidence in coming up with my own experiments and treatment programmes.	Confidence in abilities	Confidence	Personal Development and growth
'Improvement of my skills to be able to be more confident with certain cases where I deliver CBT ...' (p74)	More confidence in abilities/skills.	Confidence in abilities/skills		
'Supervision from a psychologist can often give reassurance and clarification, making me feel like a more confident practitioner.' (p36)	Supervision provides reassurance and clarification, making me feel more confident.	Confident in practice		
'I am more likely to have the confidence to try new ideas.' (p43)	More confident to try new things.	Confident in abilities		
'... and I am more confident working in a group setting.' (p73)	More confident in group settings.	Confident in groups		
'I feel more confident in my abilities as a group facilitator.' (p100)	More confident in group settings.			
'My supervision with the psychologist is different to my normal supervision as I can use it to talk about how I feel about my work, and I learn more about myself to improve my work when working with more challenging clients.' (p50)	Can talk about how I feel about work and learn more about myself.	Emotional coping Personal development	Emotional coping	Emotional coping
'Psychology supervision is also an important grounding opportunity as workload has been increasing and peer support has proved harder to access.' (p68)	An important grounding opportunity when workload is increasing.	Grounding		
'It has helped me to develop a more compassionate perspective toward myself and clients.' (p68)	Helped to develop a more compassionate perspective towards myself.	Compassionate towards self		
'... is a space to offload anything which is stressing me out!' (p100)				

<i>Meaning unit</i>	<i>Condensed meaning unit</i>	<i>Code</i>	<i>Sub-theme</i>	<i>Theme</i>
<p>'Yes the ability to cope with challenging behaviours' (p31)</p> <p>'I learn things about myself so I know what I find more challenging in the future.' (p50)</p> <p>'I think it helps me manage the difficult emotions related to work more than my practice' (p101)</p> <p>'...more emotional support to cope with the demands of the job.' (p102)</p>	<p>Cope better with challenging behaviours.</p> <p>I learn things about myself.</p> <p>Manage emotions related to work.</p> <p>Emotional support to cope with job demands.</p>	<p>Emotional coping</p> <p>Personal development</p> <p>Emotional coping</p> <p>Emotional coping</p>		<p>Personal Development and growth</p>
<p>'Learning ways to approach patients with high levels of anxiety with regard to rehab for chronic pain' (p49)</p> <p>'Guidance on the psychological work I am undertaking' (p51)</p> <p>'Encouragement to... do formulations.' (p66)</p> <p>'Validation of the skills I already have... I also feel they help me keep very focussed and use the model to work out formulations and enrich my treatment plans,' (p74)</p> <p>'I enjoy that they share their knowledge and skills which enables me to be a better practitioner.' (p74)</p> <p>I find out new techniques to use in clinical work and help with formulation... (p103)</p> <p>'Enhance skills in area of psychological intervention.' (p19)</p> <p>'It encourages me to adapt my practice- for example changing a stretching session into a mindful movement session.' (p49)</p> <p>'... and have a host of tools which they are willing to share and teach.' (p74)</p> <p>'To enable me to learn and develop new skills and knowledge.' (p68)</p>	<p>Learning new approaches.</p> <p>Guidance for interventions.</p> <p>Developing formulation skills</p> <p>Validation of skills I already have and develop formulation skills.</p> <p>Gain skills which enable me to be a better practitioner.</p> <p>Gain techniques and develop formulation skills.</p> <p>Gain intervention skills.</p> <p>Adapts clinical practice.</p> <p>Gain new tools.</p> <p>Develop new skills and knowledge.</p>	<p>Intervention skills</p> <p>Intervention skills</p> <p>Formulation skills</p> <p>Intervention skills</p> <p>Formulation skills</p> <p>Intervention skills</p> <p>Intervention skills</p> <p>Intervention skills</p> <p>Skills and knowledge</p>	<p>Knowledge and Skills</p> <p>Intervention skills</p> <p>Formulation skills</p> <p>Intervention skills</p> <p>Formulation skills</p> <p>Intervention skills</p> <p>Intervention skills</p> <p>Skills and knowledge</p>	<p>Professional Development and growth</p>

<i>Meaning unit</i>	<i>Condensed meaning unit</i>	<i>Code</i>	<i>Sub-theme</i>	<i>Theme</i>
'Increases my knowledge around psychological therapies to work more effectively with clients. It gives me a plan of the work I will be undertaking.' (p51)	Increase knowledge of psychological therapies.	Psychological knowledge		
'Increased understanding of psychological therapies and how they can be implemented at an acute level in the community with service users who are in acute mental health crisis.' (p23)	More understanding of psychological therapies.	Therapeutic understanding	Understanding	Professional Development and growth
'I feel I gain understanding into specific patients, e.g. anorexia.' (p31)	Understanding of patient needs.	Understanding of patient need		
'I learn more about formulation, and how this helps to understand the client better.' (p50)	Better understanding of formulation and the client.	Understanding of formulation		
'As I am new to understanding CBT the support has been invaluable especially when I have got stuck on a case. Supervision with a psychologist has helped me to work through the difficulties.' (p60)	Understanding of CBT and helped work through difficulties.	Understanding of patient need		
'A better understanding of the patients within the group.' (p73)	Better understanding of patients.	Understanding of patient need		
'I understand the clients more and feel I do more to help them.' (p76)	Better understanding of the patients.	Understanding of patient need		
'... help with formulation and a better understanding of why our patients might act the way they do.' (p103)	Better understanding of formulation and patients.	Understanding of formulation		
'A dedicated time to discuss any clients I am having some difficulties with.' (p51)	Time to discuss difficulties with clients.	Support with difficulties	Support in managing complexity	
'... and support when working with people who requires support with managing their emotions.' (p29)	Support in managing client emotions.	Support with difficult emotions		
'... the support has been invaluable when I have got stuck on a case. Supervision with a psychologist has helped me work through the difficulties.' (p60)	Supervision has helped me work through difficulties with clients.	Managing complexity		

<i>Meaning unit</i>	<i>Condensed meaning unit</i>	<i>Code</i>	<i>Sub-theme</i>	<i>Theme</i>
<p>'Guidance and support for my client work.' (p76)</p> <p>'I think the benefits come from the supervision process (i.e. case discussion, monitoring of work, feedback and clinical governance).' (p42)</p> <p>'It allows me to maintain best practice. I am 'held' by the supervisor.' (p61)</p>	<p>Guidance and support with clients</p> <p>Supervision process supports case discussion, workload etc.</p> <p>Support to maintain best practice, feel 'held' by the psychologist.</p>	<p>Support</p> <p>Support</p> <p>Support</p>		

