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CONTENTS – Volume 1, Issue 3, December 2015

| | |
|----|--|
| 3 | Editorial <i>Kaye Horley</i> |
| 4 | From the President <i>Judy Hyde</i> |
| 5 | Letters, Opinion, Comments Comments on Statham, D. (2015). An Overview of Psychometric Measures for Obsessive-Compulsive Disorder <i>Australian Clinical Psychologist</i> 1(1), 74-76. <i>Raymond Rudd & Henry Jackson</i> |
| 7 | Why We Should Read Qualitative Inquiry <i>Paul Rhodes</i> |
| 11 | Supervision and Reflective Practice Centre for Clinical Interventions: Integrating Clinical Practice, Research, Training, and Supervision <i>Louise J. Andony & David M. Erceg-Hurn</i> |
| 14 | Reflections on the Supervisory Experience <i>Judy Hyde</i> |
| 19 | The Impact of Shame on Disclosure in Supervision <i>Fiona Bailey, D. Psych. (Clin.)</i> |
| 24 | Practical Guidelines for Integrating Reflective Practice in Clinical Supervision for Psychologists <i>Christine Senediak</i> |
| 33 | Reflective Practice: Understanding and Managing Countertransference <i>Claire Cartwright & Kerry Gibson</i> |
| 38 | PhD Spotlight Dialogical Reflexivity in Supervision <i>Fiona Calvert</i> |
| 44 | Malcolm Macmillan Prize Clinical Psychology Practice: Art or Science? <i>Nicole Carrigan</i> |
| 47 | Ethics and Legal Dilemmas 'Trust Me, I'm an Expert' <i>Jeanette Stewart & Ilana Hepner</i> |
| 52 | Book Review: Clinical Handbook of Couple Therapy (5th Ed.). <i>Kim Halford</i> |
| 53 | Editorial Policy and Guidelines |
| 55 | Advertising Rate Card |

Editorial

Kaye Horley, PhD

Supervision is a complex, critical core process encompassing teaching and evaluation of clinical competence to attain the goal of best clinical practice. At the same time, the supervisor needs have the necessary clinical and interpersonal skills to effectively achieve this aim within a collaborative relationship. Implicit within effective supervision is the development of reflective practice associated with personal and professional development.

A nationally recognised model of excellence, incorporating the core components of clinical practice, is exemplified in the specialist Centre for Clinical Interventions (CCI) in Western Australia. Andony and Erceg-Hurn outline the close integration of clinical practice, on-going supervision and training, underpinned by research, within various treatment programs. Such engagement helps clinicians maintain high levels of skill in clinical practice and enhances reflective practice.

Although an important aspect of the supervisory process, there is limited research examining the development of therapeutic relationship competencies. In our PhD Spotlight, Calvert seeks to redress this by researching the reflective dialogue that takes place within the supervisory relationship that serves to enhance clinical competence. Three associated investigative studies are outlined.

An understanding of the inherent anxieties among clinical psychology students that come to the fore in supervision, their inexperience a threat to the core self, is exemplified by Hyde in reflections on her experience as a supervisor. The difficult role of the supervisor, responding to particular psychological defences within the framework of providing guidance in the therapeutic role, and the ongoing psychodynamics between the two, is aptly described. The significance of disclosure, with admittance of difficulties by the trainee within supervision, is emphasised by Bailey, specifically that with connotations of shame. How increased vulnerability as an inevitability of this affective response affects the relationship, and is managed, is explored.

Facilitation of reflective practice within clinical supervision, and encouragement of critical analysis, is

essential in promoting personal and professional development. But how does this occur? Senediak provides a guiding framework for integrating reflective practice within supervision and discusses its implementation.

The therapeutic relationship is considered a fundamental therapy outcome factor. A crucial aspect of this alliance is understanding and managing countertransference (CT). Cartwright and Gibson outline CT concepts, and note its increasing recognition by cognitive and cognitive-behavioural (CB) therapists. They present a practical five-step CT program, developed by the first author, designed to guide reflective practice, particularly for those from a CB perspective.

The importance of reflective practice is further highlighted by Stewart and Hepner, who offer salient advice to psychologists in their duty of care as expert witnesses within the legal system. Providing an overview of the concept of expert witness, emphasis is placed upon the potential for bias in the provision of expert evidence and the variable quality of expert evidence and opinion. The duty of psychologists is highlighted.

The 2015 Malcolm Macmillan prize has been awarded to Nicole Carrington for her essay entitled *Clinical Psychology: Art or Practice?* The dialectical tension between art and science is explored, and the idea as to whether we can be both scientist and artist is questioned, promoting further reflection. Another paper for stimulating intellectual debate is that by Rhodes, presenting an argument for increased recognition of qualitative research, particularly within Australia (see *Letters, Opinion and Comments*). Offering an important source for reflective practice, new developments are outlined, and their place within, for example, the therapeutic relationship are emphasised.

This is my last editorial as I am standing down as Editor. It has been a privilege to have been the founding Editor and to have been assisted by a team of highly supportive Associate Editors. It is with great pleasure that I welcome Bronwyn Williams from Perth as the new Editor of the *Australian Clinical Psychologist*.

From the President

Judy Hyde, PhD

The past year has been a significant one for the mental health sector, psychology and ACPA, as we find ourselves on the cusp of vast change that will bring challenges and opportunities for clinical psychology in the recognition and value of the training we bring to these areas. The Review of Mental Health Services by the National Mental Health Commission has brought to Government awareness the current poor structure of mental health services; its silo approach, crisis orientation of services, and the domination of State/Federal cost shifting leading to fragmented, discontinuous, inadequate care and confusion for consumers. The triage service portal and provision of funding for services to the 31 Primary Health Networks aim to address this lack of integration through a stepped care model that starts with online services and steps up and down as required.

While clinical psychology is seen as having a central role in providing psychological services in the mental health field, particularly at the more moderate to severe end of the spectrum, we are still to understand how these services will be offered. Detail on the planned changes is still lacking.

Professionally, international competency standards for professional psychology are about to be released. Further reform is being brought to fruition in Australia with new, updated, competency-based standards for training, in line with these international competencies, about to be released and new models of training and pathways to registration proposed. The foundation of our profession is due for change as we continue to struggle with the lowest standards of training for psychologists in the Western world.

It is important that ACPA contribute to these developments and we have been very involved through members with Board positions for the Australian Psychology Accreditation Council (APAC) and consultation with the Psychology Board of Australia (PsyBA). We appreciate our inclusion in APAC and stakeholder consultations and meetings that shape psychology in Australia. As part of this, ACPA has recently made submission to the Psychology Board of Australia to approach the Ministers for Health to grant specialist recognition for qualified clinical psychologists in order to protect the public. It is too soon to determine how successful this will be.

While psychology changes on both the national and international stages, ACPA continues to flourish and grow and new member benefits have been introduced. Most significant this year include the removal of student membership fees

and the introduction of free PsyBA compliant insurance for students and registrars who are members of ACPA.

The past year has also seen the introduction of the free online Continuing Professional Development videos for members under the initiative of Tony Merritt and soon to be handed over to Dr Erika Penny, an early career clinical psychologist, of whom the University of Sydney is most proud. We thank Tony for this excellent contribution to the member benefits of ACPA.

Over the year memberships have continued to grow with an increase of approximately 35%. We like to think this is due to the innovative benefits we have developed for members that focus on the professional needs of clinical psychologists, registrars and trainees and our successful raising of the profile and value of clinical psychology training. Our focus is to put members first and lead the way for other professional organisations to follow suit where this focus has been lost.

Our wonderful *Australian Clinical Psychologist* has seen the loss of Dr Kaye Horley as Editor, and we wish to thank her for her enormous commitment to the establishment and development of the ACPARIAN, which has morphed into the *Australian Clinical Psychologist*. Kaye will be succeeded by Bronwyn Williams from Western Australia who has been a valued member of the Editorial Board and will continue to develop the *Australian Clinical Psychologist*.

I would like to again thank Sam May and Sandy Kastner for the amazing and highly successful conference they organised and offered to us. This came with some challenges that these two wonderful women managed brilliantly for an outstanding event.

Finally, I want to thank the members of this magnificent organisation for being so inspiring, so dedicated to the profession, and so supportive of the work ACPA members undertake in order to represent clinical psychology wherever possible. All members who actively run the company and contribute to submissions and committees are voluntary and are buffered and motivated by the support of the members, who are the heart and soul of the organisation. I particularly want to thank the young members of the profession for their faith in us and their warmth and encouragement as we do all we can to prepare clinical psychology in Australia in the future in good shape for them to take over and forward. Warm wishes for a safe and happy holiday season shared with love and well-earned pleasures.

Letters, Opinion, Comments

Comments on Statham, D. (2015). An overview of psychometric measures for obsessive-compulsive disorder. *Australian Clinical Psychologist* 1(1), 74-76.

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We read with interest the recent article by Dr Dixie Statham (2015) published in this journal in which she reviews various OCD measures. We were particularly interested in her description of the CY-BOCS. It is pure happenstance that we are currently examining the psychometric properties of the Children's YBOCs and therefore we would like to comment on her section focusing on the instrument.

CY-BOCS was initially developed by Goodman et al. (1989) as an offshoot of their Y-BOCS. It comprises two parts: a "Severity Scale" by which patients' symptoms for both obsessions and compulsions are rated 0-4 on time spent, interference, distress, resistance and control; and, a "Symptom Checklist" comprising common obsessions and compulsions. Clinicians use a semi-structured interview to elicit symptoms and the Symptom Checklist "to ensure symptoms are not overlooked" (Goodman et al., 1989, p.1008). We would like to make a general point about the CY-BOCS and papers cited by Dr Statham.

First Dr Statham states that the CY-BOCS possesses "good psychometrics" (page 75). We are not as sanguine about the measure. We have a number of issues with the relevant studies examining the measure conducted to date, including: the nature of the samples, size of the samples, age range of the samples, and the use of fit statistics as in confirmatory factor analysis (CFA).

To us, the soundness of a measure rests fundamentally on the factor structure underpinning the measure: Is the measure (and its subscales) coherent and (in the absence of treatment) stable over time? Whilst there have been claims of the same four-factor structure underlying the CY-BOCs, not all studies have found exactly the same factors (for some discussion see Bernstein, Victor, Nelson, & Lee, 2013). A second consequential point is that at the item level, CY-BOCS items may, or may not, align with factors *specified* as in confirmatory factor analysis (CFA) or *obtained* as in exploratory factor (EFA).

We turn to articles cited by Dr Statham (2015). In addition to Wu et al. (2014), two other authors mentioned by Dr Statham as supportive of CY-BOCS psychometrics are Scahill et al. (1997) and Gallant et al. (2008). For both Gallant et al. and Scahill et al. the design and scope of their studies is very limited and the focus is only on correlations with other OCD

severity scales. Scahill et al. (1997), examined only the CY-BOCS severity scale correlations with the self-report Leyton survey (Berg, Whitaker, Davies, Flament, & Rapoport, 1988), and reported $r = .62$ for CY-BOCS Total severity score (composite of obsessions' and compulsions' scores). They did not conduct a more fundamental analysis.

Gallant et al.'s (2008) focus was the Symptom Checklist and its correlations with other measures, primarily the ADIS-IV-P OCD section. Again, there was no fundamental analysis of their own: symptoms were clustered according to a prior five-factor solution by Mataix-Cols, Rauch, Manzo, Jenike, and Baer (1999). Gallant et al. (2008) do point out there is no agreed position regarding the best factorial solution, and "... a number of miscellaneous symptoms do not functionally load on any of the five factor-analytically derived dimensions" (p.1375). A review of factor analytic studies by Mataix-Cols, Rosario-Campos, and Leckman (2005) concluded that the CY-BOCS structure "...is far from definitive and still subject to revision" (p.235). Indeed, a more recent study referred to previously still highlights that varying factor solutions exist (Bernstein et al., 2013).

The most recent study apart from Wu et al. (2014) is by Lewin et al. (2014). Despite the large sample size ($n=815$), the authors focus is only on severity scale scores. The stated intent is to arrive at some cut-off levels of mild, moderate, etc. for the CY-BOCS Total Severity score.

Overall, then, validity of the CY-BOCS Symptom Checklist remains a vexed issue. Dr Statham (2015) makes no mention of the significant unresolved matter of basic factor structure. Perhaps there is no such resolution for the CY-BOCS. Wu et al. admit that "...factor analytic studies have garnered conflicting results", but in the same paragraph the authors state that CY-BOCS "...is considered the gold standard..." (p.202). Gallant et al. (2008) and Lewin et al. (2014) also use that description.

However, we are left with considerable uncertainty regarding the psychometric status of CY-BOCS, despite its having been first developed some 26 years ago and spawning many further studies. Those studies show varying methods, analytic procedures and results, with little agreement about underlying factors or even the number and type of items for the Symptom Checklist. For example, in relation to the Symptom Checklist, Goodman et al. (1989) identified "...50 obsessions and compulsions in 15 larger categories" (p.1008), but Gallant et al. (2008) mention 62 symptoms in 17 categories (p.1370). Additionally, in a review of factor analytic studies, Mataix-Cols et al. (2005) state that the hoarding factor

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has the strongest evidence. Adding to this confusion is the fact that hoarding is now regarded as a separate disorder from OCD (DSM-5, APA, 2013).

Two issues emerge. First and most important, the use of the term “gold standard” is problematic, since it indicates little if any room for doubt regarding psychometric status. In our opinion, the label is not applicable to the CY-BOCS. If the term is used at all, we would recommend restricting it to assessments with professionally recognised psychometric status, e.g., BDI-II (Beck, Steer, & Brown, 1996). Ideally, we would not employ the term given its absolutist tenor and the potential attractiveness of the label as a form of justification for tools that may not be adequately supported.

Second, in the contemporary clinical assessment market, which has become a very large source of income for suppliers, there is obviously extra status or perhaps even price to be gained by the ‘gold standard’ appellation. We do not suggest that a primary motivation of developers or suppliers is to secure such opinion; the unsupported use of the term may occur inadvertently, but the flow-on effect for clinical practitioners’ decisions could well be inappropriate.

We recommend marked caution and careful checking of instrument credentials when considering any unfamiliar instrument, and probably more than in the past. Informal recommendation by peers or others would not seem sufficient, especially given the commercial impetus and more widespread marketing that now exists with clinical assessments. Practitioners need to determine the actual psychometric status of an instrument themselves. The other important issue to consider, which fully justifies allocating sufficient time to investigate, is that many tools such as the CY-BOCS are utilized in formal evaluations of cognitive behaviour therapy or medication effectiveness, or both concurrently, e.g., The Pediatric Obsessive-Compulsive Disorder Treatment Study (2004). This is an issue that concerns us.

In conclusion, we would argue caution in using the CY-BOCS post a diagnosis of OCD and would therefore welcome a large, detailed and well-planned effort to better determine its characteristics.

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Why We Should Read Qualitative Inquiry

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Abstract

Qualitative research has not been fully recognised by clinical psychology in Australia, yet it provides a rich source of information on many issues that concern us. In this paper I advocate for a variety of sophisticated methods, from conversational analysis, interpersonal process recall, participatory action, narrative inquiry and discourse analysis. These methods introduce new types of information into the scientist-practitioner cycle, ones that can be an important source for reflection, innovation and practice.

"I don't think things are moving toward an omega point; I think they're moving toward more diversity." Clifford Geertz (Olson, 1991, p231)

As clinical psychologists, the central principle that unites us has been the scientist-practitioner model, one that invites us to participate in the cycle of research and practice so that we can maximise our effectiveness and maintain some boundaries of accountability. This cycle has led to the development of new treatments and guides us on a daily basis when making decisions with our clients. To a large degree, however, we have looked to the empirical research literature to perform this function. Qualitative research has not played a central role.

Much of the qualitative research that has been recognised in clinical psychology has focused on content analysis, thematic analysis or grounded theory. These methods share a common empirical epistemology with qualitative research, presenting findings in terms of descriptive statistics, sets of themes, or models that have much in common with treatment formulations. In the last ten years, however, there have been many changes overseas, with greater diversity encouraged in qualitative research. In 2006, the American Psychological Society widened its definition of evidence to include a much more comprehensive range of qualitative methods, recommending the study of in-session processes, the role of race and culture and the nature and management of the therapeutic relationship (American Psychological Association, 2006). This was followed by the first publication of the journal *Qualitative Psychology* in 2014, which has included papers that directly relate to clinical practice. Britain is also emerging as a major force, establishing a dedicated section in the British Psychological Society in 2005, supporting sophisticated qualitative research to match quantitative endeavours. In Australia, however, our response has been muted, with relatively poor engagement by academics and limited publication of qualitative studies.

The aim of this paper is to invite the recognition of a wide range of qualitative methods in clinical psychology, including phenomenological analysis, interpersonal process recall, narrative inquiry, participatory action research and discourse analysis. Research conducted using these methods

can widen the types of conversations we have with each other, introducing new types of knowledge into the scientist-practice cycle. This can strengthen rather than weaken our profession, opening up new ways of understanding human distress and change. I want to argue that this can further humanise our field, helping us to grow as reflective and critical practitioners, without damaging our scientist-practitioner heritage.

So how best to define qualitative research? It can help to position these methods along a spectrum, from those most closely affiliated with the empirical sciences to those closer to social science and the humanities. Content, thematic and grounded theory analysis claim to produce results that are the most objective, or most closely follow the words and meanings described by participants. Researchers using these methods employ a variety of techniques to try and deal with their own biases, conducting analysis with multiple coders and checking with participants once analysis is complete. Since the 1970's, however, these methods have been under scrutiny.

Researchers now claim that their interaction with participants can never be truly objective, given that the focus is on making meaning rather than finding truths. We have come to accept that no matter how hard we try, qualitative research will always involve a collaborative endeavour to make sense of the world together. The type of knowledge sought in qualitative research is created between people, not found. But how then can we judge the credibility of research? How can we trust the results? Researchers tackle this problem by making sure that participants themselves are more actively involved in the interpretation of their own lived experience. Researchers are also now more honest in disclosing the values and theories that have guided their interpretations.

The idea that qualitative researchers accept that their findings are not objective may be challenging for some readers. The aim of qualitative research, however, is not to determine facts, but instead to inspire reflection, open dialogue and foster insight. The generalisability that might be possible in a quantitative study is sacrificed for complexity and depth. I would now like to discuss four examples of ways I think this kind of research can be of use to us as clinical psychologists.

1. Qualitative inquiry can sensitise us to the intersubjective nature of therapy

Outcome studies are unable to represent the complex decision-making processes of therapy. As practicing

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clinicians we know that no 'Outcome' is possible unless it is built on 'outcomes' that occur in our conversations with clients. There are moments in therapy when we shift from education to treatment, from treatment to therapy and sometimes, if we are lucky, from therapy to dialogue and transformation. What are these moments? How did we get there? These are questions that a few different types of qualitative research can answer. Conversational Analysis (CA), for example, is the careful study of turn-taking processes which can map out specific interactions that are linked to therapeutic change. Interpersonal Process Recall (IPR) can take the analysis one step further, discovering what therapist and client were actually thinking during these exchanges. This is done by asking both parties to meet with the researcher separately to review the videotape of a recent session. They stop the video at pivotal moments and are interviewed about their own internal dialogue at the time. Perakyla (2012) provides a fascinating example of CA, demystifying the process of psychodynamic interpretation in psychoanalysis. She carefully reveals the long lead up to the actual interpretation, unveiling the art of building foundations prior to intervention. We used IPR to understand why new therapists avoid active interventions in sessions (Burgess, Rhodes & Wilson, 2013). Students were found to revert to non-directive counselling because their anxiety clouded their capacity to reflect on the changing formulation and make clinical decisions on the run. Both of these studies can inform our everyday practice as therapists or educators.

2. **Qualitative inquiry can contextualise the treatment we provide within recovery stories**

As professionals we use a variety of techniques to try and explain why a person is suffering from a specific disorder. For the cognitive behaviour therapist this might involve the development of a formulation. A family therapist might employ systemic or structural hypothesising. Both of these methods, however, are a form of expert knowledge that differs significantly from the way people make meaning in their own lives. My own view is that we are much more likely to talk to ourselves along storied lines than use such sophisticated models of explanation. Narrative inquiry is a research method that allows for the careful collection and analysis of such stories, inviting us to enter more empathically into the world of others. Such narratives can help us to provide a temporal and living context for the therapy we conduct, especially when these stories relate to the different ways in which people journey towards recovery. Narrative researchers are able to point to the many different types of stories that might be experienced in overcoming or living with a particular problem, thus sensitising the therapist to possible trajectories of change. Our own study of people who hear voices is one example of such research (De Jager et al., 2015). We were able to discover that people diagnosed with 'psychosis' could recover after a period of significant suffering and distress and community-based support and solidarity. Two recovery typologies emerged. Some turned toward their voices, developing a normalised account of them, building voice-specific skills, integrating them into daily life, and resulting in a transformation of identity. Others turned away to protect themselves, harnessing all their available resources to survive. This research supports an alternative paradigm for psychosis,

one that has been promulgated by Hearing Voices Networks, but has received relatively little attention in the literature.

3. **Qualitative inquiry can engage us more collaboratively with local communities, supporting them to find their own solutions to psychological concerns.**

Here we venture into a less familiar, but important territory for clinical psychologists, community development. Sometimes it is important for communities to find their own solutions to psychological problems, rather than have them imposed by people who do not understand their specific conditions or culture. Kral and Idluit, for example, have successfully decreased the youth suicide rate in indigenous Canadian communities (Kral & Idluit, 2009). This was not done through government programs or a randomised control trial, but through the active engagement of local communities in developing innovative approaches to their own problems. They employed a practice called Participatory Action Research, where the researcher serves as a conduit for change, interviewing stakeholders before and after they try to solve problems, until success is achieved.

4. **Qualitative inquiry can help us question some of the taken-for-granted assumptions in our field, including those relating to questions of relational ethics and power.**

One of the problems of the scientist-practitioner cycle is that it can become a closed and stale system if there are no opportunities to question ourselves and the practices that we have grown accustomed to. I'm sure we sometimes all have nagging concerns about a variety of issues in our field. The role of the DSM? The increasing audit that we are all faced with under the Better Access Scheme? Balancing the benefits and disadvantages of manualised treatments? Are we at risk of commodifying therapy? Have we become intertwined with neoliberalism? These are important questions that can all be explored using the practice of Discourse Analysis. This method allows us to interpret a variety of texts to tease out the societal forces that might be at play. This kind of inquiry can 'keep us on our toes', make us more vigilant to protect the field, and preserve what we hold dear in the face of industry, government and wider societal problems. A good example is the work of Crowe (2000) who carefully analysed the text of the DSM-IV to try and tease out the ways in which it constructed mental illness. He found that the DSM implied that mental illness occurs in the context of faulty individual functioning, to the relative exclusion of social and cultural context. Diagnosis was found to be built on the assumptions that normal behaviour is characterised by moderation, productivity and rationality.

Conclusion

The aim of this paper has been to advocate for the recognition of qualitative research in clinical psychology. I have endeavoured to avoid the 'paradigm wars' elevating qualitative methods to the higher moral ground or quantitative methods as more trustworthy. These types of politics have been destructive in academia and research, cutting us off from a

process of mutual influence that can only enhance and mature our field. I have suggested instead that both types of research are complementary, one providing us with a degree of certainty and accountability when making clinical decisions, the other fostering insight, reflection and critique. There is room in clinical psychology for both objectivity and subjectivity, for both quantitative and qualitative research.

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Advances in Treating Traumatic Stress Reactions - Melbourne - 1-Day Clinical Workshop with Professor Richard A. Bryant



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Clinical psychologists are specialists in the assessment and evidence-based treatment of a wide range of mental health problems, including:

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- Drug & Alcohol Abuse
- Eating Disorders
- Emotional & Behavioural Problems in Children
- Fears, Phobias, Anxiety & Panic Attacks
- Grief, Loss & Bereavement
- Obsessions & Compulsive Behaviour
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Supervision and Reflective Practice

Centre for Clinical Interventions: Integrating Clinical Practice, Research, Training, and Supervision

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Abstract

The Centre for Clinical Interventions (CCI) is a specialist state-wide clinical psychology service in Western Australia. The primary function of the Centre is to provide effective psychotherapy to adults suffering from complex mood, anxiety, and eating disorders. CCI also conducts clinically applied research, develops innovative new treatments, provides introductory and advanced training to professionals, and disseminates evidence-supported resources to the public and practitioners via the CCI website. Clinicians employed by CCI engage in supervisory processes that help to maintain their competency in clinical practice. In this article we provide an overview of the Centre and describe how its clinicians integrate clinical practice, research, training and supervision.

The Centre for Clinical Interventions (CCI) is a Western Australian specialist mental health service that:

- Treats adults suffering from complex anxiety, mood, and eating disorders.
- Conducts clinically applied research.
- Develops innovative new treatments.
- Provides training in empirically supported psychological therapies.
- Disseminates evidence-supported workbooks and other resources to consumers, carers, and practitioners via the CCI website.

The vision underpinning CCI was developed in the late 1990s by Paula Nathan. The Centre is staffed by 10 full-time equivalent clinical psychologists who work in three distinct programmes: Anxiety and Depression, Eating Disorders and Bipolar Disorder. As CCI is part of the public mental health system, services are offered to clients free of charge.

Treatment Programmes

Anxiety and Depression

The Anxiety and Depression stream was the first treatment program established at CCI. Most clients referred to this program have chronic and severe mental health problems. The median time since the onset of client's psychological problems is 10 years. More than 90% of clients referred to the program have tried medication or other psychological services, but not experienced an adequate response to therapy. About 1 in 3 have attempted suicide, and many have been hospitalised for psychiatric problems.

Anxiety and depression treatments are primarily delivered in a small group format. Each group typically comprises between six and 12 clients, and is normally facilitated by two Clinical Psychologists, or a Clinical

Psychologist and a trainee. Groups involve weekly, two-hour sessions of between six and 12 weeks. There is also a one-month follow up session, which is used to reinforce skills learnt during therapy, help prevent relapse, and identify clients who may need additional intervention.

CCI's clinicians have developed treatment manuals that are used to facilitate each group. The manuals contain detailed therapist instructions, patient handouts, and worksheets. The manuals are based on protocols that have been demonstrated to be effective in clinical trials. Currently, CCI offers the following anxiety and depression group treatment programmes:

CBT Mood Management Course

This is a 10-session transdiagnostic treatment for depressive and anxiety disorders. The course utilises traditional CBT techniques such as behavioural activation, cognitive restructuring, and graded exposure. Benchmarking studies have shown that the outcomes achieved by clients in the Mood Management Course are comparable to those in clinical trials for diagnosis-specific depressive and anxiety treatments (McEvoy & Nathan, 2007).

Imagery-Enhanced CBT Social Anxiety Group

This is a 12-session treatment for clients diagnosed with primary or comorbid social phobia. Between 2007 and 2012 the treatment was based on Rapee's CBT group protocol for social phobia (McEvoy, Nathan, Rapee, & Campbell, 2012). CCI clients were found to have outcomes comparable to those achieved in research settings, despite being more severe and having more comorbidities. This suggests that empirically-supported treatments can be transported from research settings into community clinics, such as CCI. In 2013, the program was enhanced by incorporating the use of imagery techniques, as negative imagery is associated with the maintenance of social anxiety and other emotional disorders. The revised treatment has recently been found to be more

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effective than the older protocol (McEvoy, Erceg-Hurn, Saulsman, & Thibodeau, 2015).

Metacognitive Repetitive Negative Thinking Group

CCI recently developed a six-session transdiagnostic metacognitive group therapy programme to target repetitive negative thinking (e.g. worry and rumination), which is thought to underlie a variety of emotional disorders. Metacognitive therapy focuses on modifying the *process* of repetitive thinking, rather than challenging specific negative cognitions as in traditional CBT. Most clients who have undertaken the group programme at CCI so far have been diagnosed with primary or comorbid Generalised Anxiety Disorder (GAD). A recent evaluation found that the treatment is at least as effective as much longer specialised treatments for GAD (McEvoy et al., 2015).

Individual therapy

Individual treatment is also offered to some clients who present with psychological issues that are unable to be treated in the aforementioned group therapy programmes (e.g., Panic Disorder, Health Anxiety).

Bipolar Disorder

CCI offers adjunctive group and individual therapy to individuals diagnosed with Bipolar Disorder (Type 1 and Type 2). Group therapy is a 10-session CBT program that helps individuals with Bipolar Disorder to learn specific strategies that can be used to help prevent manic episodes, and manage depressive episodes more effectively. The program also highlights the importance of identifying early warning signs that can trigger an episode, and helps clients develop a personalised self-management plan. The effectiveness of the course is currently being evaluated.

Eating Disorders

The Eating Disorders Programme operating at CCI is a specialist service for individuals (aged 16+) diagnosed with eating disorders such as Anorexia Nervosa and Bulimia Nervosa. The programme is the only public health specialist service available for adult clients with eating disorders in Western Australia. The programme utilises Enhanced Cognitive Behaviour Therapy (CBT-E; Fairburn, Cooper, & Shafran, 2003) as its central treatment approach. This is a transdiagnostic treatment that can be used to treat all forms of eating disorders, and has been found to be similarly effective in clinical trials and real-world settings (Byrne, Fursland, Allen, & Watson, 2011; Fairburn et al., 2009). In younger clients, Family-Based Treatment (FBT) may be offered to suitable clients and their families, as recommended by NICE guidelines. In line with evidence-based protocols, eating disorder treatment is provided in an individual therapy format.

Research

CCI conducts clinically applied research. The centre employs a part-time research psychologist whose primary role is to manage CCI's database, and to conduct research that enhances the services that clinicians provide. Clinical staff also participate in research, by generating research questions, collecting outcome measures, giving presentations at national and international conferences, and co-authoring journal articles.

The clinicians and research psychologist meet weekly to discuss ongoing projects, plan new ones, and to review recently published journal papers that may influence future clinical practice and/or research interests. In addition to doing our own research, we collaborate with staff at Universities, other health services, and the community.

CCI's research often examines the translatability of outcomes from laboratory and efficacy studies into real-world clinical settings. We routinely evaluate the effectiveness of our treatments, and use the findings to guide revisions of the treatment protocols. We also study mechanisms that may be responsible for driving symptom change.

Outcome Measurement

An important aspect of routine clinical practice within CCI is the administration of client outcome measures at specific time points throughout treatment. To obtain a comprehensive assessment of client psychopathology, we administer a battery of measures with established reliability and validity when clients first attend the service. Select measures are completed again during and after treatment in order to track client progress over time. Clients are consistently provided with verbal and/or written feedback regarding their scores on these measures, and this information is used to inform future treatment planning. The data collected via these measures is also used to conduct further research (with patient consent).

Dissemination of Evidence-Based Practice

Website materials

CCI offers a series of self-guided treatment modules on our website, whereby individuals who are unable or unwilling to access services can systematically work towards improving their psychological wellbeing. These modules provide a step-by-step approach to address a range of difficulties including low mood, health anxiety, repetitive negative thinking, panic attacks, body dysmorphia, health anxiety, disordered eating, low self-esteem and problems with assertiveness. This website attracts more than 4000 *unique* visitors each day. CCI regularly receives excellent feedback from help-seeking individuals, and from practitioners who use these modules to enhance their clinical practice. We regularly update existing modules to ensure they are reflective of best practice, and invest time developing new modules.

Training workshops

CCI also disseminates evidence-based treatments via the provision of training to other health professionals. Training workshops are designed to equip participants with the knowledge and skills to implement treatments that are utilised within routine clinical practice at CCI. Each CCI clinician typically co-facilitates two training workshops each year and the workshops are usually two days in duration. To date, CCI has provided over 1600 participants with training, which suggests we are significant contributors to the up-skilling of the clinical workforce.

Importantly, facilitators often note that their skills regarding treatment paradigms become fine-tuned following facilitation of these trainings, and this subsequently translates

favourably into their clinical practice. More specifically, it furthers their ability to remain focused on the key targets of treatments, and enables them to avoid “therapist drift”, which reflects a common tendency whereby therapists intentionally or unintentionally deviate from adhering to evidence-based protocols (Waller, 2009).

Supervision

Regular clinical supervision is viewed as an integral part of maintaining competency in clinical practice at CCI. It promotes theoretical learning, and furthers therapeutic skills in applying evidence-based treatment. CCI adopts a hierarchical supervision framework, whereby Clinical Psychologist Registrars and Clinical Psychologist Trainees are supervised by senior clinicians (typically on a weekly basis), and senior clinicians access peer supervision with fellow senior clinicians (typically on a fortnightly basis). Normally at CCI, new clinicians undertake supervision individually whilst more senior clinicians may meet in groups of three.

Supervisees are required to provide a review of their clinical cases to their supervisor. The challenging aspects of treatment will be discussed, in addition to the areas that are progressing well. Typically, supervisees will select individual cases to review in detail, rather than providing a general overview of their caseload. Supervisors will provide detailed and constructive feedback regarding supervisees’ clinical skills in case formulation and treatment implementation. With more junior clinicians, senior supervisors will also model key concepts, and set specific professional goals for the clinician to work towards. This approach appears to be consistent with evidence-based supervisory practices (Milne & James, 2000). CCI supervisors typically adopt a CBT stance when conducting supervision, as we aim to be collaborative and Socratic when eliciting information about the patient case, the challenges, and the clinicians’ plan to address such challenges.

Another key aspect of CCI’s supervisory framework involves clinicians meeting in pairs and collaboratively reviewing audiotaped/videotaped recordings of therapy sessions. Whilst reviewing the taped session, clinicians will use the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980; Vallis, Shaw, & Dobson, 1986) to provide a measure of therapist skill in applying CBT techniques. The CTRS assesses both adherence to the CBT model, and competency in delivering CBT-based interventions in line with protocols. The CTRS contains 8 items, which reflect skills such as setting an appropriate session agenda, eliciting key cognitions and behaviours, applying specific cognitive-behavioural techniques and reviewing and setting homework tasks. The specified therapist behaviours are rated on a 7-point Likert scale ranging from Poor to Excellent. The CTRS is a useful tool that provides detailed feedback regarding therapist strengths and relative weaknesses.

Finally, CCI incorporates weekly case review meetings, whereby clinicians present a current case in detail to the remainder of the treating team. Similarly to individual supervision, they will receive extensive feedback regarding their formulation of presenting issues and the treatment

approach they have taken. Clinicians will usually present their most challenging case, where they have struggled to facilitate significant change. The CCI team will assist the presenting clinician by offering new perspectives on the case, and offering suggestions that may aid future treatment success.

Conclusion

In conclusion, CCI is an outpatient clinical psychology clinic that is committed to providing expert, evidence-based psychological treatments to clients presenting with a range of psychiatric conditions. CCI also conducts clinically applied research, develops innovative new treatments, provides introductory and advanced training to professionals, and disseminates evidence-supported resources to the public and practitioners via the CCI website. Clinicians engage in supervisory processes that help maintain their competency in clinical practice. Regular, quality supervision is viewed as an important aspect of maintaining a high level of clinical skill and practice. The close integration of clinical practice, research, training, and supervision is fundamental to what CCI does, and makes for an effective and fulfilling work environment.

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Reflections on the The Supervisory Experience

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Abstract

The utilisation of the therapeutic relationship, and the relational and personal capacities of the self as the instrument for therapy, activate particular anxieties amongst trainees. These threaten self-esteem and lead to particular defences that need to be dissolved to enable the therapeutic relationship to flourish. Highly intelligent, capable and competent young adults who have a strong history of academic success find themselves feeling de-skilled, inadequate and examined for their personal qualities in supervision, threatening their identity as a high achiever. Supervisors are seen as all powerful in the evaluation of these personal qualities. Trainees respond with perfectionistic ideals of omnipotence, omniscience and benevolence leading to the patient being lost in the process and therapy to falter, as the relationship and understanding remain undeveloped. The solution is the painful process of disillusionment, leading to a more realistic perspective that frees the trainee from perfectionism and allows for focus on the patient, personal and professional growth, and the development of creativity in the work. It is then that the trainee begins to thrive.

We can all remember the anxieties of our first supervisory experiences during training. We remember the overwhelming anxiety and the weight of unmanageable responsibility, pervaded by the evaluation of the impossible expectations we believed were being held of us. Those of us later becoming supervisors also remember having these same anxieties re-activated when we undertook supervision with our first trainee and often yet again in the early stages of every supervisory relationship. This paper is an account of such experiences within the context of the author's personal perspective as a clinical supervisor.

The Activation of Situational Narcissistic Anxieties

McWilliams (1994) says that "medical schools and psychotherapy training programs are renowned for taking successful, competent adults and turning them into incompetent children" (p. 185). Supervisees come to us as academic successes. They are highly intelligent, capable, and gifted achievers; they enjoy learning and succeed brilliantly. This is what they know of themselves, it is a central part of their identity. Coming into supervision in training, they believe all that work is about to pay off; their dream is about to be realised; they are going to become a clinical psychologist! However, all that is lost to them when they are faced with their first patients or clients in practice with a new supervisor. Exposure and examination of the therapeutic process by a new supervisor correspondingly threatens self-esteem, exposing the core of the self and stirring up enormous anxieties, with their resultant defences. For, as Goldberg (1986) claims, the practice of psychotherapy is felt to be inextricably bound with the identity of the practitioner. In supervision, we feel all our core selves are exposed, leaving us not so much concerned about our patient's or client's capacity to flourish or flounder, but our own.

The rules and measures by which trainees have accomplished so much have now changed. They feel totally de-skilled and de-powered, lost and adrift; their talents, abilities, and knowledge unknown, dismissed, or abandoned as irrelevant or inadequate. Their fascination with the human condition, and the lifetime of training they have undertaken in understanding it, has become meaningless to them. The very basis on which they have built their identity, achievement, is under direct scrutiny.

Dual Roles

The trainee's role is replete with duality. To the patient, the trainee clinical psychologist is the knowledgeable one, the expert, yet they come to supervision as the inexperienced, unknowing, de-powered one, seeking support, guidance, expertise, and reassurance. They are constantly aware of and fear that their performance is being evaluated and examined for weaknesses or vulnerabilities. They fear doing the 'wrong' thing, damaging the patient and failing in the glaring spotlight of supervision. How can a supervisee bring to supervision their struggles, their difficulties, their failures and fears, if these are the very things they believe will lead to a poor evaluation? How do they cope with this dichotomy? How do we?

Dual roles for the supervisor present equally impossible struggles. Our purpose to mentor, to guide, to support, to teach, and to encourage is pitted against an equal and opposite requirement to evaluate, to correct and, at times, to discipline which can, on occasion, lead to the ultimate breach of faith - to fail a supervisee. While we might feel ourselves sliding between these roles as the situation demands, to the supervisee the potential for this shift can feel sudden and inexplicable, yet always pending, further feeding their fears and ambivalence.

The duality of our roles can frequently present situations that require management in both domains simultaneously. From which perspective does one respond to a

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supervisee saying that he offered a client a ride home on his motorbike after session? In such situations, a decision often needs to be made very quickly and before one has time to consider the alternatives and work through an approach. At such times, we can often feel, like our supervisees, that everything we say and do has enormous consequence, yet we must be 'therapeutic' and benevolent at all costs.

The Power of the Supervisor

Sharaf and Levinson (1964) point out that the dynamics of power in the supervisory relationship, combined with a long period of dependency on the ambivalently valued and feared supervisor who is seen to have great powers over trainees, leads to idealisation and fear. We are seen to possess all knowledge and wisdom and are believed to be magical in our perceptiveness, as, when discussing clients, experience throws up for us understanding and dynamics not as readily accessible to the trainee. We recognise and comprehend pathology where the trainee does not, and our predictions about the processes of therapy often come to pass. This makes us extremely frightening as supervisees suppose such capacities may also be readily applied to them without their knowledge, and with potentially devastating consequences as they fail to hide their inner feelings and fears from us.

As a supervisor, it is disconcerting to have, as happens on occasion, one's every gesture acted upon as though it were a threat or an attack. On one occasion a previously very skittish trainee told me she had gone back through some emails we had exchanged early in her placement, which at the time she had experienced as very angry and attacking on my part, and reported she was shocked to find them, in fact, quite benign. These dynamics may be due in part to the ready activation of latent parental transferences within the supervisory roles. It is not uncommon to have supervisees relating that particular behaviour of the supervisor reminds them of a parent. What supervisor too can claim not to feel particular warmth towards a supervisee who reminds them of a beloved child?

There is interplay, however, between reality and distortion. Supervisors are, in fact, in a position of relative power and knowledge, knowing while the trainee struggles to know. We are an authority; with our experience, our more objective stance, and our lack of emotional involvement with the patient, we do have some capacity and knowledge that the trainee is desperate to acquire. To the trainee, blinded by their own anxiety and perceived inadequacies, this seems utterly magical and their idealisations and distortions can at times transcend reality to absurd levels. When a question was raised in group supervision about whether a patient's sibling was married and the treating therapist could not recall, I said that I thought he was, and gave information to support this. Another trainee turned to me in awe asking, "How did you *know* that?" The room filled with relieved laughter when I responded, "I listened to the session tape". I had acquired the knowledge using normal senses after all!

The ideals of omnipotence, omniscience, and benevolence

Our supervisees' perceptions of us as infallible, omnipotent, and omniscient pervade the goals they set for themselves, influencing their views of what a clinical

psychologist actually is and should be. Their ideals are inflated, unachievable, and grandiose, and are exaggerated by their wishes and fantasies. The 'perfect' therapist is thought to possess omnipotence, omniscience, and benevolence (Brightman, 1984) and if one fails to live up to these ideals, they will fail the patient in both the supervisor's eyes and their own.

Trainees bring the belief that they need to be omnipotent in their capacity to 'fix' the patient. This leads them to take on enormous responsibility for things not in their control. A young trainee, who had worked with some remarkable success with an extremely narcissistic client, ended her placement of nine months devastated that his personality dynamics were still very evident. She stated, "I wanted to transform him". In the belief that they are entirely responsible for all that happens to the patient, they can also become excessively controlling. When asked why he was anxious about his patient looking up her medical condition in a local library, a trainee responded, "I have a vision of how I want her to be, and I want to control all the influences in her environment so I can lead her along the path that will enable her to become what I want for her". In the trainee, such ideals and fantasies have not been diminished by experience. While, as supervisors, we might clearly identify them as unrealistic, for many of us such fantasies can linger in an image we hold of the supervisee's preferred development. This can readily lead to subtle expressions of control and dominance.

The lure of omnipotence also taunts the supervisor and can be heightened dramatically if we feel we need to live up to the projected ideals cast upon us by our supervisees. When patients pressure the trainee for a 'magic' cure, the trainee is readily hooked into believing they should be able to provide it; in parallel, they pressure the supervisor to give them this cure. If our own ideals have not been modified, we too can get caught into trying to answer the unanswerable, resolve the insoluble, and cure the incurable - all in 10 easy sessions!

Trainees also feel they need to be, at all times, omniscient. When things do not go as planned in therapy, it is always *their* doing, *their* failure, and *their* inadequacy as they should have foreseen the course of events and managed sessions so problems did not arise. A sensitive, warm, and responsive trainee was shocked and horrified when he had suggested that he and a patient look at reducing a safety behaviour that was maintaining her fears. Despite his gentle approach, his patient attacked him, telling him he was a terrible therapist, that he was in the wrong profession, and that he should be a gardener where he couldn't harm people. He felt this was *his* fault! He should have *seen* her terror, her rage, and her need for control and predicted her response, despite having little training in the psychology of personality or trauma at that stage.

Then there's the ideal of benevolence. Trainees project their own dynamics into their patients and, bolstered by Rogerian counselling skills, they believe that love will cure, so they give, give, give. All the while they avoid actually dealing with the patient's fears, behaviour or reactions for fear of 'hurting' them or damaging rapport. This can lead to a lack of empathy for the patient in terms of their real needs.

The most common reaction amongst trainees to a narcissistic client who creates distance and safety by filling sessions with the trivia of their lives, and uses the therapist as an audience, is, "I let them talk to build rapport". When asked if this is successful, they recognise it is not and acknowledge they feel unseen and unheard by the patient, to the point of feeling they could be replaced in the room with little reaction from the patient. It is so difficult for them to push for connection, to 'intrude' into the world of the client, to 'impose', to claim their own space in the room and to use it. In being the 'selfless giver' they can accept the unacceptable, putting up with attacks and abuse in the name of understanding and empathy, and blaming themselves for these onslaughts as they 'should' have understood better, explained better, known more, and given more. Such dynamics also pervade their personal lives. A group discussion about how we tend to create the therapeutic role in our other relationships, led a trainee to comment in surprise, "My God! I don't have friends ... I have a caseload!"

For the supervisor too, engaged in a constant battle to keep their workload down to somewhat reasonable levels, the needs to be benevolent and giving and always meeting others' needs first can be treacherous allies. When asked to take on a greater workload for an enthusiastic trainee, who would benefit from the work, the temptation is enormous despite its demands.

The Need for Certainty and Perfectionism

Embroiled in challenging and demanding emotional work with a supervisor who is both admired and feared as a guide, the supervisee can turn to the model of therapy for direction and certainty, resulting in idealisation of the model itself. The model of therapy is venerated, held up as the magic cure, the solution to all problems, giver of all power. In a quest for assurance, bolstered by a professional literature that reports only on success, supervisees entertain no room for uncertainty and self-doubt. Relevantly, Kottler and Blau (1989) observed that research findings of failure or no effect are rarely accepted for publication; the one third of participants who do no better, or get worse, in treatment are not examined, and those who drop-out are ignored. A literature that claims the methods taught are 'evidence-based' and therefore *must* work to relieve clients' problems leads to blindness and defensiveness.

A patient in a pain clinic had presented with major depression. She was offered treatment for her depression through six sessions of cognitive behaviour therapy. The model was explained and monitoring sheets were given for homework. The patient seemed to accept this and was keen to undertake the therapy. The following week she returned considerably more depressed. She said she did not want to continue with the treatment as the homework was overwhelming and she felt a failure because she couldn't do it. She said that she was going back to her psychiatrist who understood her. Utilising a concept from analytic work to bolster her own position and avoid examining her approach and its meaning for the client, the supervisee wrote in the notes that the patient was 'resistant'.

Inflated ideals, idealisation, and the wish to succeed leave one very vulnerable. A trainee once explicated this, "The only way to succeed is to be perfect". Trainees can believe that there is only one way to do things – the right way; any other way is 'bad' therapy. They should inherently know the 'right' thing to do at all times in order to succeed! If they say the 'wrong' thing, they will cause untold harm and irreparable damage to the fragile and needy patient who looks to them for guidance.

Inflated ideals and perfectionism lead to a focus on the self. Instead of focussing on the trainee's experience, the supervision can become about us as we watch closely to ensure we are living up to the fantasy of the perfect, all-knowing, all-seeing supervisor. Instead of focussing on the patient's experience, the trainee too watches their own performance throughout, evaluating, judging, and criticising everything they say and do; in the process they lose sight of the patient almost entirely. This can lead also to immobilising passivity and restraint.

The resultant sense of inadequacy

This intense scrutiny, coupled with a constant comparison with inflated ideals, and for some backed by a ruthless and vicious internal supervisor, increases the fragility of self-esteem and leads to the common experience of being an impostor as a therapist. The trainee knows they cannot embody the ideals they hold to be necessary for the work, yet they believe that the client assumes they are the incarnation of these ideals. As a consequence, any perceived difficulty to live up to their perfectionistic ideals leads to the collapse of self-worth, resulting in enormous shame and/or guilt.

Shame drives one to hide one's perceived faults, while guilt drives one to confess. When suffused with shame, trainees bring little to supervision, or, in an attempt to avoid this most uncomfortable feeling, repeatedly tell tales of how well they are doing, focussing on and amplifying their successes; it's all about them, not the patient. At these times, for the supervisor, supervision feels empty and boring as the trainee skates across the surface of issues, not revealing what is truly happening, not describing sessions or the patient sufficiently for the supervisor to get a sense of the process, all with a brittleness and brightness that betrays their underlying vulnerability. They use the supervisor to mirror their great successes. They challenge the supervisor to connect and make real the client, the process, and themselves. More guilt-prone, supervisees come to supervision as to a confessional, laying out their perceived transgressions in great detail as they feel an overwhelming sense of failure. Their faults are minutely examined in every session. They come with lists of what they have 'done wrongly', but have little overall sense of the client. The client's every reaction and response is closely examined, not for understanding of their difficulties and dynamics, but for the trainee's failures.

Supervisors too can be beset with fears of inadequacy, marked by feelings of not knowing and uncertainty, both in terms of patient care and supervisory direction. Newer supervisors cling to didactic approaches, regardless of the supervisee's experience, and feel threatened

when questioned about the approach taken. They too are subject to shame and guilt.

While it may seem that the narcissistic vulnerabilities drawn here are quintessential images capturing and focussing the varied possible anxieties of the supervisor and supervisee, any examination of underlying dynamics present in the supervisory experience leads one to conclude that they are, in fact, largely essential universal themes inherent within the supervisory process itself. Thus, while they may seem like an extreme portrait, these are the parameters of anxiety brought to the fore by this rare experience; seeing them enables you to contain the anxiety and modulate it so that change can occur in learning, recognition of the other, and acceptance of one's own way of working (with doubt and uncertainty, as always, co-pilots in this flight). (D. McIlwain, personal communication, January 28, 2005).

The solution – disillusionment and growth

Disillusionment is essential for change to occur and for the resolution of perfectionism and idealisation. Through disillusionment, ideals become more realistic and achievable, leading to greater satisfaction. Weathering the process of professional disillusionment Sussman (1992) says, enhances self-acceptance and brings maturity, authentic hope, genuineness, and a more accurate and fuller perception of reality. With disillusionment, energy is directed less towards maintaining the idealised self and constant comparison of ourselves to inflated ideals, and is directed more towards transformative and creative activities. It leads to sublimation and creativity and what Winnicott (1960) might have called the 'good enough' therapist.

Disillusionment in our models is a further critical element, as insight, cognition, empathy, techniques, and the like, whether they are used in various forms of psychodynamic or in more cognitive and/or behavioural therapies, are inevitably found to be limited. In reality, the foundation of every model is revealed to be inadequate to deal with the range of presenting patients and their various psychological needs. This awareness leads to a crucial and painful transition in our development as we struggle with our personal and professional limitations in our attempts to treat the patient or train the supervisee. The two are inextricably intertwined. If we, as supervisors, can't give up our illusions, we impose unrealistic standards on our trainees, reinforcing their excessive and perfectionistic ideals. In group supervision a trainee presented a video of an extremely disassociated client with whom she was having difficulty engaging. The video showed continued disassociation and a somewhat psychotic flavour to the presentation as the trainee struggled to 'ground' the client with skill, warmth, and empathy, but without success. My response to her question of what she could do to 'fix' this client was spontaneous – "I couldn't 'fix' this client!" The trainee was shocked! Afterwards she sought me out to say that this was the most powerful

supervision she had experienced as it suddenly became clear to her she was not fully responsible for curing all clients.

For both the supervisor and the supervisee, the process of supervision, like the practice of psychotherapy, leads to maturity and growth. For both, the practice of their roles offers opportunities for transformation. As we struggle to understand our trainees, and they their clients, we experience a process that involves elucidation and creation of different patterns of meaning. This intense interest in learning about the other leads to self-mastery. Indeed, the work of Faber and Heifetz (1981) found an increase in assertiveness, self-assurance, self-reliance, psychological mindedness, introspection, and sensitivity over the lives of therapists.

However, if the process of professional disillusionment is avoided, there is a danger of burnout or retreat. As Horner (1993) points out, shame associated with failure to live up to perfectionistic ideals leaves the therapist excessively vulnerable, causing repeated wounding which can lead to burnout. Clinging to certainty can lead to paternalism, over-direction and authoritarianism, and a retreat to dogma. The cocoon of narcissism is reinforced.

Conclusion

In summary, then, a major aspect of our work as supervisors is to re-skill, re-power, and return confidence to our supervisees. We need to find each other through the terrors and projections of the supervisory experience just as we seek out our patients in therapy. By fostering the resolution of inflated ideals and idealisations for both parties, we can act as guides through the torments of disillusionment towards acceptance of our human limitations, and through transformation and growth to again find security in our true selves.

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The Impact of Shame on Disclosure in Supervision

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Abstract

In the reflective and guided space of clinical supervision, successes and triumphs in therapeutic work will usually take second place to the examination of areas in which psychologists struggle. The unedifying therapeutic ruptures, the shaky decision making, the misguided efforts to bring about change and the failures of process and outcomes, are the currency of good clinical supervision and in this, psychologists are likely to suffer the painful discrepancy between how they would like themselves to be, and how they truly are. Confronting this discrepancy in the presence of another can be an uneasy experience for supervisees. This article discusses research in the area of supervisee disclosure and the inhibiting role of shame.

Disclosure in Supervision

Supervision has been defined as an “intervention” with several functions which include “clinical governance duties of evaluating clinicians’ fitness to practice, ensuring they are advancing in their professional competence and are supported in managing the emotional demands of their practice” (Spence, Fox, Golding & Daiches, 2014, p. 178). For supervision to achieve these aims, disclosure must be an essential part of the process between supervisor and supervisee. Without meaningful, accurate and honest disclosure, the supervisor is unable to provide perspective and guidance that will deepen understanding of a client and build their capacity for clinical work. Where material is withheld or denied, supervision will ultimately be less effective and possibly achieve only limited aims in providing support and general guidance.

The assumption of disclosure on which supervision hinges is not always borne out in practice. Yourman (2003) notes that non-disclosure is in fact a normal and frequent aspect of clinical supervision. This is supported by other studies where it was found that within a single supervision session, 84.3% of supervisees withheld some information from their supervisors (Mehr, Ladany & Caskie, 2010) and in a sample of clinical doctoral students, 97.2% reported withholding some information from supervisors (Ladany, Hill, Corbette & Nutt, 1996).

Non-disclosure can present widely, from fabrication of therapeutic material to editing events and censoring information, and then to seemingly benign ‘forgetting to mention’ or diverting away from salient case material. Common to these experiences is likely to be the desire to present material that helps the supervisee to look good, to appear competent enough, and to preserve self-image; this occurs across all types of supervision, across different stages of training and with varying supervisors (Wallace & Alonso, 1994). The drive to withhold information in supervision has several determinants. Issues within the supervisory relationship have been cited as among the primary reasons for non-disclosure (Falender & Shafranske, 2004). Discussed in terms of the supervisory *alliance*, optimal components include feelings of

safety, collaboration, supervisor commitment, supervisee contribution, transparency and respectful feedback. Unsurprisingly, where the supervisory alliance is weak, non-disclosure is more likely (Mehr, Ladany & Caskie, 2010).

Positive feelings towards the supervisor can also contribute to non-disclosure (Ladany et al., 1996; Talbot, 1995; Yourman & Farber, 1996). Irrespective of the stage of career of a psychologist, there is a tendency to seek out supervisors who are thought to be more knowledgeable, more experienced, or well regarded. It is common to approach the supervisory relationship with an idealised view of the supervisor. This idealisation tends to hold the supervisor in a position of power, and with it the power to humiliate and expose failings (Hahn, 2001). In this climate of apprehension and idealisation, disclosure will be less likely for supervisees.

In a more recent study using qualitative methods, Spence et al. (2014) discuss the multi-factorial aspects of supervision that come to bear on a supervisee’s decision to disclose salient material to supervisors and highlight the role of fear of negative evaluations and fear of negative consequences. They note that the drive in clinical psychologists in trying to maintain a favourable impression may limit their depth and amount of disclosure with a supervisor.

A drive to preserve a positive impression, idealised views of the supervisor, fear of humiliation and failing and poor supervisory alliance can be summarised as the key reasons for non-disclosure. What is not illuminated in these descriptions, or indeed, the wider literature, is the affective experience of the supervisee, primarily the role of shame in inhibiting disclosure.

While this article does not provide new data on disclosure or shame experiences in supervisees, it is intended to inform further discussion and research in the area.

Shame in the Supervisory Experience

Shame is the emotion associated with exposing failing or weakness. It relates to how we are seen, or how believe ourselves to be seen in the eyes of others. Shame is a likely part of supervision where our professional vulnerabilities are elucidated and our failings (real or perceived) are examined.

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Shame may be activated when too much is revealed through self-disclosure, or when personal characteristics are illuminated in some way (Hahn, 2001). Not only is the professional self-revealed in this process, but inadvertently and necessarily, aspects of the therapist's own personality are shown (Talbot, 1995). Blind-spots, vulnerabilities, weaknesses, gaps in knowledge and counter-transference responses are illuminated through the process of examining therapeutic work and this can be an uneasy space for the supervisee to occupy. Wallace and Alonso (1994) refer to this as "a position of narcissistic vulnerability... [whereby] professional self-esteem is threatened by exposure of therapeutic work to an idealized other" (p. 218).

Shame responses

Important in the experience of shame is the way in which it is dealt with or defended against. Shame coping styles have been developed into a model by Nathanson (1992). Labelled the *Compass of Shame*, it details four shame-scripts, or shame-management responses, representing differing motivations, affects, cognitions, behaviours and interpersonal responses. Withdrawing from others, avoidance, attacking self and attacking others are the four compass points of shame-coping and have been empirically validated with the development of the *Compass of Shame Scale* (Elison, Lennon & Pulos, 2006).

Withdrawing from the other in the interpersonal (supervision) context can be both observed and felt. Distance making, reducing eye contact, looking away, passivity in problem solving and maintaining a deferential interactional style are forms of withdrawal. The more extreme could be discontinuing supervision or changing supervisor. Evidently, the motivation for withdrawal is to hide and to limit further exposure to the shame-inducing source.

Whether it is recognised explicitly or not, avoidance is another defence against shame that psychologists may employ in supervision. The experience of shame may be less acknowledged than with withdrawal, and the primary motivation is to divert, distract self and others from the painful shame feelings (Elison et al., 2006). Withholding salient case material, failure to connect with emotional aspects of therapy, making light of difficulties, being dismissive or minimising difficulties, relying heavily on theoretical frameworks and their strict application, excessive focus on client details rather than process, intellectualising and an unwillingness to discuss and explore alternate frameworks to broaden understanding of a client, can be viewed as forms of avoidance.

Feelings of shame can readily be displaced through passive or overt expressions of anger. 'Attack other' as a defence can be a form of turning the tables, blaming other to make them feel inferior and to bolster one's own image. These expressions may occur within the supervisory relationship in the form of a dismissive attitude, rebuffing and rejecting of formulations, determined efforts to elicit greater justification from the supervisor or defence of a perspective. Outside of the relationship, this may be expressed through denigration of the supervisor and disregard for the frame. Within the clinical/therapeutic context, attacking others is often expressed

through a tendency to pathologise a client and to place over-due responsibility on a 'difficult' client for therapeutic ruptures (Talbot, 1995).

'Attack self' is a form of turning anger inwards and accepting the shame message as valid; that the self is lacking and deficient. Importantly, the motivation for responding with attacks on the self is to preserve the interpersonal relationship. Ranging from subtle self-deprecation to internalised anger and self-criticism, attacks on self can serve as a pre-emptive strike, to elicit the expected rejection, criticism and humiliation from another (the supervisor) before it is forthcoming, in an effort to preserve the alignment with the supervisor, and maintain the interpersonal connection (Gilbert & Proctor, 2006; Hahn, 2001).

As Alonso and Rutan (1988) described, patients will frequently rail against the 'ineptness' of clinicians for not ridding them of their suffering, leaving the psychologist with few options for escaping this projected shame. They can take on this denigration and see it as accurate (accept the shame message and respond with attack-self), they can withdraw to a distant position from the client and view them clinically, or they can retaliate against the client with scorn and derision of their own (attack other). Outside of the interaction with the client, the psychologist can feel ashamed and appalled at their response during therapy and will likely find this re-shaming and difficult to confront in supervision. While the action tendencies and the motivations associated with each of the four points differ, they share the role of protecting the individual against experiences of shame.

Implications for Clinical Supervision and Supervisors

Shame is everywhere in the therapeutic process. There is the shame in clients coming to treatment, in having to ask for help, in revealing one's self, one's vulnerabilities and hidden dimensions. There is potential shame in providing therapy too, with uncertain outcomes, overt or veiled attacks on competence and self, feelings of inadequacy for unsuccessful outcomes and ineffective treatment efforts. Supervisees can be helped to manage shame related to their work in the supervisory relationship without straying into the territory of personal therapy.

Recognising shame

In therapy, it is widely acknowledged that the first step in addressing shame is to help the client to recognise, understand and verbalise their own shame (Greenberg & Iwakabe, 2011). Through supervision, drawing focus to the inevitability of shame for clients in therapy means that supervisees can be more alert to its expression and its effects on the relationship with the therapist. From here, supervisees can be helped to recognise 'whose shame' they are experiencing and in so doing to separate communications of shame that come from the client from their own feelings of failure or inadequacy.

Managing idealisation of the supervisor

Supervisors can help to manage the likely power imbalance felt by supervisees by holding the supervisees in the

position of 'best judge' of the client they are working with. By supporting the supervisee to see themselves as best placed to understand a client - by making suggestions while drawing on the strength the supervisee has - their first-hand knowledge of a client helps to build an atmosphere of collaboration. Expressing the notion of 'two minds thinking together' can help to reduce idealisation, reduce shame in the 'not knowing' and feeling inadequate in the face of the supervisor's superior knowledge.

Shame regulation through compassion

Who among us does not know the feeling of failure and being 'less-than'? Supervisees particularly in earlier stages of their career will be more prone to these feelings and the sense of being isolated in what they likely feel to be a unique experience of shame. Much can be offered through normalising difficult experiences for psychologists and in validating and affirming the common and understood challenges in clinical work. In so doing, supervisors can model an attitude of compassion and acceptance of the trials and challenges of clinical work that do not rest only with the young, early career and developing therapist, but with all therapists. Such a response does not necessarily lead the supervisor into personal disclosures, but genuine acknowledgement of the struggles of being confronted by a shame-inducing client, or recognition of feelings of inadequacy that besiege even the most seasoned therapist.

The role of self-compassion in managing shame is well supported (Gilbert, 2008; Gilbert & Irons, 2005) and encouraging and even teaching of self-compassion in countering shame can be used in supervision. For example, supervisees can be encouraged to 'take the self out of the equation' (Tangney & Dearing, 2011) and to consider how they might view another psychologist who was also confronted by such a situation. People are often better at offering compassion to others than to themselves (Gilbert, 2011).

Re-framing experiences

In the common aim of CBT, supervisees can be encouraged to generate their own thinking around evidence for seeing themselves as deficient, and to consider any exceptions to this view. Are they always so confused and unsure with clients, or could there be something about this situation that was particularly challenging? Perceived failures can be re-framed in this way, and supervisees shown how to regulate their own shame feelings regarding their clinical work.

These suggestions for managing supervisee shame are naturally drawn from therapeutic material. Whereas supervision is not therapy, supervision need not exclude the possibility of it being therapeutic. The supervisor can model attitudes of self-compassion and can use re-framing, normalising and validation with the supervisee without moving into the realm of personal therapy. The supervisory relationship is no different to other interpersonal relationships in the matter of shame, where failings are exposed and vulnerabilities revealed, and it follows that non-disclosure will be a likely outcome in these situations.

Compassion for the struggles of the clinical work, sensitivity to shame-inducing experiences in supervision, and recognition that shame will likely sit behind these protective responses, can be sufficient to prevent the supervisory relationship being derailed or becoming redundant to the supervisee and painful for the supervisor. Disclosure will be more likely where a strong supervisory relationship exists, where failings can be normalised and idealisation of the supervisor managed.

Conclusion

Drawing together research from across psychotherapy, clinical psychology and psychoanalytic literature, it is evident that shame is an inevitability of supervision as professional vulnerabilities are exposed and failings offered up for scrutiny. The psychologist's sense of competence, independence and self is often challenged through therapeutic work as well as in supervision. It is fertile ground for shame, and as such, the tension exists between wanting to preserve the professional self while recognising the need for input into areas of weakness.

There will understandably be individual aspects of both the supervisor and supervisee that contribute to the presence of shame in clinical supervision. As noted by other authors (Tangney & Dearing, 2011; Watkins, 2010), personal factors of supervisors and supervisor's experiences of shame can restrict the ability to connect with and relate to supervisees in an authentic and meaningful way, limiting the learning and development of the supervisee. To examine supervisor shame and the impact on supervision and disclosure is an area for further investigation and beyond the scope of this paper.

Shame prompts us to retreat and protect; to remain passive and hidden, to disown responsibility, to dismiss and devalue so as to avoid the injury of it on our sense of self (Gilbert & Proctor, 2006; Lewis, 2003; Talbot, 1996). In a professional space where psychologists work for the benefit of their clients to stabilise therapeutic processes in order to unearth troubling aspects of therapeutic work, to receive support and bolster against the complexities of the work, and to add surety to ethical and difficult decision making, it is imperative that psychologists find it in themselves to offer up the less glorious moments. Whilst psychologists risk shame and humiliation in these moments, they do so in the service of themselves as professionals, and in the service of their clients who seek help. Awareness and acknowledgment of this experience for supervisees may help to mitigate the effects of shame on the personal and professional self and encourage greater disclosure, openness and exploration of therapeutic work to ultimately benefit those for whom psychologists work.

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Practical Guidelines for Integrating Reflective Practice in Clinical Supervision for Psychologists

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Abstract

Clinical supervision is widely regarded as an important and necessary part of developing and maintaining good clinical practice. Supervision involves learning and refinement of knowledge and skills through modelling, teaching and the application of reflective practice. Reflective practice has long been considered a useful process to refine clinical practice through thoughtful consideration of one's experience and applying sound theoretical knowledge when working with clients. Reflective practice supervision encourages independent learning, enhances clinical skills and helps the psychologist to develop self-awareness, insight and ethical awareness. The purpose of this paper is to provide a framework for applying reflective practice for the supervision of psychologists. It includes how to explain reflective practice when negotiating the contracted working alliance, the application of reflectivity in supervision, and the identification of specific problematic issues where reflection and action is warranted (for example, managing triggers and countertransference). For the purpose of this paper the terms psychologist, supervisee, therapist and clinician are used interchangeably.

Introduction

Supervision provides a context for education and training where psychologists learn skills and develop independent and critical thinking to be in a position to work as an autonomous, competent and ethical practitioner. Psychologists learn from experience through observing and practicing therapeutic interventions, and by applying this knowledge and learning in their everyday practice. Supervisors are in the position to help the supervisee move from being a novice practitioner to being able to work skillfully, independently and with confidence. It is acknowledged in the literature that good supervision relies on the interplay of a number of factors including a facilitative supervisory relationship, and an educational component with a focus on developing technical skills and critical inquiry (Bernard & Goodyear, 2004; Falender & Shafranske, 2007).

In order for learning to take place, a strong working alliance needs to be established that allows for reflective practice to be applied 'within' and 'outside' the supervisory context (Carroll, 2010). The ideas of reflectivity have been around for many decades with Dewey (1938; as cited in Ward, 1998) initially describing reflective practice as "an active, persistent and careful consideration of belief ... or knowledge" guiding thoughtful experimentation (p. 43). Kolb (1984) subsequently described reflection as an experiential learning cycle (doing, reflecting, learning and applying learning) as a way to learn from experience. Gibb (1988) labelled the process of 'reflection on action' as a way to develop new understanding by critically analysing practice. Schön (1994) made a clear distinction between two types of reflection: 'reflection-in-action' versus 'reflection-on-action' suggesting that the clinician needs to have critical awareness when engaged in an intervention and also when engaged in analysis after the session to plan for future work.

Psychologists who systematically and critically reflect on their work-practice develop personal awareness, clinical insight and resilience. Supervision should result in a supervisee being able to notice what s/he is doing differently *now* compared to *before* supervision and be able to apply what was learnt in the supervision room to their work. Supervision results in positive changes in action and behaviour over time (Falender & Shafranske, 2004; Hawkins & Shohet, 2006). Good supervision facilitates supervisees to be introspective by systemically reviewing their work considering emotional, cognitive and behavioural processes that ultimately leads to 'mindful' practice (Carroll, 2009).

This paper is divided into three sections: firstly it describes how to introduce the notion of reflective practice in the early stages of supervision so that the supervisee is cognisant of its importance in their learning process. Secondly it provides some examples of how to use reflective questions in supervision allowing the supervisee to take responsibility for their learning in combination with skills training, instruction and feedback in supervision. Thirdly, it extends the way reflective practice can be applied in supervision by exploring supervisee reactions to their clinical work, as well as recognition and management of emotions in supervision.

Setting up 'Good' Supervision

The goals of supervision are many, but overall there are three core aims. First, it is to develop competency and to enhance the clinical care of clients (Barnett, Cornish, Goodyear & Lichtenberg, 2007; Carroll & Gilbert, 2008). Second, supervision encourages independence and refinement of skills and knowledge and a commitment to best practice and lifelong learning (Carroll, 2010; Falender & Shafranske, 2007; Senediak, 2014). Third, supervision seeks to ensure that clinicians develop wisdom and clinical confidence across diverse areas of mental health assessment and practice (Aten, Stran, & Gillespie, 2008; Senediak & Bowden, 2007).

Good supervision is based on establishing a solid foundation to work collaboratively with the supervisee,

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considering wider system requirements (e.g. placement and organisational goals) and in accordance with their assessed learning needs and goals. The supervisor needs to have knowledge of supervision models (Bernard & Goodyear, 2009), be able to assess the developmental needs of the supervisee and provide effective and unbiased feedback. Central to good supervision is a supervisor who can provide a supportive and facilitative relationship which allows the supervisee to critically analyse and respond to what is happening in the therapy room. It needs to be developmentally appropriate and provide a balance of education, formative and evaluative feedback, and reflection (Chur-Hansen & McLean, 2006; Hunt & Sharpe, 2008; Lehrman-Waterman & Ladany, 2001; Noelle, 2002).

Figure 1 provides a supervision framework incorporating a reflective practice stance within supervision. This diagram shows the flow of supervision from initial contact, assessment of learning goals and contract setting to establishing a collaborative working relationship based on the supervisee employing active critical reflection. An explanation of the practice of reflection needs to be introduced in the early stages of the supervisory alliance. Psychologists at all developmental levels can apply reflection; their skills in critical reflection are likely to parallel technical skills (Martin, Garske & Davis, 2000; Milne, Aylott, Fitzpatrick & Ellis, 2008). As such, the supervisor needs to *model* reflection by asking questions that helps the supervisee critically review their practice when reviewing cases or when using observational methods, such as recordings and role play. Targeting questions that invite discussion and reflection promotes independent learning and confidence as the psychologist gains new insight of their clinical practice (Carroll, 2010; Regan, 2008).

1. Establishing the working alliance

It is well documented that supervision works best when there are clear goals and a contract for supervision has been established (Baker, Exum & Tyler, 2002; Bambling & King, 2000; Bernard & Goodyear, 2009). First and foremost the supervisee needs to be a 'customer' (an active participant) and remain a customer of supervision in taking responsibility to participate and learn from feedback provided in supervision; come prepared and work on issues that arise in supervision (including possible 'self-issues' identified in investigations of transference and countertransference); is organised and is 'retrospectively introspective'. The supervisee needs to integrate and apply new learning in current and future practice (Ladany, Friedlander & Nelson, 2005).

It is important at the early stage of the development of the relationship to make explicit learning goals as to how feedback and evaluation will be used to facilitate psychological competence. Evidence suggests that a solid working alliance reduces supervisee anxiety and improves therapy outcome which encourages openness, feedback and critical review (Haynes, Corey & Moulton, 2003).

The first meeting is where supervisor and supervisee meet to discuss the supervisory process and determine if a good fit exists to work together. At this meeting the learning contract is negotiated, expectations are discussed and supervisory processes are reviewed. It is important to discuss expectations

of supervision, from the perspective of both supervisor and supervisee and considering the developmental stage and systemic context that supervision will take place. It is also the time where the supervisor and supervisee have an explicit discussion about goals and preferred ways of working. The supervisor as *mentor* should assess supervisee developmental competencies and discuss how education, instruction and reflection will co-exist in the supervision room. The supervisor as *model* demonstrates appropriate reflective questioning and at all times relates this to targeted psychological competency skills (AHPRA; 2013).

The use of observational methods should be discussed and actively applied for new and experienced clinicians. The supervisee 'does not know what they do not know', so the reflective supervisor needs to both teach skills and model critical reflection. Evidence shows that without review of observational methods, clinicians under-report or misreport information (Ellis, Krengele & Beck, 2002; Hill, Crowe & Gonsalvez, 2015; Noelle, 2002). The supervisor introduces how reflective practice can be integrated into supervision which provides a balance between *supervisor-led teaching*, evaluation and experiential learning and *supervisee led self-exploration*. Table 1 is a summary of some questions that can be used to introduce a reflective dialogue at the initial stages of establishing a supervisory alliance.

2. Integrating reflective practice in supervision

Reflective practice has the advantage of stimulating the clinician's curiosity and creativity about the work that is carried out in a clinical context. It brings to the attention awareness of feelings and thoughts about self and the client (Flaskas, 2004). It allows the clinician to think about transference and countertransference (Rober, 2011) and to examine inner dialogue (Anderson, King & Lalande, 2010; Vandenberghe & da Silveira, 2013). Overall, reflection can provide diverse perspectives of the therapist's thoughts, feelings and behaviours, increasing empathic understanding for the therapist about client experience within the relational systemic context (Regan, 2008; Senediak, 2014).

'Reflection-in-action' occurs while events are happening. Here the supervisee needs to focus on observing, recognising, and where necessary, make adjustments to practice whilst in the session. This might take the form of a behavioural change (responding differently to the client), emotional change (managing emotions), or cognitive change (thinking differently about the therapist-client interaction). The supervisee has, in this instance, developed the capacity to think about and act *within* the practice context as it occurs, quickly drawing on these emotional, behavioural and cognitive interpretations. To be able to reflect in the session, the psychologist needs to be able to respond in the moment, drawing on existing theoretical and clinical knowledge. In this instance the clinician becomes both observer and facilitator in the practice setting. This form of reflective practice is often used in live supervision (or review of recordings) contexts where the supervisor models reflective questions and guides self-exploration (Carroll, 2009; Hunt & Sharpe, 2008; Lowe, Hunt & Simmons, 2008).

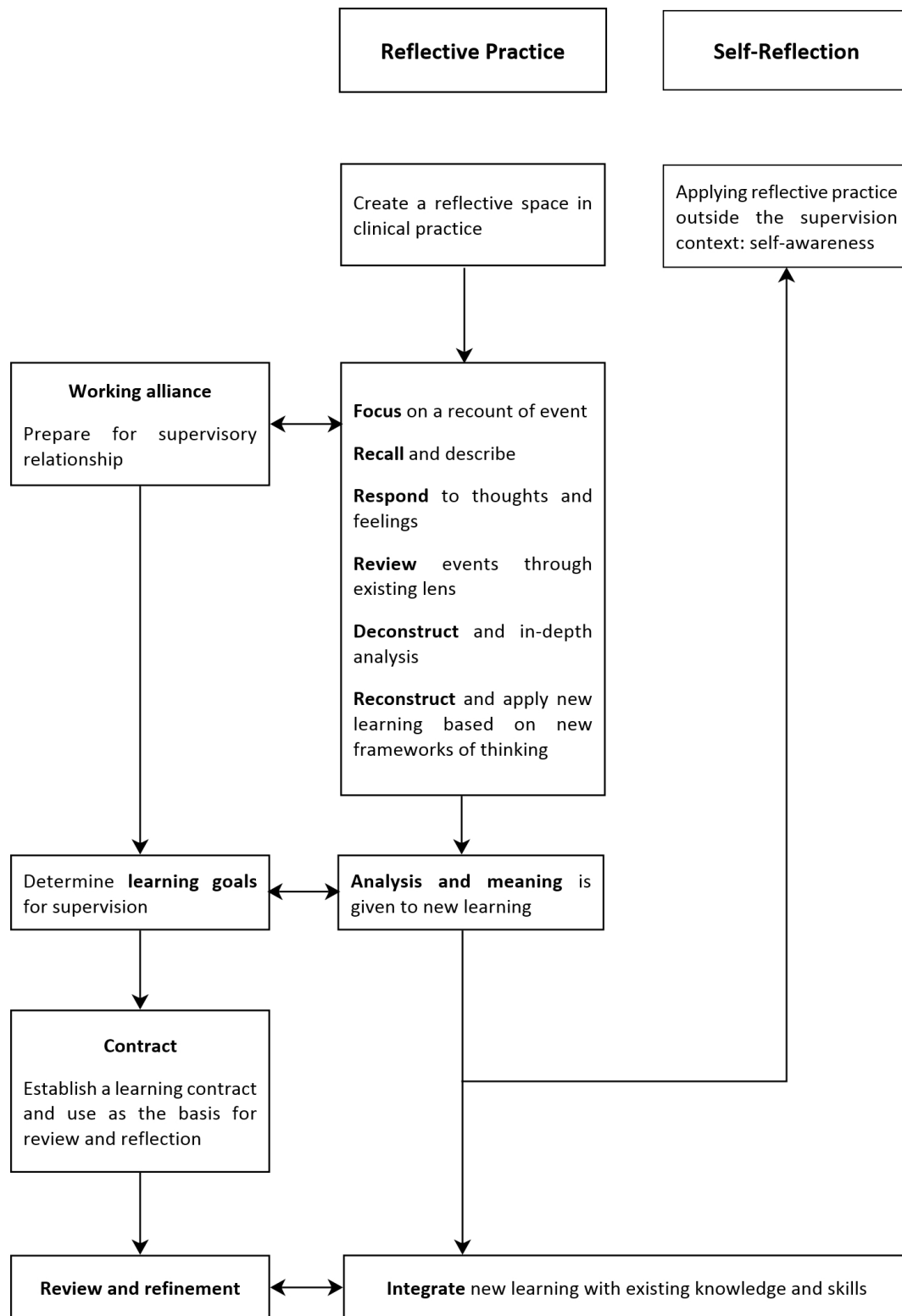


Figure 1. Preparation for the Working Alliance.

Table 1. Working Alliance Template (For Supervisors).

In this the early stage of 'getting to know each other', there is a focus on engagement of the supervisory relationship covering a discussion on orientation, experience and background. Both supervisor and supervisee share their clinical and supervisory experiences and expectations to determine if there a match between orientation, expectations and style. Questions should be open-ended and enquiring, modelling collaborative and reflective exploration.

1. Discuss **expectations** for supervision:
 - What is your preferred learning style?
 - How might we encourage critical discussion and reflection in sessions?
 - If directive feedback/instruction and/or experiential learning are required how do you think this could be introduced in the session? (It is important to encourage open discussion with the use of a 360 degree procedure for observation of clinical work, open feedback, and acceptance of possible discomfort in formative and evaluative feedback).
2. What have been your **experiences** of supervision?
 - What you have learnt from your experiences that might influence how we might work together?
 - How do these experiences inform the way you use supervision? If initial supervisory experience, consider 'hypothetical 'experience' or your 'ideal' supervision.
3. Reflect on **goals**:
 - What do you want to get out of supervision? For a placement, what specific tasks are required (e.g. psychometric assessments, counselling, organisational site visits, group skills practice, report writing)?
 - How are your goals linked to core psychological competencies?
 - How will you know you are working towards or have achieved these goals?
 - How can we integrate specific evaluation strategies which will measure attainment of goals?
4. Perceived supervisee **strengths** (competence) **and needs** (areas for further skills development and/or theoretical knowledge) are reviewed through guided discussion, unpacked and explored.
 - What do you see as your personal and professional strengths (and needs)?
 - How do you utilise these strengths in practice?
5. What **evaluation** processes will be used?
 - How have you incorporated (supervision) feedback in the past?
 - What qualitative and quantitative measures have you used in the past? How have these aided your learning?
 - When being evaluated how you do best incorporate feedback? If feedback is negative and change is needed how do you best learn from these experiences? (Be hypothetical if needed.)
 - How can you integrate self-reflection in your learning?
6. Introduce discussion on how to implement and consistently employ a reflective practice framework (discussion on the role of critical reflection, how and when it is used, responsibilities 'in and outside' the supervisory session) – provide descriptors of reflective questions that can be used (Table 2).
7. Discuss how you will balance supervisor-led feedback, teaching, experiential learning with supervisee-led reflective exploration.

Note: The supervisor models reflective questioning, articulates the strengths and restraints of being reflective and when instruction, education and experiential learning takes precedence. In beginning with reflective practice questioning at an early stage in the working alliance, the supervisee knows s/he has to do some work prior to, during and after the session. They cannot simply come to the session and say 'help with this client' – they must at least think about, and begin to articulate where they are stuck, what they want help with, and how the supervisor might help them. If the supervisee is 'on the wrong track' it is the supervisor's responsibility to model appropriate reflective questions that will help further unpack the clinical presentation and offer instruction and formative feedback.

Reflection-on-practice' occurs after the session and is retrospective. This is traditionally the more common approach to supervision where case discussion and review of clinical process takes place with the guidance of a skilled supervisor. Both approaches take a 'looking glass' stance and promote self-awareness and improved knowledge about the clinical context with the psychologist gaining a deeper understanding about ways to respond to a situation (Orchowski, Evangelist & Probst, 2010; Senediak, 2014). This is similar to Kagan's Interpersonal Process Recall (IPR) method (Kagan, 1980).

Questions can be applied in supervision that foster reflective practice and a number of creative reflective practices have been generated in more contemporary theories, such as systemic, dialogical and narrative approaches (Flaskas, 2012).

Creating space in the supervisory context to examine the therapist's inner dialogue promotes a sense of mindfulness and introspection (Carroll, 2009; Lichtenstein & Lustig, 2006), and with further exploration on the 'self of the therapist', one can identify and reflect if unresolved issues exist (e.g. family-of-origin, countertransference) which may hinder therapeutic processes (Brown, 2007; Framo, 1992). By using 'reflection-on-practice' in this way, differing influencing factors can be identified, and then managed, to further the supervisee's personal and professional development. In this case, the supervisor needs to be particularly mindful of the developmental stage, the supervisee's capacity for introspective reflection, and how to use this material sensitively for the benefit of professional practice.

Table 2. Reflective Questions for Supervision (For Supervisees).

1. What is my question for supervision?
2. What do I need help with?
3. What informs my practice in this context now? (Theory, past experience, emotional well-being, systemic context of practice).
4. What am I feeling? Where is this coming from?
5. How do I make sense of this interaction and my reaction to this interaction?
6. What concerns me most about this situation? Why?
7. What, if any, attempts have I made to change the way I respond to this situation? Why do I think that it is not working in this instance?
8. What theories do I use to understand what is influencing the current situation, and my current ways of responding?
9. What past professional and personal experiences affect my understanding of the situation?
10. What is the interaction/interrelationship between the psychologist, the client and the wider system/s?
11. Do I need to consider transference and countertransference issues? If so, how might this impact on my feelings, thinking and on the actions present and future focussed?
12. Are there other ways that I might interpret this event and interactions in the session? Should I consider a different lens (theory and/or practice modality)?
13. How might I use my personal and professional strengths to better manage this situation?
14. Who can I recruit for support in managing this situation?
15. What are my personal and professional strengths that I can draw on to help me better manage this situation?
16. How might I be able to test out different ways of responding safely? Can these be tried in the supervisory context before applying to the therapy room?
17. What ideas do I have about the way the client/s might react to new ways of working?
18. How can I bring all this information together that I have examined in the supervision room to the therapy room?
19. Is there anything or anybody that is getting in the way of change? What can I do about this?
20. How can I continue to use personal reflection to further improve my way of working therapeutically? How might my supervisor help me in this journey?

The focus of reflective enquiry depends much on the therapeutic orientation of supervisor and supervisee and the goals of supervisory enquiry. A common aim, however, is that it allows new openings for different thinking outside of what is already known and practiced, so the psychologist can step back, take a look at what is happening, examine the impact of self in the therapeutic context and consider alternatives in therapy. In a sense the psychologist deconstructs, and then reconstructs, new meaning to the situation.

Reflectivity pays attention to feedback, ecology, circularity and language, and it is the supervisor who guides this discussion through careful open-ended questioning, contemplation and review by the supervisee (Flaskas, 2012). Table 2 provides a summary of some of the questions that a supervisor can use in the supervisory context that encourages reflection. These questions can be used as a guide for enquiry to examine:

1. Supervisor – supervisee relationship: Is there ‘mirroring’ or a parallel process occurring in the supervisory relationship?
2. Supervisee-client relationship: The supervisee’s emotional response to the work with the client and context), and
3. Supervisor – client relationship: The supervisor’s own response to the supervision material; does the supervisor have expectations regarding what should be happening in therapy? How might they use this reaction to help guide the supervisee?

Identifying ‘red lights’: Enhanced reflection

When adopting an active reflective position, in combination with mentoring by the supervisor, it is not uncommon for the psychologist to identify how professional

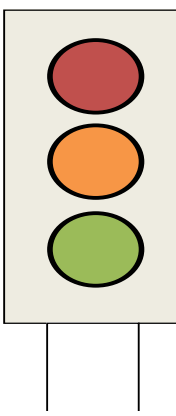
impasses resonate with personal themes (Haber & Hawley, 2004). Further examination of such sensitive areas in practice can reveal triggers or ‘red lights’ (Table 3) which can adversely impact on professional practice and when left unexamined can be destabilising and possibly lead to burnout, poor boundaries and inappropriate use of self-disclosure in therapy (Mason, Gibney & Crago, 2002; Rhodes, Nge, Wallis, & Hunt, 2001).

By encouraging the psychologist to identify potential triggers in supervision, the supervisor guides the supervisee to recognise and manage underlying emotions, beliefs, stereotypes and biases that can act as restraints in practice. Reflective questioning incorporating exploration of self in this way opens up a dialogue to further explore and manage personal triggers. Once potential triggers are identified, reflective supervision can help unpack and manage contributing factors, ultimately turning a restraint into strength.

3. Self-supervision

Lastly, the psychologist should be encouraged to practice reflective thinking outside the supervision session. Once a week, fortnight or monthly reflection on practice is insufficient. Critical reflection and self-supervision needs to become second nature and a preventative intervention rather than a reactive intervention only to be utilised in the supervision session, or when something has gone wrong (Fook, White & Gardner, 2006; Lowe, 2002). The supervisor can encourage the psychologist from an early stage of training to take more responsibility for their own learning and self-care by employing self-supervision (Dennin & Ellis, 2003; Heson, 2002; Morrisette, 2013; Senediak 2013). This can take the form of diary or journal writing - or using similar questions like those in Table 2 - that draw on reflective consideration of self, client and context. By engaging in a silent conversation with self, the

Table 3: Identifying Triggers in Practice (Traffic Lights).

|  | Reflection – Self Assessment | Action |
|---|--|---|
| | RED: Triggers strong reaction (may be emotional, cognitive or behavioural). (These may be ‘self-issues’ related to countertransference.) | Don’t delay – something is triggering a strong response and identifying the issue/s will help to improve your clinical awareness and practice. Use self-reflection to help identify and manage emotions. Take to supervision for reflective analysis. |
| | AMBER: Triggers an emotional response but less extreme. (Supervisee may be left with uncomfortable feeling and uncertainty.) | Needs attention: Self-reflection or at supervision using reflective analysis with supervisor guidance. Left unresolved, these issues will reappear and impact on clinical practice and self-care. |
| | GREEN: No particular strong emotional reactions are experienced. | Nil required. Awareness of personal and professional strengths help manage amber and red triggers. |

psychologist can challenge their understanding of the situation and the way it was handled. Personal critical inquiry may not necessarily facilitate immediate change, but it can heighten understanding so the sense of ‘stuckness’ or distress can be contained, at least until taken to supervision for further triadic (supervisor – supervisee - client) exploration. Again, the supervisor can use this information (the supervisee’s perception) and situate it alongside actual and assessable competencies (e.g. ‘*is your perception and analysis of the situation consistent with actual performance?*’)

Application of Reflective Practice in Supervision: Some Examples

Example 1: Individual Session

Megan (pseudonym) is a young clinical psychology registrar contracted to meet weekly. Each session she presents a list of questions eager to have them answered so they can be applied strategically in case management. She is eager to learn and achieve her learning goals. Megan is encouraged to reflect on patterns that exist in her practice with difficult, complex clients who present with dual diagnosis and a long list of social and family issues. She is initially resistant to ‘observe’ relationship issues and the wider systemic factors that contribute to the client’s problems, as this does not fit the CBT lens applied in practice. Court reports, strict probation and parole restrictions and family-at-risk matters all need to be managed and she wants to tick them off one by one. Once best practice therapeutic interventions are reviewed, supervision is able to focus on the therapeutic relationship and how she relates to the client and system/s.

Supervision questioning maps out where Megan sits in the eco-system (multidisciplinary team, court, and client) and she is encouraged to reflect on relationships within these systems. Megan is able to become more attuned to self-issues and her personal reactions to the client, which she then uses to manage transference and countertransference responses in the sessions. The focus changes to reflect on systemic issues rather than specific treatment issues. Over the course of the registrar program Megan moves from being technique and

solely CBT focused to being more reflective of self, in relation to the client and the wider systems. Her presentations become more mature in that she attends sessions already having thought about personal responses to the clinical material and the interplay of relational factors. This results in a more collaborative discussion on process issues alongside a review of specific interventions.

Example 2: Group supervision

Similar to an individual context, reflective practice is explicitly modelled in a group context and the parameters of clinical discussion clearly articulated, including the balance between skill acquisition, experiential learning and reflective questioning. In addition, group leadership skills are needed to manage difference and balance skills acquisition and facilitative reflection by group members.

In this example, a group of psychologists specialising in cross-cultural practice meet monthly. The presenting clinician leads the discussion by presenting an intergenerational genogram incorporating a ‘culture-gram’ (migration history) and socio-gram (services and wider systems issues). Presentations usually take 20 - 30 minutes followed by group peers reflecting on personal reactions to the material presented and/or asking reflective questions to the presenter e.g. ‘*I have a sense that the client...?*’; ‘*What strengths do you think the client has in managing...?*’; ‘*How do you interpret the client’s actions?*’; ‘*I wonder how being of the same CALD background to the client influences your relationship?*’ Such questions focus on relationship and examination of emotions, *rather* than gathering further information or detail of the case.

In this context, reflective practice is used as a way to open up a relational dialogue about therapist and client, unpack systemic issues at play within the wider context, *and* to engage supervisees to reflect on the therapeutic process. Themes are drawn from the presentation and discussion, and the supervisor invites group members to consider what they might take from the session and apply in their own practice contexts. Where necessary, the supervisor offers direction and

links theory to practice, ensuring a best practice framework is employed. Less experienced group members learn from their peers in considering multiple lenses and alternative therapeutic ways of working.

Example 3: Family therapy supervision

Those that come for family therapy supervision typically have a keen interest in wider systems issues. Many supervisees have been exposed to personal therapy as part of their training using a family-of-origin framework which engages the therapist to recognise personal restraints and to use their reactions to session material as a therapeutic tool (e.g. see Figure 1). Reflective practice within a family therapy framework uses an intergenerational genogram, eco-gram and socio-gram and also places the therapist in the picture e.g. 'Who are you aligned to most', 'How do you make sense of your reactions to 'X' in the family?' Whilst drawing on strengths within the family genogram and how family members have managed adversity across and within generations (Andolfi & Haber, 1994; Andolfi & Mascellani, 2013), the supervisor helps to create a new lens and new meaning to the presenting dilemma. The supervisor can encourage the therapist to ask questions that opens up further exploration of family issues thus creating a reflective stance for the family. For example, 'If your father were here now how would he...?' 'What would need to happen to allow your family to...?' 'When else have you been able to talk openly with your sister about...?' 'Hypothetically if you were able to talk to your mother about ... what do you think might be different?' Family therapy reflective supervision creates new meaning by asking the supervisee to think systemically, developmentally (intergenerationally), and reflectively about change and invites the family to do the same (Senediak, 2014).

These three examples show that taking a reflective stance within the supervisory context invites the supervisee to consider new ways of working with the client. Reflective questioning generates a sense of curiosity which in turn, generates different ways of deciphering and managing problems as they are presented in the clinical context.

Conclusion

This paper has provided a framework for applying reflective practice in supervision. Clinical supervision is widely considered a necessary part of every psychologist's practice in promoting critical analysis of client and relational factors and systemic issues in the therapeutic context. Preparation is the backbone to supervision, and allows for the development of a solid supervisory relationship. Introducing a reflective framework and modelling reflectivity in supervision invites the supervisee to also apply reflective practice in their everyday work, combining personal and professional learning and improved self-awareness, new insights and new behaviours. Identifying potential triggers, and working through these in supervision, can further facilitate growth and maturity of the psychologist. Supervision that embraces a stance of reflectivity fosters independent learning and critical thinking. Teaching the supervisee to 'fish' rather than always 'being fed' promotes a safe and sustainable supervisory relationship. Being a

supervisor that models reflectivity in collaboration with skills based learning fosters competency in skills development and learning.

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Reflective Practice: Understanding and Managing Countertransference

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Abstract

Countertransference enactment can have a negative effect on the therapeutic alliance. On the other hand, being able to conceptualise and manage countertransference can protect the therapeutic alliance. This paper briefly examines the concept of countertransference, its historical development, and areas of agreement and debate in this regard. While countertransference is a psychodynamic concept, there is general acknowledgement across different therapy approaches that countertransference is a common part of the therapist's daily experience. The paper briefly presents a five-step method designed to guide reflective practice in relation to countertransference for psychologists and trainees who are not psychodynamically trained (Cartwright & Read, 2011). The five-step method focuses particularly on understanding and conceptualising 'objective countertransference' that is evoked or provoked in the therapist by the client's interpersonal style. Psychologists and clinical psychology trainees have positively evaluated this five-step method. A clinical vignette is used to illustrate this method.

The working or therapeutic alliance, the real relationship, and the transference-countertransference relationship are three aspects of the therapeutic relationship that are a focus for research and clinical discussion (Horvath, 2000; Gelso, 2013). This paper focuses on the transference-countertransference relationship and in particular therapists' experiences of countertransference (CT) responses to their clients. CT is commonly understood as the therapist's emotional-cognitive responses to the client (Gabbard, 2004). Research suggests that it is common for therapists to experience CT (Gelso, 2013). For example, eight expert therapists taking part in a study of CT reported experiencing CT in 80% of 127 sessions of brief therapy (Gelso & Hayes, 1998). Therapists also appear to experience a wide range of different countertransference responses. A study that examined the CT responses of 181 psychiatrists and clinical psychologists in the United States reported a number of dimensions of CT including feeling overwhelmed/disorganised, helpless/inadequate, positive, special/over-involved, sexualised, disengaged, parental/protective, and criticised/mistreated (Betan, Heim, Conklin & Westen, 2005).

It is important to distinguish, however, between having a CT response and engaging in CT behaviours (such as acting in a critical manner towards a client, withdrawing from a client, or attempting to rescue a client). The frequency of CT behaviours (or enactment of CT) is less than the frequency of experiencing CT (Gelso & Hayes, 2007). In other words, therapists can manage their CT feelings and thoughts and do not always act on CT.

A recent meta-analysis of CT research concluded that CT behaviours can negatively impact the therapeutic alliance between therapist and client within sessions (Hayes, Gelso & Hummel, 2011). The reviewers also found evidence that the therapist's conceptualisation and management of CT is associated with better therapy outcomes (Hayes et al., 2011). Hence, it is important that clinicians and trainees have well-developed methods for understanding and managing CT. However, the majority of post-graduate clinical psychology programs in Australia and New Zealand provide training in

cognitive and behavioural therapies (Kazantzis & Munro, 2011) and do not offer training in understanding and managing CT, which has traditionally been associated with psychodynamic therapies. It seems to us that experienced and effective therapists from different therapeutic approaches are likely to have developed their own methods for managing CT. This is highlighted by Fatter and Hayes' (2013) argument that the ability to understand and manage CT is an important therapist factor that influences the therapeutic alliance.

This current paper examines a number of concepts related to CT that may be helpful for clinicians who are not psychodynamically trained and provides an overview of the debates in this area. It looks briefly at the increasing interest in cognitive therapy in CT and presents a five-step method for understanding and managing CT that has been developed by the first author and evaluated as clinically useful by psychologists in New Zealand (Cartwright & Read, 2011) and clinical psychology trainees in Australia and New Zealand (Cartwright, Rhodes, King & Shires, 2015). A clinical vignette is used to illustrate the five steps.

Development of the Concept of Countertransference

The concepts of transference and CT are now over a century old. Freud initially viewed transference as the process by which the patient unconsciously attributed or transferred attitudes and ideas onto the therapist that originated from within early relationships, especially with parents (Storr, 1989). He conceptualised CT as the analyst's unconscious responses to the unconscious of the client and regarded CT as a potential 'impediment' to therapy. However, from around 1950 onwards, CT began to be viewed as clinically meaningful for therapists who pay attention to it. Paula Heimann wrote that "the analyst's immediate emotional response to his patient is a significant pointer to the patient's unconscious processes and guides him (the analyst) towards fuller understanding" of the client (1950, p. 83). Winnicott (1949) described two aspects of CT – 'subjective' and 'objective'. He referred to subjective CT as relating to "an analyst's personal experiences and personal development", and objective CT as the therapist's "reaction to the actual personality and behavior of the patient, based on objective observation" (p. 350).

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More recently, Shafranske and Falender (2008), in their competency-based approach to clinical supervision, provided definitions of subjective and objective CT that are complementary to cognitive perspectives. They view objective CT as therapists' reactions that are induced by the client's maladaptive perceptions, affects, and behaviours, and point out that these reactions are often consistent with those of significant others in the clients' lives. They view subjective CT, on the other hand, as maladaptive reactions of the therapist emanating from personal factors (Shafranske & Falender, 2008).

In practice, it seems likely that any given countertransference will include both subjective and objective aspects. The therapist brings his or her own sensitivities to the relationship and clients provoke or evoke emotional responses in the therapist. An inter-subjective perspective views CT as 'jointly created' by the client and the therapist (Gabbard, 2001, p. 984). Hence, as Gabbard (2004) points out, it is important to consider what we contribute to the CT (subjective CT) and what the client contributes (objective CT). This latter can be a source of information about the client's experiences (Betan et al., 2005).

While CT research is in its infancy, there is some empirical support for the notion of objective CT (see Cartwright & Read, 2011 for a fuller discussion of this). For example, in the study with 181 Psychiatrists and Clinical Psychologists discussed earlier, Betan et al. (2005) concluded that clients elicit what they called "average expectable CT responses" in therapists (p. 895). They found that clinicians from different orientations had similar types of CT to clients with similar types of problems or personality styles, even when therapists reported that they did not believe in CT.

Debates about countertransference

It is important to note that there are debates about the definitions of CT as well as areas of agreement. There is agreement that therapists commonly experience CT and that CT enactment is problematic (Gabbard, 2001). There is also agreement that clients engage in a range of behaviours in therapy and towards the therapist that tend to 'evoke' certain types of responses from therapists (e.g., Dahl, Rossberg, Bogwalds, Gabbard & Hoglend, 2012; Fatter & Hayes, 2103; Gelso & Hayes, 2007). However, Gelso and Hayes (2007) argue that all CT is rooted in the therapist's conflicts and vulnerabilities – even if CT is evoked or provoked by the client's behaviour. They further argue that "what is evoked from the patient is best viewed as simply the therapist's affect or cognition, or perhaps patient-evoked affect and/or cognition" (Gelso & Hayes, 2007, p. 82). On the other hand, others argue that it is important to consider both objective CT and subjective CT (Betan et al., 2005; Cartwright et al., 2014; Gabbard, 2004; Hafkenscheid, 2012) especially since it may have "important heuristic value in clinical situations" (Hafkenscheid, 2012, p. 38). According to these viewpoints, and the viewpoint of the authors, the important challenge is to be able to distinguish the aspects of CT that relate to our own personal issues as therapists and those that relate to the client's personality and behaviour.

Cognitive perspectives of countertransference

Cognitive and cognitive-behavioural therapists have begun to acknowledge the importance of CT in the last decade, perhaps as a result of the increased research in this area (Hayes, Gelso & Hummel, 2011). Aaron Beck and colleagues wrote briefly about CT in their book on cognitive therapy with clients who were diagnosed with personality disorders (Beck et al., 2004). In discussing transference and countertransference, they refer to the "emotional reactions of both patient and therapist" ... "within the therapy process" (p. 108) and argue that attending to the client's emotional reactions to the therapist can be "windows into the patient's private world", while attending to one's own emotional responses can "be bridges to change rather than barriers to progress" (p. 108). Beck et al. (2004) also noted that therapist emotions can arise from a variety of sources, including "the interaction with the patient's problematic behaviors" (p. 110).

Robert Leahy (2008) examines the therapist's CT, although he considers only subjective CT which he links to the therapist's schemas about the self and interpersonal schemas about others. Leahy (2008) also talks about the therapist's 'emotional philosophy' or response to the expression of emotion, and argues that those who view expression of emotion negatively may communicate this negativity to clients which in turn may reinforce a client's negative schemas about self or others.

More recently, Newman (2013) discusses transference and CT from a CBT perspective. He argues that transference can be understood as the client's "overgeneralised interpersonal beliefs" and CT as the therapist's "cognitive, emotional and behavioral responses to the client" (p. 500). He also briefly addresses objective CT, although he does not name it as such. Instead, he states that CT can be a "normative response" that results from the problematic impact that a client can have on others. It is also important to note that methods have been developed to assist CBT therapists to consider CT, although these methods address only subjective CT (e.g., Bennett-Levy & Thwaites, 2007; Haarhoff, 2006). Hence, there appears to be increasing interest in CT within cognitive behavioural therapies, although CT is discussed briefly and focuses mainly on subjective aspects of CT.

The method presented in the next section was designed to assist therapists and trainees from cognitive behavioural traditions to have ways of conceptualising CT that are complementary with a CBT approach (Cartwright & Read, 2011). It gives particular attention to the notion of objective countertransference as a source of information about the client.

Understanding and Managing Countertransference: A Five Step Method

The first author designed a 5-step method for considering CT that has been evaluated by psychologists in Auckland (Cartwright and Read, 2011), and clinical psychology students at three training programs in Australian and one in New

Zealand (Cartwright et al., 2015). The psychologists completed a two-day workshop in the method and evaluated its usefulness for their professional practice (Cartwright & Read, 2011). The mean rating for the statement "The course has enabled me to enhance my professional practice" was 5.7 on a 6-point scale. The psychologists also analysed written case material before and after the workshop. Analysis of responses revealed a significant shift from reflecting mainly on the subjective aspects of CT pre-workshop to considering the client's experience and the interpersonal processes that influence the CT responses post-workshop (for a fuller discussion, see Cartwright & Read, 2011). Psychologists reported that having a method to think about objective CT was useful for them. As one participant wrote,

Previously I understood CT as a negative event, a reflection of a personal limitation. Now I understand CT as something to be identified and considered from both the therapist and client perspectives as something that adds information to the therapeutic relationship and provides a prompt for deeper exploration of client feelings (Cartwright & Read, 2011, p. 51).

This method was also evaluated with students in four clinical psychology programs in Australia and New Zealand in 2013 (Cartwright et al., 2015). Clinical psychology students were aware of their CT experiences and were able to write about these (Cartwright et al., 2014). Those who took part in the evaluation rated the statements: "The training will be useful for my professional development" (mean rating of 4.35 on a 5 point scale); "the training helped me to understand the concepts of CT" (4.37), "I intend to use the concepts of CT taught in the course" (4.6), and "I agree that CT can be a source of information about the client" (4.75). Trainees were less confident about being able to manage their CT (3.73). However, some caution around this in the early stages of professional development may be desirable. The next section outlines the 5-step method (Cartwright & Read, 2011) and uses a clinical vignette to illustrate the concepts.

Clinical vignette

Therapist Michael is working with 38-year old Jane who reports that she wants to be married and have children. She reports a history of "failed" relationships that start out well, deteriorate, and then feels as if she is "thrown off like an old rag". Jane grew up as an only child believing that her parents really wanted a boy. Jane recalls finding it difficult getting her parent's attention as a child. Her parents worked together in a business and worked long hours. She recalls clinging to her mother or father and crying when they left her with carers, their anger and frustration when she did this and the way they pushed her away. She says she still feels "depleted" when she thinks of how hard she had to work to ever get their attention. In the third and fourth session, Michael finds himself beginning to feel irritated by Jane as she 'regales' him with stories of how she has been mistreated by a series of people throughout her life. In the fifth session, when he reminds her about the break in sessions that is coming up, she becomes tearful and panicky and talks about her worries about not ever having a family of

her own. Michael has a sensation of her clinging to his legs and feels angry with her and wants to push her away. He struggles to remain engaged and to be empathic to her plight. He finds himself thinking that she's a heavy weight he has to carry.

Step One: Being aware of and monitoring CT responses.

There is evidence that individuals vary in their awareness of their own CT (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). To be able to understand and manage our CT we need first to be able to recognise it. In the vignette above, the therapist appears to have a good awareness of his responses, firstly of irritation, and then of a shift to feeling angry and wanting to push the client away as he has the sensation of her clinging to him. He is also aware of his thought that she is a "heavy weight" to carry.

Step Two: Considering objective and subjective countertransference.

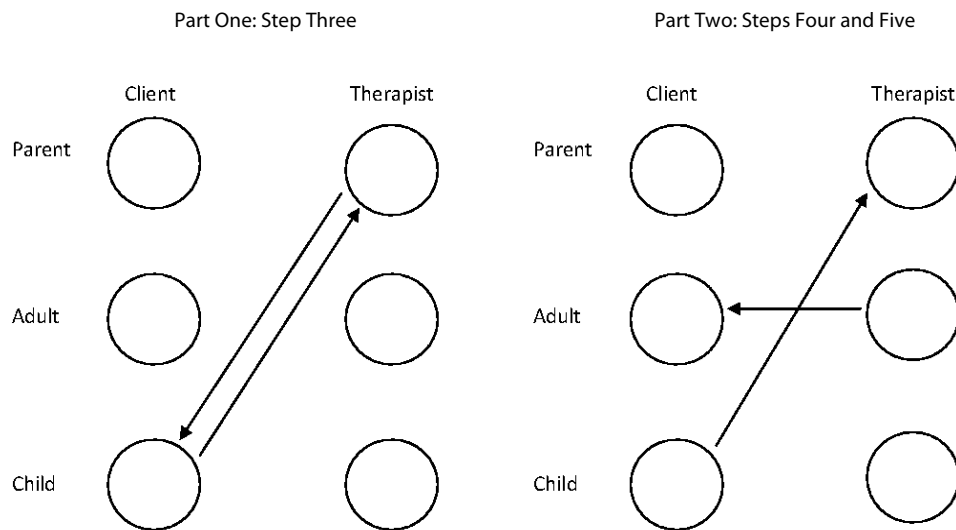
When we notice a CT response, it is helpful to reflect on our personal contribution to the CT (subjective) and the client's contribution (objective) (Gabbard, 2004). In reflecting on his response, Michael remembers how he sometimes felt that his mother was clinging to him when his father was away for extended periods at work and how he hated this feeling. This situation might be particularly triggering for him (subjective CT). However, in the next step he can also consider how the client might be evoking these thoughts and feelings in him (objective CT).

Step Three: Developing a conceptualisation of the objective countertransference.

This step is the most complex (see Cartwright and Read (2011) for a more detailed overview of the method and its rationale). In order to understand the client's templates for relationships that s/he brings to therapy, the therapist considers the client's representations of self and other that developed through formative experiences. We can hypothesise that client Jane developed a representation of herself as unwanted/unloved and others as unloving/rejecting. She may also have a representation of herself as invisible to others and of others as invalidating or dismissing. She appears to view herself as needy and dependent on others and others as having power – to either meet her needs or withhold from her or mistreat her. Her stories in therapy suggest hurt, resentment and anger towards others for what she sees as their rejecting and belittling ("thrown away like an old rag") behaviour towards her.

Cartwright and Read (2011) use the Transactional Analysis model of Parent, Adult, Child (Berne, 1961) to reflect on the interpersonal processes occurring between therapist and client. This method was first used by Brown and Pedder (1991). Figure 1 below presents this in diagrammatic form. In this instance, we hypothesise that Michael is experiencing a complementary countertransference towards Jane. As Jane talks to Michael about her experiences of rejection and mistreatment, she may expect or fear that Michael, her therapist, will also become critical or rejecting towards her as others have (other representations). Michael does begin to feel irritated with her as she 'regales' him with her stories. When Michael mentions the break in sessions, this fear or expectation of rejection may have become heightened, resulting in Jane's anxious worrying and apparent feelings of

Figure 1. Using the TA Map to Reflect on Countertransference.



neediness toward the therapist and the sessions. Michael, for his part, appears to have identified with Jane's representations of others and responds in a complementary way (complementary CT). As her parents did, he begins to feel annoyed with her, has a sense of her clinging to his legs after he mentions the break in sessions, and wants to push her away, as she felt her parents did. If Michael acts on these feelings (withdraws from the client, appears annoyed, or shows criticism or rejecting behavior) the client's transference expectations will be fulfilled.

Steps Four and Five: Using a calming strategy and moving back into the adult. These steps include managing the sometimes powerful emotions that are evoked in the moment or throughout sessions. They are illustrated in Part Two of Figure 1. It is helpful to use a breathing technique and calming thoughts ('It's okay. I'm having a CT response. I'll just breathe and stay calm. I can think about this later or talk about it in supervision'). We can also shift to a more empathic view of the client. ('So perhaps this is what happens for Jane. She thinks I am going to reject her like others have and she's started behaving in this clingy way – perhaps it is all she knows how to do. She seems to feel quite powerless with others and now with myself'). Michael might also remind himself about his potential subjective CT. ('It's reminding me of when my mother got clingy. Just breathe and stay calm!').

In Step Five, it can be useful to think about coaching ourselves back into the Adult – even if we still have not made sense of our CT. Once again, it is also helpful to regain our empathy. Michael might say to himself, "I'm starting to respond to Jane like her parents. That will be quite painful for her. I can focus on moving back into my Adult/ Wise Self and I can work through this later". If Michael is able to move back into an empathic Adult position then he may be able to use his experience therapeutically. "Jane, I have the impression at the

moment that you might be feeling anxious or worried about our sessions. I'm wondering if talking about the break in sessions has affected you or if something else is worrying you?"

Conclusion

This paper briefly discussed the development of the concepts of CT including the notion that clients provoke or evoke CT responses in therapists, as they do with others in their lives. Therapists on the other hand also bring their own personal issues that contribute to CT reactions. The five-step method by Cartwright and Read (2011) was introduced and is designed to assist therapists and trainees to be able to conceptualise and manage their CT responses. CT responses can provide information about the client's experiences that are otherwise inaccessible. Understanding and managing our CT responses also helps to protect the therapeutic alliance. Given the recent research into CT, it seems important that all therapeutic approaches provide training in this ever-present therapist experience.

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Dialogical Reflexivity in Supervision

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Abstract

This article reports on the proposed research protocol for a Doctor of Philosophy (PhD) currently undertaken at the University of Wollongong. The PhD thesis is titled: *An examination of the effect of reflective dialogue within the supervisory relationship to enhance supervisory and clinical outcomes* and is being undertaken with the supervision of Dr Trevor Crowe and co-supervision of Professor Brin Grenyer. The article will begin with a review of relevant literature and rationale for the proposed research. An overview of the proposed research, separated into three studies, will follow.

Literature Review and Research Rationale

Relational and reflective competencies in supervision

Recently, we have seen the emergence of competency-based models of supervision in psychology (Falender & Shafranske, 2004; Gonsalves & Calvert, 2014; Gonsalves, Oades, & Freestone, 2002). Within this literature, relationship is recognised as a central foundation to other competencies in psychological practice (National Council of Schools and Programs in Professional Psychology, 2007) and has been considered “the substratum existing under and supporting other competencies” (Mangione & Nadkarni, 2010, p. 69). This competency implies more than just basic interpersonal and counselling skills; it also refers to therapist’s ability to be constantly attuned to their own moment-to-moment cognitive and affective experiences in order to practice reflexive processing of relationship material (Mangione & Nadkarni, 2010). Despite the importance of this ability, there is a relative lack of research investigating supervisory strategies for the development of therapeutic relationship competencies, including therapist reflective capacity (Gonsalves & Crowe, 2014).

Central to definitions of the relationship competency is the ability to reflect upon oneself and the relational dynamics at play, also described as *metaperspective* (Mangione & Nadkarni, 2010). Broadly speaking, reflective practice refers to a purposeful analysis of one’s experience, in order to access deeper meaning and understanding (Mann, Gordon, & MacLeod, 2009). It is here that relational and reflective competencies converge to create a reflective position in relationships where therapists engage with the relational situation and critically examine their own reactions, affect, and behaviour (Mangione & Nadkarni, 2010; Safran & Muran, 2000).

Perhaps the most challenging of the reflective skills is that of reflection-in-action (Falender & Shafranske, 2010). Originally articulated by Schön (1983), reflection-in-action involves engaging in reflection as a relational event is unfolding, making decisions and adjustments to our actions in a moment-to-moment fashion (Schön, 1983, 1987). Schön

distinguished reflection-in-action from two other forms of reflection: reflection-on-action (making sense of an event that has already taken place) and reflection-for-action (using past reflections to guide future action). Each of these reflective processes represents an important relational skill and practitioners should develop the ability to engage in critical awareness of their experiences both during and after therapeutic interventions (Hallett, 1997).

Strategies for developing relational and reflective competencies in supervision

A number of supervision interventions have been proposed for enhancing relational and reflective competencies. Firstly, several approaches have been outlined in which the supervisee engages in independent reflection, which can then be processed within the supervision session. Reflecting on a therapeutic dilemma has been proposed as a method of developing reflectivity and relational competence. In this approach, supervisees are encouraged to create written responses to questions exploring their cognitions, emotions, intentions, and possible responses to a therapeutic dilemma. Their responses are later processed in supervision (Holloway & Carroll, 1999; Neufeldt, 1999). Journaling is another suggested method for enhancing supervisee reflective and relational awareness (Orchowski, Evangelista, & Probst, 2010; Osborn, Paez, & Carribean, 2007) with journal entries processed in supervision (Billings & Kowalski, 2006).

Interventions for use exclusively within the supervision session have also been articulated for the development of relational and reflective competencies. Supervisors may model relational and reflective skills so that the supervisee has the opportunity to observe and make use of these skills in his or her own practice (Goodyear, 2014). Supervisors might model these competencies through activities like role-playing, microskills training, and active listening practice (Mangione & Nadkarni, 2010). *Interpersonal process recall (IPR)* (Kagan, 1980) is a supervisory strategy aimed at increasing therapist awareness of interpersonal dynamics in the therapeutic relationship. In this approach, the supervisor and supervisee view a tape of a therapy session, pausing it at perplexing or interesting points for analysis. The supervisor facilitates reflection, prompting exploration of emotions, intentions and perceptions (Bernard & Goodyear, 2014).

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Table 1: Methods for facilitating the development of relational and reflective competencies in supervision.

| Methods utilising reflection- <i>on</i> -action | Methods utilising reflection- <i>in</i> -action |
|---|--|
| <p>Reflecting on a therapeutic dilemma (Holloway & Carroll, 1999; Neufeldt, 1999).</p> <p>Journaling (Orchowski, Evangelista, & Probst, 2010; Osborn, Paez, & Carribean, 2007) and processing journal entries in supervision (Billings & Kowalski, 2006).</p> <p>Supervisor modelling of relational skills e.g. role playing (Mangione & Nadkarni, 2010)</p> <p>Viewing clinical videos- Interpersonal Process Recall (Kagan, 1980)</p> | <p>Dialogical reflexivity (outlined in this paper) - a present and relational focus in supervision, created through a direct, reflexive conversation between the supervisor and supervisee and a narrative about the supervision process itself. For example:</p> <p>-What are our thoughts/feelings/experiences as we are having this discussion?</p> <p>-How emotionally safe does this relationship/conversation feel?</p> <p>-To what extent are we collaborating with one another?</p> <p>-How could we do things differently in this moment to improve the process of supervision?</p> |

These strategies represent the development of relational and reflective competencies utilising processes of reflection-on-action and reflection-for-action. While these forms of reflection are important, there is also a need to attend to the ability to engage in moment-to-moment reflection and processing of relational dynamics (reflection-in-action). In addressing this need, the supervisory relationship should be considered a space of experiential learning.

Supervision as a Space of Experiential Learning

In order to develop supervisees' capacity to engage in reflection-in-action, the supervisory relationship itself can be used as a vehicle for real-time learning about relational dynamics (Kaslow & Bell, 2008; Orchowski et al., 2010). Such an approach to supervision moves beyond reflective dialogues about therapeutic events, viewing of therapy videos, and the use of role play to teach therapy skills. Purely didactic approaches to supervision that give limited attention to therapists' affective experiences may create practitioners who have sound knowledge and technical skills, but are less able to respond effectively to challenging relational dynamics in therapy (Ensink et al., 2013; Markovitz & Milrod, 2011). Therapists are required to engage in complex processing of relational phenomenon with clients, utilising automatic or intuitive responses (Safran & Muran, 2001). In order for therapists to integrate complex perceptual, affective, and behavioural resources to respond to relational patterns in an authentic and present manner, learning must occur at an experiential level, not just a conceptual one.

Supervision provides an optimal space for trainee therapists to develop their attunement to the range of relational processes occurring in human engagement (Falender & Shafranske, 2010). Just as one cannot learn to play basketball or draw just by reading or talking about the skills involved, one cannot develop relational and reflective competencies as a therapist by simply talking about relevant concepts and principles. The supervision relationship offers a potential mirror to treatment that can be used for supervisees to try out relational processing that may be used in the therapy room. Thus, the function of the supervisory relationship is not simply the transmission of knowledge and skill, but rather the creation of a space for interactional learning to enhance

supervisee competencies in relational and reflective processes (Gonsalvez et al., 2002; North, 2013).

The supervisory relationship: A tripartite model

In considering the use of the supervisory relationship as a platform of experiential learning, it is necessary to consider the nature and composition of this relationship. A great deal of attention has been given to understanding the supervisory relationship within the psychoanalytic literature, with much focus on the supervisory working alliance and the transference-countertransference configuration (including parallel process phenomena). More recently, Watkins (2011) proposed a tripartite model of the supervisory relationship, adding the *real* or personal relationship to current representations of the supervisory bond. Each of these proposed processes of the supervisory relationship is important in the use of supervision for experiential and transformational learning.

Supervisory alliance. The supervisory working alliance is often credited as the primary means through which supervisee competence and development is facilitated (Bordin, 1983; Efstation, Patton, & Kardash, 1990; Ladany, Ellis, & Friedlander, 1999). The supervisory working alliance is based on mutual agreement concerning the goals and tasks of supervision, as well as the development of a strong emotional bond between supervisor and supervisee (Bordin, 1994). Research has indicated that a strong supervisory working alliance is linked to increased supervisory satisfaction (Ladany et al., 1999) as well as to increased quality of the supervisory relationship leading to improvements in supervisee confidence, professional identity, and clinical perception (Worthen & McNeill, 1996).

Parallel process. In theoretically explaining the phenomenon of material moving partly unconsciously from one relationship to another, the concept of parallel process becomes vital. Parallel process occurs when similar interactional patterns arise within both the supervisor-therapist and therapist-client relationships. Initial articulations of parallel process phenomena focused on how the relational processes occurring within the supervisory context appear to mirror those taking place in the therapy room (Bromberg, 1982; Caligor, 1984; Ekstein & Wallerstein, 1972; Searles, 1955). More recent evidence for

parallel process has shown that relationship dynamics also travel downwards from supervision to therapy in a bi-directional translation of relationship dynamics across the different settings (Tracey, Bludworth, & Glidden-Tracey, 2012; Williams, 2000). Active efforts to develop the supervisee's capacity to engage in moment-to-moment reflection within the supervisory relationship may travel "down the line" (Crowe, Oades, Deane, Ciarrochi, & Williams, 2011, p. 57), enhancing the supervisee's understanding of moment-to-moment relational processes within the therapy room (Binder, 1999; Crowe et al., 2011; Neufeldt, 2004; Safran & Muran, 2000). Dialogical reflexivity interventions may create changes in supervisee-client interactions through an osmosis process of relational patterns and dynamics travelling from supervision to therapy.

Real relationship. In examining strategies incorporating experiential learning opportunities through the engagement with relational processes in supervision, it is important to consider the *real relationship* (Adler, 1980; Greenson, 1965; Greenson, 1967) between supervisor and supervisee. Watkins (2011) posited that the real or personal relationship in supervision exerts a substantial influence upon the development and maintenance of a successful learning alliance, as well as the expression and utilisation of parallel processes in this context. The significance of the real relationship in experiential learning is underlined by Martin Buber's (1958) articulation of the 'I-Thou' relationship, an interaction that is mutual, affective, and necessary for reflective learning. According to Buber, when people agree to be mutually authentic with one another in communication, the result is genuine dialogue and rich learning. Buber asserted that "the learner is educated by relationships" (1965, p. 90) and that the 'I-Thou' relationship produces optimal experiential learning.

Dialogical Reflexivity: Definition and Aims

In incorporating experiential opportunities for developing reflective and relational competencies within the supervisory relationship, practitioners might use a process we term *dialogical reflexivity*. The term *dialogical* is here used to denote a focus on the real experience of relational processes. Distinguished from *reflectivity*, the term *reflexivity* is used here to describe a responsive and genuine engagement with an 'other', aimed at bringing about relational change. Dialogical reflexivity, therefore, refers to a present and relational focus in supervision, created through a direct conversation between the supervisor and supervisee and a narrative about the supervision process itself. This involves engaging in dialogue about unseen or neglected aspects of supervision, focusing reflectively on each person's experience of supervision, and engaging in direct discussion about the supervisory relationship. A recent study conducted by Hill et al. (2015) illustrates purposeful reflection within the supervisory relationship by investigating the use of videos of supervision to initiate collaborative, reflective dialogue between supervisors and supervisees regarding the supervisory exchange. However, we emphasise the importance of using the immediacy of relational engagement in supervision to promote real-time reflection, rather than reflection on the supervision relationship after the fact (i.e., merely requesting feedback about the relationship generally). In this sense,

dialogical reflexivity reflects Schön's (1983, 1987) concept of *reflection-in-action* while moving beyond removed reflection to reflexive engagement in relational processes.

Research has consistently revealed a rich territory of relational dynamics at play within supervision and pointed to the importance of attending to these dynamics. Several studies have demonstrated that supervisees withhold relevant information from their supervisors on intentional and unintentional bases, particularly thoughts and emotions regarding the supervision relationship (Ladany, 2004; Ladany, Hill, Corbett, & Nutt, 1996; Pisani, 2005). Supervisees report that they find openness within supervision relationships to be useful (Johnstone & Milne, 2012; Murphy & Wright, 2005) and perceive supervisor self-disclosure positively (Ancis & Marshall, 2010). Open, non-judgemental, and supportive supervisory relationships create emotional safety for supervisees to be vulnerable and take risks in asking difficult questions or discussing material critically with supervisors (Ancis & Marshall, 2010; DeStefano et al., 2007). A lack of safety and openness in the supervisory relationship may hinder supervisee disclosure of personal feelings, which could impact clinical development (Murphy & Wright, 2005).

Authentic relational dialogue is particularly important in the face of negative or unhelpful events occurring within supervision. Research demonstrates that supervisees wish that their supervisor would create space for an authentic and acknowledging conversation about such events, yet supervisees tend not to disclose such feelings to their supervisors. Hence, these negative supervisory events often remain unresolved (Gray, Ladany, Walker, & Ancis, 2001; Nelson & Friedlander, 2001). These issues regarding non-disclosure and unhelpful supervisory dynamics highlight the importance of interventions to elicit appropriate discussion of unacknowledged or unspoken aspects of the supervisory relationship. They also point to the scope of territory in which supervisees and supervisors can engage in real-time reflection upon and engagement with relational processes as an experiential supervisory intervention.

Using dialogical reflexivity in supervision

Authentic, real-time engagement in the dynamics of the supervisory relationship might take a number of forms. A potential strategy for engaging supervisees in an authentic and direct conversation regarding the supervision process itself is the use of video recordings of supervision interactions. Researchers (Gonsalvez & Milne, 2010; James, Allen, & Collerton, 2004; North, 2013) have suggested that the review of video and/or audio recordings of supervision may assist participants in focusing on important aspects of supervision that are otherwise unattended. In this manner, reviewing video of supervision may act as a gateway for dialogical reflexivity to occur, sparking direct conversation about, and engagement with, the processes occurring in supervision. To date, a small number of studies have investigated the use of supervision videos to promote reflective practice (James et al., 2004; North, 2013). A recent study conducted by Hill et al. (2015) investigated the use of videos of supervision to initiate collaborative, reflective dialogue between supervisors and supervisees. Seven supervisory dyads participated in a reflective practice protocol in which they viewed a video of

their most recent supervision session and then engaged in collaborative reflection about the supervisory processes and dynamics observed on the video with their supervisor. Thematic analysis of participants' individual reflections regarding the intervention resulted in several dominant themes: increased discussion of the supervisee's anxiety and themes of autonomy and dependence; intentions to change practices in supervision as a result of engaging in the protocol; identification and consideration of parallel process; and a range of perceived improvement in the supervisory alliance.

Another potential method of incorporating authentic and direct conversations about the supervisory relationship might involve pausing at moments in the course of the supervision session to make contact with the relational processes unfolding in the here-and-now. Questions to prompt discussion of deeper processes and dynamics within supervision might include: *What are our thoughts/feelings/experiences as we are having this discussion? How emotionally safe does this relationship/conversation feel? To what extent are we collaborating with one another? How could we do things differently in this moment to improve the process of supervision?*

Overview of Proposed Research

The proposed investigation of reflective dialogue in supervision involves three distinct yet related research studies investigating the use of dialogical reflexivity interventions in supervision.

Study One

The first of the three studies is exploratory in nature and aims to capture a snapshot of current practices used in the supervision of psychologists regarding the development of relational and reflective competencies. Participating supervisors and supervisees will complete an online survey investigating how supervisory practices aimed at developing relational and reflective competencies are related to supervisor/supervisee theoretical orientation, working alliance, real relationship and attention to parallel process. The online questionnaire contains a combination of open-ended questions relating to current practices in supervision, rating scales related to perceived usefulness of various proposed supervision strategies, and established scales measuring the nature and quality of the supervisory relationship.

Study Two

In study two, we plan to develop a measure of relationship competence to be used in observer ratings and to conduct a preliminary examination of its inter-rater reliability. It is hoped that this study will represent a significant contribution to the literature as, to our knowledge, such a measure does not currently exist. To create the rating scale, we will firstly conduct focus groups and individual interviews with various clinical experts to explore and define the construct of relational competence in psychological practice. Interviews and focus groups will be facilitated by a number of questions regarding the definition of relational competence, developmental stages of the competence, and behavioural markers of relational competence. Following the open-response phase of the interview/focus group, participating experts will be presented with a list of suggested components and markers of

relationship competence based on previous literature and asked to comment on these. The interviews and focus groups will be recorded and transcribed and an initial relational competency assessment scale will be developed. The devised items will then be refined through analysis, evaluation and feedback from a select group of clinical experts. In the next phase, supervising psychologists will rate three video vignettes of therapist relational competence using the rating scale. We will then analyse the data to explore the inter-rater reliability of the scale and will also collect qualitative response data regarding the face validity and ease of use of the measure.

Study Three

Study three aims to investigate the effectiveness of a dialogical reflexivity protocol in terms of the development of relational and reflective competence. In other words, we aim to explore whether the experience of dialogical reflexivity within the supervisory context can 'travel down the line' to enhance an individual's relationship competence for clinical use. We also wish to examine the feasibility and usability of a dialogical reflexivity protocol within supervision through participant feedback. We plan to conduct the study with trainee psychologists within University settings as the target participants.

Participants will be randomly allocated to one of three groups: 1) dialogical reflexivity; 2) supervisee independent journaling; or 3) supervisee journaling with reflective discussion in supervision. Those in the dialogical reflexivity condition will be given a brief protocol to use in supervision to stimulate reflexive discussion about and engagement with processes unfolding within the supervisory relationship. Participants in the journaling groups will be asked to respond to some brief reflective questions in writing after each of their three supervision sessions (one group will process the journal entries in supervision). Following sessions of supervision, trainee psychologists will be asked to submit a role play demonstration of a clinical interview and these tapes will be rated by independent raters blind to participants' study conditions. Participants will also be asked to complete measures of supervisory working alliance, parallel process, and real relationship at three time points: after completing the first session using the protocol, after completing three sessions using the protocol, and one month later. The evaluation of the feasibility and usability of each protocol will be collected in the form of qualitative responses to various open prompts regarding participants' experiences of the intervention and suggested changes to each protocol.

Ethical and Feasibility Considerations

Approval from the University of Wollongong's Human Research Ethics committee has been obtained for study one (HE14/492). This is a completely anonymous online survey and we do not foresee risks associated with participation. For study three, particular consideration will be given to confidentiality and the risks/benefits of participating in the research. As participants will need to be identifiable when randomly allocated to conditions, their questionnaire responses will be coded with a participant number. No personally identifiable information will be attached to the information. All identifiable information (including videos in study 3) will be securely stored and viewed only by blind raters.

In regard to the feasibility of the proposed studies, we are aware of the potential difficulties in recruiting supervisory dyads to participate in study three. We have allocated 18 months for data collection in study three and hope that this time-frame is realistic for recruitment. Further, we plan to recruit participating dyads through the Psychology Clinic at the University of Wollongong. In the event that our target figure seems unachievable, we plan to increase our focus on qualitative data and adjust quantitative analyses to accommodate for a small sample design.

Conclusion

This paper provides an overview of a current research project conducted at the University of Wollongong in New South Wales. The research project contains three major studies which explore the use of dialogical reflexivity interventions in supervision. The findings from this research could provide evidence for the use of this approach in supervision by enhancing practitioners' relational and reflective competencies.

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Clinical Psychology Practice: Art or Science?

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Abstract

Clinical psychology is a field in its youth. Whilst principles of the scientist-practitioner approach are emphasised in training, many clinicians sense that there is also an art to effective practice. This paper sought to examine the ongoing dialectical tension between science and art in psychology. The role and impact of research on current clinical psychology practice is considered, and contrasting concepts such as clinical intuition are also explored. It is possible that clinical psychologists could be considered to be both scientists and artists; however, we are yet to understand how we might integrate these two concepts. This poses difficulty for research and clinicians, particularly those early in their clinical training.

Clinical Psychology Practice: Art or Science?

Those who research psychology have fought hard over the past two centuries to shape the study of the mind into a science, away from its original underpinnings in philosophy. Along the way, there have been various twists and turns in theory, which have subsequently shaped popular therapeutic approaches. Today, most universities place psychology within health or science faculties, whilst in clinical settings, psychological services tend to be viewed as an adjunct to physical medicine. Despite the now massive pool of research and widening public acceptance of psychology as a facet of health care, clinicians themselves seem to be less certain: is practice a direct application of research-derived techniques, or does it also include something else?

Clinical psychology practice as science

Fundamental in clinical psychology training today is the Boulder model, more commonly referred to as the scientist-practitioner approach (Raimy, 1950). This approach places equal emphasis on clinical practice and research, with trainees expected to attain a high level of competence in each (Jones & Mehr, 2007). Ongoing observation and measurement are essential, with trained scientist-practitioners committed to developing and testing hypotheses, gauging progress, and continuously adjusting interventions in response to findings (Shapiro, 2002). In addition, scientist-practitioners use their research training to identify and utilise evidence-based treatments (hereafter, EBTs) to ensure that they use the most effective therapy for any disorder a client presents. These principles are so strongly held that they now constitute an ethical standard; the Australian Psychological Society's Code of Ethics stipulates that psychologists must provide services based on established scientific knowledge of the discipline (Standard B.1.2; 2007).

In accordance with these ideals, Australian training institutions focus on EBTs, primarily cognitive behavioural therapy (CBT) or one of its subsets (Pachana, O'Donovan, & Helmes, 2006). The research providing support for disorder-

specific treatments has burgeoned in recent decades, and as a result there exist a number of treatment manuals that promise good outcomes. Among the most notable are exposure-based CBT manuals for anxiety disorders, which show consistently high efficacy (see Olatunji, Cisler, & Deacon, 2010). However, whilst research-backed manuals are produced in ever-increasing numbers and levels of sophistication, as clinicians we must consider: how well do they translate into practice?

The ability to efficiently disseminate new treatments from academia to clinic is one of the main drawcards of treatment manuals; their ease of use also appeals, perhaps particularly so for new psychologists. However, findings on the impact of manual use on client outcomes have been mixed, suggesting that the transportability of manuals into 'real world' clinical settings is limited (Duncan & Miller, 2005). Whilst many clinical psychologists will incorporate components of manuals into therapy, as few as 10% report that they adhere completely to manualised treatments (Becker, Smith, & Jensen-Doss, 2013). This is perhaps unsurprising when we consider the complexity of communicating core aspects of new treatments to psychologists, and the difference in financial and time constraints in public health settings as opposed to university-supported clinical trials. Also pertinent are variations in clinician attitudes towards manual use, including beliefs about their impact on the client-therapist relationship, flexibility in accommodating individual differences, and restrictions on therapist innovation (Addis, Wade, & Hatgis, 1999; Waller et al., 2013). Whilst manuals are undoubtedly a useful tool for clinical psychologists and one of the central means of disseminating EBTs, how to ensure they are used in a way that preserves their scientifically-ascertained mechanisms for change is a problem that deserves further attention.

This issue may be a symptom of a broader problem within research: perhaps we are yet to perfect the study of clinical psychology. The majority of academic research appears to be geared towards which type of therapy to use, rather than the nuances of conducting therapy: *what* to do, rather than *how* to do it. This is particularly problematic when we consider the 'dodo bird verdict' (Wampold et al., 1997), which purports that, across studies, true differences between comparisons of bona fide psychological treatments are zero. That is, the 'ingredients' unique to different types of therapies don't seem to account for beneficial effects; rather, common factors such

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as the therapeutic alliance and therapist warmth are shared and are responsible for making all therapies equally effective (Wampold & Brown, 2005). In fact, common factors are thought to account for about 30% of variation in client outcomes (Lambert & Barley, 2001). Research into how best to manipulate these factors to improve client outcomes remains ongoing. There are many difficulties inherent in designing ways to study the processes of real world psychotherapy in any depth. However, essential to a true scientist-practitioner approach is successful integration of research and practice (Jones & Mehr, 2007), and whilst this remains the ideal for clinical psychologists, in reality our practice is likely falling short.

Clinical psychology practice as art

Separate to the debate around differential treatment efficacy, many clinicians might agree that there is more to therapy than that which can be found in any manual. We do more than act as the (interchangeable) instrument through which the treatment must be administered, as evidenced by findings around the effects of therapist factors on outcomes. These beliefs also link to the slightly mystic-sounding concept of clinical intuition: psychologists apparently having the ability to 'see through' clients, or to 'go with their gut' to make successful therapeutic decisions they can't quite explain. Magical though such judgements may seem to lay people (and, perhaps, many trainee clinicians), it has been proposed that intuition is similar to more conscious analytic processes; a reflection of professional knowledge that has been internalised via clinical practice (Wittman, Spaanjaars, & Aarts, 2012). However, clinicians themselves continue to consistently describe intuition as a 'feeling,' rather than coherent cognition (Wittman et al., 2012). Thus, it seems likely that many psychologists' own conceptualisations of clinical practice include more subtle sensing or artistic elements, in direct contrast to the ideals of their training in hard-nosed scientific scepticism.

To consider the possibility that psychological practice is more 'artist-clinician' than scientist-practitioner, we must consider some of the key components of art: flexible interaction with the environment; creation of something new using those materials that are accessible. Widespread deviation from manualised treatments certainly suggests some level of flexibility amongst clinicians, and most psychotherapeutic approaches can be interpreted as involving a process of creation: of new thoughts, feelings, behaviour, narratives, self, and meaning. Meanwhile, extra-therapeutic factors such as client social supports, treatment history, functional impairment, and readiness to change (Hubble, Duncan, & Miller, 2008) may be thought of as the 'materials' available to the artist-clinician. It is important to note that, far from being just another element in the mix of psychological practice, these factors account for the most variation in therapy outcomes: around 40% (Lambert & Barley, 2001). Regardless of therapeutic orientation, and with all the flexibility and creativity in the world, perhaps we can really only – much like a tormented artist – work with what we're given.

What then, are the implications of the artist-clinician conceptualisation for improving outcomes? Are flexibility and intuition developed only through experience, so that the best clinicians are those who have practiced in their chosen field for

the longest time? The data firmly contradicts this, with several studies failing to identify any correlation between experience and client outcomes (see Tracey, Wampold, Lichtenberg, & Goodyear, 2014). How do we make sense of this? Perhaps some clinicians are inherently more talented, and therefore, effective, than others. There do exist so-called 'super-therapists,' whose clients enjoy better outcomes than those of the majority of other therapists (Okiishi, Lambert, Nielsen, & Ogles, 2003). In a sample of community-based therapists, clients of the 'best' clinicians improved at rates 50% higher, and dropped out at rates 50% lower, than those assigned to the 'worst' clinicians (Wampold & Brown, 2005). What exactly allows super-therapists to rise above the rest remains unclear; outcomes seem unrelated to variation in factors that are usually pertinent, such as therapist experience and orientation, or client gender, age, or previous treatment (Hubble et al., 2008).

Rather than talent, Hubble and colleagues (2007) argue that the success of individual super-therapists is due to their being deliberate in their practice, as well as their effective use of feedback and reflection. At this point, we seem to have come full circle: the super-therapist is simply taking the scientist-practitioner approach of observation, hypothesis testing, and measurement. Given the shortcomings of clinical research and our continued conflation of success to particular therapies (Hubble et al., 2008), perhaps the perception of 'art' in clinical psychology is a type of defence mechanism, present only to help us explain why so very few of us – the super-therapists – are actually achieving the ideal integration of science and practice, and the results that come with this.

Can we be both scientists and artists?

The pull between empirically-supported knowledge and clinical intuition is one that is familiar to many clinical psychologists; an ever-present 'dialectical tension' (Addis, 2000). We can't quite shake the 'feelings' we have about what we should do in therapy, but for clinical psychologists trained in the rigours of critical thinking and research design, clinical intuition, though valuable, is simply not enough to justify desertion of the principle of psychology as science.

Perhaps a useful analogy for the clinical psychologist's fusion of science and art is the musician. Making music involves knowledge about concepts such as chord construction, tempo, and style, but also a good ear. Thus, in music, too, there exists a recognised dialectic between intuitive and analytical ways of thinking (Swanwick, 1994). Clinical psychologists must hold the scientific and professional knowledge available, but are also justified in utilising their creativity to fill in where our (still limited) knowledge falls short. Perhaps Addis (2000) summed this up most concisely: "know the research literature, use it when it provides guidance, and use your best judgment when it doesn't" (p. 59).

How are we best to train new clinical psychologists?

The implications of this ongoing dialectic for the training of new clinical psychologists constitute some of the major reasons this debate deserves ongoing attention. Firstly, and ignoring the problems inherent in accepting talent as a determinant of therapeutic outcomes, the fact that we are yet

to understand what makes super-therapists 'super' suggests that a training approach focused solely on particular therapies is hugely problematic. Referring again to the idea of a musician, perhaps trainee psychologists must learn the theory and practise set pieces, but also gradually develop their own style and ability for improvisation under the guidance of someone more experienced.

Simply trying to acknowledge both scientific and artistic elements of psychological practice in training, however, is not enough. Trainees must take on large amounts of new knowledge whilst working to develop clinical skills; simultaneously they are discovering the analytic-intuitive tension and trying to determine what to do with it. Whilst most university courses focus on delivering training in EBTs, clinical supervision often aims to develop more subjective aspects of practice; for example, case conceptualisation, management of transference and countertransference, and reflective skills. The contrast between coursework and supervision can serve to widen the science-art divide in the minds of trainees, leading to confusion about how practice should be understood. In order to ensure true scientist-practitioner training is provided, further discussion about what it actually means to integrate research with practice is vital.

Conclusion

It is difficult to argue that only science or only art can contribute meaningfully to the practice of clinical psychology. However, the scientific principles of our training mean that 'fence sitting' is rarely admitted to, and this has inhibited discussion on how to manage clinicians' inevitable experiences of tension. A shift towards more clinically relevant research - that is, research that helps elucidate *how* we can conduct therapy in the most effective way - is necessary to aide this discussion. In the meantime, we as clinicians need to not only sit with, but also to develop our awareness of the contradictions of our practice. It may be uncomfortable, but collectively we seem to have a feeling it must be worth it.

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Ethics and Legal Dilemmas

'Trust me, I'm an expert'

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Abstract

Clinically trained psychologists can provide invaluable professional assistance in legal cases and our opinions are highly respected and regularly sought. This article offers an overview of potential sources of bias in expert evidence along with some advice to psychologists working in, or considering working, as an expert witness. In this context, the article also considers a psychologist's responsibility to adhere to the expert witness code of conduct, in addition to professional and ethical practice codes. The authors submit that delivery of expert evidence, reflecting as it does expertise within a particular discipline, should be regarded as a professional activity. As such we consider whether there should be greater accountability of psychologists working as expert witnesses by our professional and/or registration body.

Background

The modern concept of the expert witness dates back to the 14th century (Dwyer, 2007). In particular, the Industrial Revolution led to the expansion of lawyers in criminal matters (Langbein, 1978). As a result, parties began to collect and present their own evidence while also developing and refining techniques to cross-examine witnesses. The courts' increasing need for expert knowledge, and the proliferation of experts in criminal matters, saw the development of highly intricate rules governing the inclusion of evidence to what had been observed or seen (the so-called 'hearsay rule'), whilst allowing evidence based on specialised knowledge of a subject matter relevant to a case (opinion evidence).

Who is an Expert?

An expert witness is a person who has specialised knowledge based on their training, study or experience. By virtue of this specialised knowledge, the expert witness is permitted to give an opinion in legal proceedings on matters that are within their area of expertise (Evidence Act, 1995). By contrast, lay witnesses are restricted to speaking about information they have experienced first-hand. In this regard, a treating psychologist called to give evidence in a case they are dealing with, would not necessarily be seen as an expert witness. Of course, psychologists acting in this manner are nonetheless still giving evidence based on specialist knowledge such that the distinction can become blurred. It is however important under these circumstances for psychologists to be clear about whether they are acting as a witness of fact (e.g., details about therapy and/or what the patient said), or as an expert witness. A treating psychologist can offer invaluable insights and opinions relevant in a legal matter. However, it may be inappropriate for a busy clinician to be drawn into the role of a formal expert witness. The psychologist may find themselves swamped with requests for

extensive documentation reviews and the need to answer questions that were not the focus of treatment. This may also negatively impact on the ongoing relationship with a client. We would strongly advise a psychologist unsure of their position to seek legal clarification before proceeding further.

Experts and Impartiality

For some time, expert witnesses across a multitude of professions have enjoyed unparalleled acceptance, their credentials unchallenged and their opinions untested (Landsman, 1995). Over time, the increasing reliance on experts, however, was accompanied by increasingly polarised evidence, with 'hired guns' badly denting judicial and public confidence in experts generally (Landsman, 1995).

In England, Lord Woolf completed a far-reaching review and overhaul of the civil justice system (Woolf, 1996). From Woolf's reforms emerged a code of conduct that stipulated the unequivocal requirement of an expert's duty to the court. Similar reviews were conducted within the criminal and family court sectors. Moreover, codes of conduct specifically highlighted the need for impartiality or objective evidence reflecting the emerging concern of bias in expert evidence.

In NSW, under the *Duty to the Court*, the code also makes clear that:

- (1) An expert witness has an overriding duty to assist the court impartially on matters relevant to the expert witness' area of expertise.
- (2) An expert witness' paramount duty is to the court and not to any party to the proceedings (including the person retaining the expert witness).
- (3) An expert witness is not an advocate for a party.

It is imperative that experts familiarise themselves with the code of conduct relevant to their jurisdiction and legal context. Experts must agree to be bound by the relevant code of conduct and there is a requirement to include a written statement to this effect. Similarly, there are also a number of

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codes of practice, that provide guidance in reporting within specific areas, e.g., Australian Standards of Practice for Family Assessments and Reporting (2015), Motor Accident Authority Guidelines on Neuropsychological Assessment (2013). Psychologists should familiarise themselves with practice guidelines relevant to their field of expertise and jurisdiction.

At a professional level, psychologists, including those acting as expert witnesses, are also mandated to practice under the principles that underlie our *Code of Ethics*. The Psychology Board of Australia has developed policies to provide guidance to the profession and has adopted the Australian Psychological Society Code of Ethics (APS, 2015). Additionally, Section 3(2) of the national law provides that national registration and accreditation schemes serve to ensure that, 'only health practitioners who are suitably trained and qualified in order to practise in a competent and ethical manner are registered' (HPRNL, 2009).

Bias in expert evidence

Psychologists providing expert evidence must be aware of the potential for sources of bias in providing their opinions. Indeed, there is mounting evidence for bias in expert evidence collated from a number of sources. These include analysis of published case law (see *Vernon v Bosley*, 1997; *Langmeil & Grange*, 2011), public outcry from high profile cases of false imprisonment leading to post-mortem examination of expert evidence (see *R v Clark*, 2003; *R v Cannings*, 2004; *R v Anthony*, 2005), judicial surveys of bias in experts (Freckelton, Reddy & Selby, 1999; Krafta, Dunn, Johnson, Cecil & Miletich, 2002), investigations into the quality of expert reports and empirical research developed to distinguish intentional and deliberate attempts to distort evidence (e.g., see Kassin, Dror, & Kukucka, 2013; Murrie, Boccaccini, Guarnera, & Rufino, 2007, 2013; Murrie et al, 2009, Otto, 1989), from unconscious bias

(heuristics). There have also been cases in which experts that have provided biased evidence have faced professional disciplinary investigations (Early Day Motion, 2010-12) and possible legal sanctions (the awarding of costs against them).

Unconscious forms of bias

Bias is often multidimensional and the product of unconscious errors of human-decision making. Psychologists (and indeed all health professionals) working clinically and/or as an expert witness are subject to such cognitive biases, even though scientific methods are intended to reduce or remove such influence.

Under certain circumstances, decisions can be made on the basis of cognitive processes ('heuristics') that impact on the interpretation of information or the weighing up of solutions to reach an outcome or decision. Heuristics therefore represent the intellectual shortcuts to decision-making and are most likely to occur under constraints of time, knowledge or information or in the face of uncertainty. The so-called 'rule of thumb', or educated guessing, enables a decision to be reached with speed, in spite of the outcome not always reflecting accuracy. The work of Dror and Cole (2010) is also worthy of an introduction. Their research notes that errors of reasoning frequently contaminate opinions and are widespread, even by well-intentioned experts.

An understanding of such error-prone attributions provides greater insights into intentional and unintentional foundations of bias in expert evidence. It is well worth revisiting this literature when working as an expert witness so that psychologists are aware of the possible influences of such biases on the provision of an opinion. Some examples can be found in Table 1.

Table 1. Examples of Unconscious Bias.

| | |
|----------------------|--|
| Confirmation Bias | The tendency to seek, look for information that supports existing beliefs, and reject data that go against what you believe. The work of Dror and Cole (2010) provides several examples of this type of bias in forensic pathology noting that cognitive biases can be positioned in the direction of affirmation and have more leeway to influence and distort, such that experts explain away or dismiss evidence that no longer support an already formed belief. |
| Prosecutors' Fallacy | An error of statistical reasoning that can have severe consequences and has resulted in miscarriages of justice. In the case of Sir Roy Meadow (Meadow v General Medical Council, 2006) he calculated the probability for sudden infant death (SIDS) occurring as one in 8,500. He further calculated that the likelihood of SIDS happening twice in the same family could be calculated by squaring the probability of it occurring once. Subsequent analysis by statistical experts said this would only be valid if we could be sure if SIDS always happened by chance and independently of family factors such as genetics and environment, which is not the case. |
| Anchoring | The tendency to rely too heavily on information gained early on in the decision-making process to make a decision i.e., 'jump to conclusions'. |
| Representativeness | The probability, or frequency, of a hypothesis is judged on what an individual knows about the probability of other similar cases rather than on statistical methods. |
| Framing | Decisions made by an individual can be systematically altered by the manner in which a problem is formulated. The effects have also been demonstrated empirically. Tversky and Kahneman (1981) note the perception of decisions, problems or evaluation of probabilities and outcomes can be manipulated when the same problem is 'framed' in differing ways. |

Conscious bias

There is little doubt that financial motivation is an extremely potent form of bias in expert evidence. It has been commonly alleged that monetary incentives primarily (or completely) motivate the testimony offered by witnesses characterised as 'hired guns' (Mossman, 1999).

Psychologists should become familiar with cases in which experts have 'confessed' to slipping into the role of 'hired gun'. Confessions are rare, but do exist. The expert in *Lander v Higgins* (1954) was asked, "Is that your conclusion; that this man is a malingerer?", and responded, "I wouldn't be testifying if I didn't think so, unless I was on the other side, then it would be a post traumatic condition". As such, the 'expert' clearly admitted that his opinion was tailor-made for his retaining party.

As far as confessionals go, the Steven Moss publication *Confessions of an Expert Witness* (2003), is particularly illuminating and highly recommended reading for any psychology expert. He writes of being intrigued by colleagues who acted as expert witnesses, funding second homes, sporting designer suits and who were also afforded considerable prestige within the firm, and that he was consequently corrupted. He felt occupationally pressured to achieve their status and income. This frank account represents a startling picture of the evolution of bias in expert evidence and it is well worth reviewing.

Deirdre Dwyer has published numerous erudite articles on the issue of expert evidence, emphasising the cause, manifestation and management of conscious bias in expert evidence. A review of her work is highly recommended. According to Dwyer (2008), experts who wish to progress their career to further sources of income and/or to gain a reputation as a particular party-based expert (whom she says is seen to assist a party to the greatest extent) are vulnerable to this type of bias. The specialist, she notes, who wishes to commercialise their expert witness consultancy has a clear interest to gain a reputation as an expert that assists their instructing party to the greatest possible extent.

Unconscious bias arising from heuristics may of course be interactive and contributory as manifestations of the more deliberate forms of bias and has to some extent been acknowledged in the models of expert bias that have emerged (Edens et al., 2012).

Studies into the quality of expert evidence

There have been recent studies examining the quality of expert evidence. Of particular concern is research undertaken in the UK by the forensic psychologist Professor Jane Ireland, who amongst other things set out to assess the quality of expert psychological assessments presented in Family Courts (Ireland, 2012). She was granted access to over 126 expert psychological reports from three separate courts, and rated the reports in accordance with how well they adhered to the UK Civil and Procedure Rules. They were also rated according to a number of criteria, i.e., the inclusion of

data from which inferences were drawn, the linking of an opinion to stated evidence in the report, the degree to which the expert had evaluated the quality of that evidence, whether a range of opinions were offered when necessary, whether opinions offered were related to theory and avoided reporting of allegations as facts. The professional credentials of the expert witnesses were also evaluated, including the degree to which an expert had experience within the field relevant to the legal matter (based on the expert's qualifications and experience) and also the degree to which the expert necessarily had competence to undertake an assessment and confine their opinion to their field of expertise.

Ireland (2012) indicated concerns regarding both the qualification of some experts, (one-fifth not deemed sufficiently qualified with evidence of unqualified experts providing psychological opinion) and the poor quality of submitted reports (two-thirds rated as poor or very poor). Ireland's findings led to significant professional backlash, and attempts to discredit her were of such magnitude that the matter was raised in the UK Parliament (Early Day Motion, 2010-12). Her work highlights the sensitive nature of investigations into expert evidence but also represents much needed and professional recognition of the need to investigate this further.

Judicial surveys of expert evidence

Concern about bias in expert evidence led the prominent barrister, Professor Ian Freckleton and colleagues (1999) to survey the entire Australian judiciary on this issue. His findings revealed that the judiciary regarded bias as a significant problem in the fact-finding process. Many respondents made comment as to the high number of experts being affiliated with the retaining side and overall, the partisanship of experts was all too often viewed as 'a given'.

Not surprisingly, Freckleton noted that if bias was so prevalent, such that over a quarter of judges in his survey encountered it 'often', then this would have ramifications for the functioning of the civil and criminal process, especially if the bias is not readily detectable or measurable.

Post-mortem examination of expert's opinions and professional anctions

Post-mortem examination of expert opinion has also been illuminating. In a number of high profile cases, expert opinion has subsequently been found to contain serious errors and/or evidence of bias. Notable amongst these are forensic medical examiners. It goes without saying though that when expert evidence is later found to be flawed, the consequences are particularly harrowing for those falsely convicted, but this also leaves serious doubts as to the credibility of experts and for the administration of the justice system.

Professor Sir Roy Meadow serves as a notable example. Meadow, a leading UK based paediatrician, gave evidence in over 81 SIDS cases. His evidence (based on the probability of more than one case of cot death in a family) led to juries finding it impossible to conclude that a child had died

naturally from SIDS. However, the evidence on which he based his opinion (his statistical analysis of the probability of more than one child in a family dying of SIDS) was later found to be grossly misleading and inaccurate. Meadow's subsequent removal from the General Medical Council register served to protect the public. However, in a High Court ruling, Justice Collins subsequently overturned the General Medical Council's decisions on the basis that Meadow had acted in 'good faith.' In this regard, his evidence was not found to be deliberately partisan but inaccurate and consequently misleading.

The evidence of pathologist Dr Michael Heath in a number of murder trials is also notable in this regard. Like Meadow, his evidence was subsequently found flawed and unreliable (see *R v Clark* [2003]). Heath later admitted that he made a number of errors in his analysis of the cause of death. He consequently faced 20 disciplinary charges, which were upheld on appeal, and his professional performance was found to fall short of the standards required of forensic pathologists by the Secretary of State.

Both these high profile cases led to a huge public outcry as a result of the false conviction and the lengthy imprisonment of innocent people. In the case of Sally Clark, a lawyer, the evidence from Meadow led to a guilty verdict for the murder of two of her sons. She was imprisoned in 1999 but released in 2003. She never recovered, however, and after developing psychiatric symptoms she later died in 2007 from alcohol poisoning.

These cases also remind psychologists that their behaviour in court can have severe professional ramifications.

Implications for Our Profession

We submit that the legal system is ill-equipped to deal in isolation with the problem of bias. The authors take the view that the delivery of expert evidence, reflecting as it does expertise within a particular discipline, should be regarded as a professional activity. Firstly, psychologists have a duty to be particularly vigilant to ensure they maintain their ethical and legal obligations, secondly, that the practice of psychologists working within the legal area be open to professional scrutiny and regulation.

We would argue that there is a need for further consideration into the possibility of greater accountability of expert witnesses to the professional and/or registration body. This might be achieved through the development of a formalised expert witness register and/or special interest expert witness group to oversee continuing education, professional development, and to maintain auditing and reporting mechanisms for psychologists acting as expert witnesses. There is clearly a need to recognise and develop mechanisms to curb the more virulent, deliberate forms of biased evidence in order to protect not only the public, but to uphold our obligations to ethical codes and avoid damaging our profession. The development of (and warning of) sanctions so grave, could help to act as powerful incentives to deter those otherwise prone to the seductive allure of financial gain.

Advice to Psychologists

The opinions offered by clinically trained psychologists have the potential to alter legal outcomes. Experts, therefore, have a significant responsibility to provide their opinions with meticulous care and honesty. Crucially, psychologists acting or thinking of working within the role of an expert witness need to be mindful of relevant codes of conduct, and ethical codes in addition to the various sources of potential bias. In particular, factors such as impartiality and the overriding duty to the Court must remain at the forefront for any psychologist who acts as an expert witness. Reflecting on one's own practice, supervision from experienced experts, and staying abreast of developments in the literature and methodological techniques, shall surely arm the psychologist with the means to make an important and unbiased contribution to the justice system. Greater input and support from registration and professional bodies to implement professional development, training and regulation of psychologist expert witnesses will also be a positive step forward for our profession and help us bridge the nexus between psychology and the law.

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SURVEY

Australian Clinical Psychologist

The editorial team would like to invite our readers to complete a brief online survey about the *Australian Clinical Psychologist*. The survey will help the Editorial Board understand who is reading the journal, including professions other than clinical psychology, how the journal is being used, and to plan future issues. Our aim is always to provide informative articles that are useful and relevant to you, so your input is important.

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Thank you for your feedback.

June 2016 Issue

ADDICTIVE DISORDERS

Contributions are invited from those with clinical, psychotherapeutic, research, or other expertise in this area by 28 February 2016.

Book Review

Clinical Handbook of Couple Therapy (5th Ed.). Gurman, A. S., Lebow, J. L., & Snyder, D. K. (Eds.). (2015). New York: Guilford. 729 pp.
ISBN 978-1-4625-1392-5.

The *Clinical Handbook of Couple Therapy* was first published under the editorship of Neil Jacobson and Alan Gurman in 1995. The handbook was one of the first truly comprehensive summaries of the field of couple therapy, and became very influential. Twenty years have passed, and sadly the original editors have both died. Neil and Alan were giants of the field of psychotherapy in general and couple therapy in particular. However, their shared vision of a book that draws together much of the thinking in couple therapy, and represents the diversity of approaches to couple therapy, lives on in the handbook's 5th edition published in 2015. The 5th edition was begun under the editorship of Alan Gurman, and after his recent sudden death, the editing was completed by Jay Lebow and Doug Snyder.

In keeping with its original editors' aspirations to be comprehensive, the 5th edition of the *Clinical Handbook of Couple Therapy* is quite a tome. There are 26 chapters spread across 701 pages, plus an extensive 28 page index. The book is structured into two major sections of 13 chapters each: models of couple therapy, and applications of couple therapy.

The first section on models of couple therapy consists of a chapter on the history of couple therapy written by Alan Gurman, and then 12 chapters on different approaches to couple therapy. All 12 chapters on models of couple therapy include similar structures: a description of the key assumptions of each approach, the conceptualisation within that framework of healthy versus dysfunctional couples; the presumed mechanisms of change; treatment applicability and empirical support, and a case illustration. The editors have done well to get the authors to follow a similar structure, which allows interesting comparisons across models. That structure will be useful in teaching couple therapy to graduate classes.

The criteria for including particular chapters in the handbook are not obvious. Some chapters on models of therapy describe evidence-based approaches that have been replicated across many studies as effective, such as emotionally focused couple therapy and cognitive-behavioural couple therapy. However, most of the chapters on models describe approaches that lack any clear evidence base for their efficacy. Some of the approaches described have been influential historically (object relations couple therapy, Bowen family) and/or proved popular at particular times (e.g. strategic couple therapy, narrative therapy). Some chapter authors clearly explicate hypothesised

mechanism of change and evidence for or against those hypothesised mechanisms, whereas other chapters were vague and provided no evidence. Some chapters did a great job summarising a lot of evidence on efficacy succinctly, others seemed to dismiss the relevance of research for evaluating their approach. Edited books can often be uneven in quality, but the weaker chapters in the first half of the book were disappointing.

The second half of the book is likely to be of greater interest to practitioners. It covers areas of couple therapy practice that are well established as effective by research, but often not included in routine practice, such as the use of couple therapy in the treatment of alcohol problems, depression, and managing chronic health problems. There are other chapters on applications of couple therapy that are relatively new, but developing an evidence base, such as couple-based treatment of PTSD, borderline personality disorder and partner aggression. I particularly liked three chapters on couple therapy encompassing diverse relationships. These chapters cover working with stepfamilies, sexual minorities and intercultural couples, respectively. The ideas discussed are of value to all couple therapists.

There are a few areas of content omission that seem surprising, for example, couple therapy in treatment of substance abuse other than alcohol, and the interaction of couple problems and child behaviour problems. Several earlier editions of the *Clinical Handbook of Couple Therapy* included chapters on early intervention and prevention. There are none in the latest edition, an interesting decision about what to exclude.

I think this is a volume that could be useful as a text for a graduate class on couple therapy. It would need supplementation with greater detail on particular approaches to guide acquisition of practical skills. Practitioners will find the second half of the book has some very useful overview chapters. Readers will find quite uneven quality across chapters in the first half of the book.

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Editorial Policy

Aim

The Australian Clinical Psychologist (ACP) is the official e-journal of the Australian Clinical Psychology Association (ACPA). The journal provides for the dissemination of knowledge on topics of interest informative to clinical psychologists. Its focus is on the latest clinical theory and research relevant to clinical practice including assessment, treatment intervention, training and professional issues. Emphasis is placed upon practical application.

Submissions to the ACP may include:

- Letters to the Editor
- General articles,
- Letters, opinions and comments
- Articles of particular ethical and/or legal interest to the profession
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- Theoretical perspectives
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From time to time, the ACP will focus upon topics or issues of interest and call for submissions accordingly. The ACPA Editorial Board welcomes contributions and suggestions for topics from the membership.

The Australian Clinical Psychologist is published twice per year.

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3. The topic is informative and adds to the knowledge and practice of clinical psychology.
4. The latest evidence-based best clinical practice / research is presented.
5. An impartial, but critical analysis of the topic is given.
6. The main literary sources are evaluated.
7. Referencing is adequate and up-to-date, and in accordance with APA (6th ed,) style.

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