Clinical psychology trainees' experiences of supervision

Michelle Waldron & Michael Byrne

A survey of clinical psychology trainees profiled their experiences of clinical placement supervision and whether these facilitated development of their competencies. They also highlighted the importance of positive feedback and constructive criticism, reflective supervision, supervision reliability and acknowledgement of transference.

CLINICAL PLACEMENT supervision is regarded as the cornerstone of training for psychologists in trainee clinical psychologists (hereafter referred to as 'trainees'). Clinical supervision is 'a relationship-based education and training' (Milne, 2007, p.440) that is developed and maintained through collaboration between the trainee and the supervisor (Milne & Grace, 2001). For many years, it has been accepted that satisfaction with supervision received is a necessary condition for high quality staff training (Kirkpatrick, 1967, as cited in Radcliffe & Milne, 2010). However, as highlighted by East (2011), clinical supervision is an extremely broad area, and while it is difficult for supervision to be perfect every time, there is some indication of what, in the supervisee's opinion, would make for good and valued practice. Building on previous research into trainees' clinical competency set and supervisory activities (O'Callaghan & Byrne, 2011) and trainees' perceptions of the supervision they receive (Milne, 2008; Wilson, 2007), this current study aimed to profile trainee perceptions of their supervisors' skills, their experiences of supervision received, and the relationship between these.

Method

Materials

In addition to demographic type questions (e.g. year of training, type of placement, teaching institution, clinical placement number (initial, second, third, etc.)), a 36-item survey questionnaire was used. It consisted of three distinct sections.

Section A: Your supervisor's skills

Adapted with the authors' permission for this study, the 17-item Supervisor: Assess Yourself SAGE (Supervision: Adherence, and Guidance Evaluation; Milne, Reiser, Cliffe & Raine, 2010) was used as a rating tool to assess trainees' supervisors' competence on a range of supervision skills, using a 7-point rating scale. The answers were scored as incompetent (0–1), competent (2–4), and expert (5–6). Cronbach's α for SAGE has been reported as 0.98 (Marrinan & Milne, 2011).

Section B: Your own competence

Drawing on various documents (e.g. BPS, 2010), the authors of this study developed an 8-item scale to assess trainees' personal competence on a range of skills, based on the supervision they had received from their current supervisor, again using a 7-point rating scale. The answers were again scored as incompetent (0–1), competent (2–4) and expert (5–6). Cronbach's α for this scale in this study was 0.86.

Section C: Your experience of supervision

The 11-item REACTS: Trainee's Feedback Form (Wilson & Milne, 2006) was used to profile participants' perceptions of their supervision experience with their current supervisor, including duration, frequency, management and support of supervision. This used a 6-point scale (1 = 'Strongly disagree'; 5 = 'Strongly agree'; N/A = 'Not applicable'). Cronbach's α for this scale in this study was 0.91. An additional two questions asked participants to detail the most helpful events that

Table 1: Mean, highest possible score, standard deviation and Cronbach's for the three sections.

	Mean score	Maximum score	Standard deviation	Cronbach's alpha
Section A	69.6	102	11.6	.95
Section B	25.3	48	6.0	.86
Section C	35.2	45	7.17	.91

occurred in their supervision sessions, and if they had any other comments (e.g. unhelpful events, unresolved problems).

Participants

Trainees from each of the four doctorate in clinical psychology training programmes in the Republic of Ireland (e.g. National University of Ireland Galway, University of Limerick, University College Dublin and Trinity College Dublin) were asked to participate.

Procedure

Using a combination of personal trainee contacts, searching the Health Service Executive e-mail address database (www.hse.ie/eng/staff /Resources/email) and asking clinical training programme administrators, the second author collated a list of all 112 trainees names and e-mail addresses. The first author then sent a cover letter and the survey questionnaire to 111 trainees via e-mail. One potential participant was excluded from the survey because they were on extended sick leave. The former outlined that only the first author would have access to individual responses and would analyse the data. As reminder e-mails (to initial non-responders) improve response rates (James, 2007), a follow-up reminder e-mail was sent two weeks after the initial e-mail to all non-responders.

Of the 111 trainees contacted by e-mail, 44 (39.6 per cent) returned completed questionnaires. Nineteen participants were in their first year of training, 14 were in their second year of training and 11 were in their third year of training.

Analysis

The data collected were analysed using Predictive Analysis Software 18.0 (PASW Statistics 18.0, formerly known as Statistical Package for the Social Sciences or SPSS Statistics). Descriptive statistics were computed for the variables, as well as correlations and t-test performed, followed by analysis of the distribution of the total scores, frequency distributions for each item, and missing values. Content analysis (Braun & Clarke, 2006) was conducted on qualitative data where the participants were free to describe helpful and unhelpful events/issues that arose for them during their supervision sessions. Due to time pressures, these were not co-rated.

Results

Combining all participant data together, total Section A, B and C scores were, respectively, M = 69.6 (SD = 11.62), M = 25.29 (SD = 6.0), and M = 35.2 (SD = 7.17). Table 1 illustrates these, along with highest possible scores and Cronbach's α for each section of the questionnaire.

As highlighted by the mean scores for Section A items (see Table 2), supervisors were ranked highest on competence in observing (M = 4.4), followed by working collaboratively, having a facilitating style, and in formulating and questioning (all M = 4.3). They were ranked lowest on competence in agenda-setting (M = 3.7), and both receiving feedback well and managing supervision sessions effectively (both M = 3.9).

The relationship between trainees' perception of their present supervisor's skills and their experience of supervision was investigated using Pearson product-moment correlation coefficient. Preliminary analyses indicated there were no violations of the assumptions of normality and linearity. A strong positive correlation between the two variables was evident (r = .62, n = 44, $p < .005$).

Table 2: Ratings of supervisors' competencies

Their supervisor...	Mean	Standard deviation
...is competent at observing	4.4	.7
...works collaboratively	4.3	.9
...has a facilitating style	4.3	.8
...is competent at formulating	4.3	.9
...is competent at questioning	4.3	.7
...is competent at discussing	4.2	.8
...is competent at listening	4.2	10
...is interpersonally effective	4.2	1.0
...is competent at giving feedback	4.1	1.0
...is competent at prompting	4.1	1.0
...is a competent teacher	4.1	.8
...is competent at training	4.1	1.0
...is competent at demonstrating	4.0	.9
...is competent at evaluating	4.0	.9
...receives feedback well	3.9	1.1
...manages sessions effectively	3.9	1.1
...is competent at agenda-setting	3.7	1.1

Using Section B total scores, an independent-samples t-test indicated that there was a significant difference in scores for trainees in Year 1 (M = 23.81, SD = 5.1) and trainees in Year 3 (M = 28.64, SD = 8.08; $t(28) = 2.0$, $p = .05$). The magnitude of the difference in the means was small ($\eta^2 = .01$).

Thematic analyses

From thematic analysis on items 6 and 7 in Section C, four primary themes emerged, with numbers in brackets representing the number of responses that fell into each category, with representative verbatim examples given in each case.

1. Positive feedback and constructive criticism (8)

Respondents detailed how they found positive feedback followed by constructive criticism encouraging:

> *'My supervisor is very encouraging and likes to pick out and discuss the positives of my work regularly. I find this especially useful for building my clinical confidence.'*

> *'She puts the positives before any constructive criticism – it has made a huge difference.'*

> *'Feedback should start with the positives of what you have done! Very demoralising to have positive aspects brushed over and focus only on what was left out or done wrong.'*

2. Reflective supervision (7)

Respondents indicated that reflective supervision was helpful in developing one's own reflective capacity to work more effectively with clients:

> *'My supervisor uses a model of reflective supervision, which is especially useful in helping me to develop my own reflective capacity and it is helping me reflect upon all the interpersonal skills constantly at use with all my clients.'*

> *'Emphasis on reflective practice, focus on the process of clinical work.'*

3. Reliability (3)

Respondents consistently highlighted the importance of regular, scheduled and uninterrupted supervision sessions with their supervisor.

> *'Supervision needs to be regular to be of maximum benefit.'*

'Consistently irregular supervision and consistently insufficient supervision time for a supervisor.'

4. Acknowledgement of transference (3)
Participants suggested that acknowledging transference during sessions makes them more mindful in future dealings with clients:

'Supervision that focuses on process and transference issues has facilitated me to engage with individuals in a more mindful and reflective way.'

'It is most useful when we reflect on the processes between myself and the client. It helps me to separate what are my issues versus the client... it is helpful to be able to differentiate between what is me and what is transference.'

Discussion

This research firstly aimed to investigate trainees' perceptions of their supervisor's skills. Using the 17-item Supervisor: Assess Yourself SAGE (Milne et al., 2010), most of the participants agreed that their current supervisor demonstrated the listed supervision skills (see Table 2). The lowest rated items were 'Receives feedback well', 'Manages sessions effectively', and 'Is competent at agenda-setting', indicating that these were relatively weak competencies. However, the differences between ratings of different supervisors' competencies were small, with a difference of 0.7 (on a 7-point scale) between the highest and lowest rated competencies. Hence, these findings need to be interpreted with caution.

The more competent they perceived their supervisor to be, the better they rated their experience of supervision.

This study also found a strong positive correlation between trainee perceptions of their supervisor's skills and their experience of supervision. The more competent they perceived their supervisor to be, the better they rated their experience of supervision. This finding supports the concept that clinical supervision is 'a relationship-based education and training' (Milne, 2007, p.440).

This current study also found a significant difference between Year 1 trainees' ratings of their own clinical competencies and that of Year 3 trainees. Assuming that this finding is not due to cohort effects, it suggests that trainees' perceptions of competency development increases over the course of their training. However, it does not inform as to what contribution, if any, the quality of supervision had on competency development. That most respondents in the current study were in their first year of clinical training may suggest that at the start of their training, trainees consider supervision to be important process, and that they are keen to reflect on this process. Indeed, one might expect trainees in their first year to be more dependent on the quality of supervision they receive. Future research in this area is warranted.

Trainee responses to the open-ended questions in Section C, describing helpful and unhelpful events/issues that arose for them during their supervision sessions, unearthed a variety of themes including feedback, reflective supervision, reliability and transference. These findings support the hypothesis that supervision is a broad area, and that there are varying personal preferences as to what supervision styles and behaviours trainees find most beneficial. What one trainee finds useful, another may not. However, some of the themes identified in this study have also emerged in other recent studies on supervision. These include supervisees' desire for supervisors to be flexible, empathic, approachable and considerate when providing negative feedback, and to be supportive (Cushway & Knibbs, 2003; East, 2011). It would appear that, in this context, clinical trainees in the Republic of Ireland place an emphasis on the relationship between the supervisor and supervisee, as opposed to a more task-orientated model of supervision. Considering that the Psychological Society of Ireland (PSI, 2009) still uses a structural model of core-plus-specialist placements when accrediting doctoral programmes in clinical psychology (rather than the more flexible competency-based model that is used by programmes in the UK), this emphasis on

the relationship between supervisor and supervisee is noteworthy. It would be interesting to further examine in future research if this is unique to trainees' experience in Ireland (relative to the UK).

This study's findings highlight ways in which supervisors can improve their supervisory practice as perceived by trainees. Both supervisors and trainees are encouraged to use the questionnaires developed by Milne and Reiser (2008) and Wilson and Milne (2006) or other relevant questionnaires to continually assess their practice so that trainees' placement learning is optimised. Additionally, there is an onus on training programmes to monitor whether supervisors are providing good quality supervision that facilitates the development of trainees' competencies. Within the 'core placement' model, trainees need to work a minimum total of 390 clinical days (over a period of three years) and a minimum of 60 days in each core and specialist placement, and they are assessed on whether they 'pass' each placement (O'Callaghan & Byrne, 2011). Therefore, trainees cannot afford even one sub-standard experience of placement supervision during their training. It is hoped that this paper will encourage supervisors to reflect on their supervisory practice and how they can enhance their trainees' learning on clinical placement.

Authors

Michelle Waldron, Research Assistant, Roscommon Service Area, Health Service Executive West, Ireland

Michael Byrne, Principal Psychology Manager, Roscommon Service Area, Health Service Executive West, Ireland; michaelj.byrne@hse.ie

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