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CBT supervision behind closed doors: Supervisor and supervisee reflections on their expectations and use of clinical supervision

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Abstract

Objective: Previous surveys examining the routine practice of cognitive behavioural therapy (CBT) supervision have consistently found that methods utilised by supervisors often drift from expert recommendations. Harmful or ineffective supervision are two potential consequences of practices which overlook one or more of the normative, formative or restorative functions. Given that most of the research to date in this area has used quantitative methods, it is important to gain a deeper understanding of the reasons why everyday supervision differs so greatly. One way of achieving this is through exploring the "lived experience" of supervisors and supervisees.

Method: Semi-structured interviews were conducted with (N = 10) supervisors and supervisees, and data were analysed using interpretative phenomenological analysis.

Results: Three superordinate themes were identified: "*inconsistency of approaches*," *"autonomy"* and *"the relationship."* The findings revealed that supervisors are practicing very differently from one another, despite awareness of expert guidance. There were some indications of supervisory drift, characterised by supervisor resistance to hierarchical structures and supervisee avoidance due to concerns about their safety within the relationship.

Conclusion: Further research is needed to better understand how supervision dyads can identify and manage dysfunctional supervision practices.

KEYWORDS
CBT, self-reflection, supervision, supervisory drift

1 | INTRODUCTION

Supervision is an activity that takes place across all health and social care disciplines, including clinical and counselling psychology, counselling, social work, nursing and specific psychological therapies such as cognitive behavioural therapy (CBT) (Hawkins & Shohet, 2000; Milne, 2017). Clinical supervision plays a significant role in the training and monitoring of CBT therapist standards, including reviewing practitioner competence (e.g., Blackburn et al., 2001; Roth & Pilling, 2008) and their adherence to evidence-based practice (e.g., Clark, 2011).

The role of a supervisor requires a range of skills that shift continually, based on the present needs of the supervisee (Pretorius, 2006;

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Roscoe, 2021b). According to Milne (2017), the supervisory relationship is a "highly collaborative, collegial and committed partnership, one that is task-focused and highly professional (e.g., interpersonally effective, confidential, empathic and warm). It is intended to support (restorative function), guide (normative function) and primarily to develop the supervisee (formative function)" (p. 98). This suggests that there will be a different emphasis placed on normative, formative or restorative needs across supervision sessions, reflecting the varying challenges faced by supervisees and their individual learning needs (Grey et al., 2014; Roscoe, 2021b). For example, in recognising the distress that arises from the supervisee's own reactions to a client, the supervisor attends to their restorative needs by suggesting some self-reflection on the supervisee's part, such as drawing out a formulation of interaction with this client in a therapy session (see Moorey & Byrne, 2019). Another supervision session might focus on formative needs by considering how best to explain an intervention to their supervisee (i.e., should they direct them to read a journal article, book chapter or to watch a YouTube demonstration or should they engage in a role play with the supervisee and model how to undertake the therapeutic task?). Finally, the supervisor may be called upon to wear the "normative" hat, whereby they must provide a pass or fail evaluation of the supervisee's clinical work. An example of this is formally rating the competence of a supervisee's audio- or video-recorded therapy session using an approved measure, such as the Cognitive Therapy Scale–Revised (CTS-R) (Blackburn et al., 2001).

1.1 | Markers of best practice in CBT supervision

At face value, CBT supervision shares many of the structural features of CBT treatment (Armstrong & Freeston, 2006; Kelly & Hassett, 2021; Prasko et al., 2012). For example, according to expert consensus within the field, it is recommended that supervision has an agreed agenda, specific task focus and review of learning, which mirrors the format of a therapy session (Gordon, 2012; Pretorius, 2006). The obvious advantage of this "reflexive" approach (Milne, 2008) is that it is parsimonious; however, it has been criticised for overlooking the complexity of being a supervisor (Milne, 2008: Reiser et al., 2018). In response to the perceived shortcomings of a purely reflexive approach, there has been a move in recent decades towards establishing more stringent markers for high-quality CBT supervision (Milne, 2017; Roth & Pilling, 2008; Turpin & Wheeler, 2011). This has included Roth and Pilling's (2008) supervisor competencies, a literature review by Pretorius (2006), Gordon's ten steps paper (2012) and the establishment of specific CBT models of supervision (e.g., Armstrong & Freeston, 2006; Corrie & Lane, 2015). Milne and colleagues (e.g., Milne, 2008; Milne & Dunkerley, 2010) have led the way in developing an evidence base for supervision, culminating in the Evidence Based Clinical Supervision framework (EBCS) (see Milne, 2017). This has included a theory of effective supervision—the tandem model (Milne & Dunkerley, 2010), where the supervisor and supervisee are likened to two cyclists on a tandem bike, with the front wheel representing the behaviours of the supervisor, and the rear wheel representing Kolb's (1984) experiential learning cycle (Milne & Dunkerley, 2010; Milne, 2017). Milne and Reiser (2014) also developed a competence measure, the Supervision Adherence and Guidance Evaluation (SAGE), which can be used to assess supervisory competence in front and rear wheel skills. SAGE utilises the Dreyfus scale and Likert ratings similar to the Cognitive Therapy Scale–Revised (CTS-R) (Blackburn et al., 2001). Reiser et al. (2018) subsequently developed a shorter version of the scale in recognition of how time-consuming it could be to undertake the original version.

In England, the rollout of the Improving Access to Psychological Therapies (IAPT) programme (National Collaborating Centre for Mental Health, 2019) saw an unprecedented increase in the training of CBT practitioners and with this came new guidance on the use of supervision (Liness & Muston, 2011; Turpin & Wheeler, 2011). Practitioners within IAPT services would receive two forms of supervision—case management, where the focus was on monitoring patient recovery rates, and clinical supervision, where the development of competence and adherence to specific treatment protocols is central (e.g., Clark, 2011). In addition, IAPT recruited health professionals from a wide range of backgrounds including social work, mental health nursing, occupational therapy, clinical psychology and psychological wellbeing practitioners. Previous research suggests there are likely to be challenges related to this role transition (Robinson et al., 2012; Roscoe et al., 2022; Wilcockson, 2020, 2022), as each enters training with different experiences. This is likely to include different supervision structures that could influence their expectations of what they believe the role entails (Johnston & Milne, 2012; Liness et al., 2019).

1.2 | Problems with the use of active supervision methods

Little is known about how CBT supervision is routinely delivered, monitored or experienced and, given the strong tradition of promoting

Implications for Practice and Policy

- The lack of uniformity in CBT supervision leads to inconsistencies in how it is delivered and experienced, increasing the risk of supervisory drift occurring.
- Supervisors need to be vigilant of their own and their supervisee's avoidance and safety-seeking behaviours within supervision, and need support in supervision to be able to manage this more effectively.
- Lack of supervisor engagement with established CBT supervision models raises questions about the quality of existing supervisor training and the provision of meta-supervision.

Further research should look to understand how supervisors and supervisees can identify and minimise supervisory drift.

adherence to research in the field, it is concerning that what little data there are suggests that everyday practices do not always mirror expert recommendations (e.g., Alfonsson et al., 2017; Milne et al., 2009; Townend et al., 2002; Simpson-Southward et al., 2018; Weck et al., 2017), with key normative, formative and restorative functions often being omitted (Proctor, 1994; Pugh & Margetts, 2020). For example, a study by Weck et al. (2017) found that the most widely used method in supervision was case discussion, with limited opportunities to give feedback on the quality of supervisees' clinical work (e.g., video footage of therapy sessions). This also restricts the likelihood of the supervisor being able to meet their various normative, formative and restorative duties. In addition, an online survey by Townend et al. (2002) found that, of a sample of 170 BABCP accredited CBT therapists, only 18% reviewed video or audio footage of their therapy sessions with their supervisor. Other action-based supervision methods, such as the direct observation of skills (i.e supervisor sitting in during a therapy session), role play or supervisor modelling were also minimally used (6% and 19%). More recently, Simpson-Southward et al. (2018) found that a supervisor's behaviour was negatively impacted by either the types of cases being presented, the gender of the therapist, or due to their own anxiety. Furthermore, Roscoe (2021a) found that CBT practitioners in training were not aware that supervision could be used to discuss interpersonal processes such as transference, counter-transference, ruptures and therapist schemas (see Haarhoff, 2006; Moorey & Byrne, 2019, for useful examples). These restrictive or unfocused forms of supervision are either initiated by the supervisor, the supervisee, or are the product of collusion (Milne et al., 2009). Collusion arises when a supervisor and supervisee avoid mutually undesirable tasks, such as setting a clear agenda, whilst keeping discussions at a superficial level.

1.3 | Supervisory drift

These incidences could be considered forms of supervisory drift (Pugh & Margetts, 2020; Roscoe, 2021b), which has been defined as instances in which "core components of supervision (e.g., outcomes monitoring, direct observation, mutual feedback) are omitted, avoided or deprioritised, resulting in a gap between supervisory theory and practice" (Pugh & Margetts, 2020, p. 5). Based on limited research, most of which pre-dates the implementation of the IAPT programme, supervisory drift may be commonplace in CBT, yet it remains poorly understood beyond this initial definition (Roscoe, 2021b). Furthermore, to the authors' knowledge, there are currently no specific measures to determine where drift begins and ends. Whilst SAGE offers a means of rating competent supervision within the EBCS framework, little is known about how much EBCS, SAGE and short SAGE are used in everyday practice (Gyani et al., 2014; Reiser et al., 2018). Crucially, the reasons for supervisory drift occurring are underexplored in CBT research, with Pugh & Margetts only speculating at this stage that potential reasons may relate to lack of supervisor confidence in using certain methods or concerns about straining the supervisory alliance by insisting upon their use.

TABLE 1 Research questions

What do expert and accrediting body guidelines for supervision mean to participants and how do they influence their practice?
How do they decide what is important to them in supervision?
Do participant accounts infer or refer to supervisory drift?
If drift is indicated, what contexts, beliefs and behaviours appear to predispose CBT practitioners to this?

2 | STUDY AIMS

To gain further insight into what happens in supervision and why, the present study used an interpretative phenomenological analysis (IPA) framework (Smith et al., 2009) to explore supervision practices from the perspective of both CBT supervisor and supervisee. IPA offers the potential for a detailed exploration of the participant's lived experience of a phenomenon. It is an opportunity to explore what the phenomenon means to the individual, how they understand it and use it to make sense of their environment (Lyons & Coyle, 2007). It was of particular interest to understand how CBT supervisors' and supervisees' lived experiences compares with their expectations, accrediting body standards and expert recommendations (see Table 1).

Using this methodology allowed for a deeper exploration of some of the topics that were addressed in previous studies that sampled supervisory practices (Reiser & Milne, 2016; Townend et al., 2002; Weck et al., 2017). For example, the Townend et al. study (2002) asked questions about aspects of supervisory practice, including the choice of the model which guided the sessions, topic choice, frequency and the level of training that supervisors had received. Whilst questionnaire methods can gather a large amount of data, they offer less scope for elaboration or in-depth exploration of responses. Consequently, a smaller, exploratory, qualitative, interview-based study was designed with the hope that it would help to facilitate supervisor and supervisee self-reflection on how they utilise supervision sessions. To our knowledge, a qualitative study which explores the meanings that CBT supervisors and supervisees make from all aspects of clinical supervision has not been undertaken in England. This is particularly overdue following the implementation of IAPT, given the seismic effects this has had on CBT provision, training and culture (Liness et al., 2019; Liness & Muston, 2011; Turpin & Wheeler, 2011).

3 | METHOD

3.1 | Participants

A purposive sample of (N = 10) CBT supervisors and supervisees were recruited from the principal researcher's professional network (participant demographics are shown in Table 2). The participants were contacted by email or recruited from a workshop that the lead author presented on CBT supervision. IPA studies typically use small samples (e.g., 1–15 participants) to allow for a detailed analysis

of each case (Pietkiewicz & Smith, 2012). This study used a large enough sample to represent a broad spectrum of supervision experiences, whilst adhering to IPA principles. It was important, therefore, that the sample included individuals who were new to the supervision process or were supervisors and supervisees themselves with differing levels of experience.

3.2 | Procedure

Individual semi-structured interviews were conducted by the first author with participants between August 2018 and May 2021, with an average duration of 50 minutes. Six of the interviews took place pre-COVID-19 and were conducted face to face and audio recorded using a Dictaphone. The four remaining interviews were conducted via Microsoft Teams. Participants were provided with a Participant Information Sheet (PIS) and a list of questions in advance of the interview, and these were used to prompt the discussion (see Table 3 for examples of the areas that were explored in the interview). The PIS informed participants that the interview was designed to help them reflect on how they used supervision and why. The questions were exploratory and broad in nature. The aim of this study was to capture the background information of each participant, to gauge their current use and experience of supervision, and their expectations of their supervisor and the supervisory experience. The questions broadly explored three areas—breadth of supervision methods utilised, understanding and awareness of best practice recommendations, and individual expectations of how they feel it should be used. Specific questions sought to understand participants' views on the importance of matters such as key supervision methods (e.g., showing recordings of their therapy sessions), supervisor training, supervision models and supervisor accreditation. Finally, participant views on the role of self-reflection in the therapist-client or supervisor-supervisee relationship were explored. The questions were chosen because they either enquired about topics where drift had been noted in previous literature (e.g., use of active methods) or to establish some understanding of topics where little is known (e.g., their opinions on accrediting body requirements).

3.3 | Ethics

Ethical approval was granted by the University of Cumbria on 6th July 2018, reference number 17/59, and the authors have abided by the Ethical Guidelines for Psychologists and Code of Conduct as set out by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) and British Psychological Society (BPS, 2017).

3.4 | Data analysis

The data was analysed using an IPA framework (see Smith & Osborne, 2003). In keeping with IPA principles, the sample group was homogeneous (UK-based CBT practitioners in receipt of or providing supervision). IPA is also idiographic in nature and was considered a suitable method of analysis for this study due to its focus on the lived experiences of individuals (Smith et al., 2009). IPA studies typically involve a small number of participants to allow the researcher to focus on the meanings that individuals derive from their experiences.

The analysis followed the six-stage process outlined by Smith et al. (2009). This involved becoming familiar with the data, achieved through transcription and reading each transcript, highlighting important and recurring words. Initial codes were then generated from this.

TABLE 2 Participant demographics

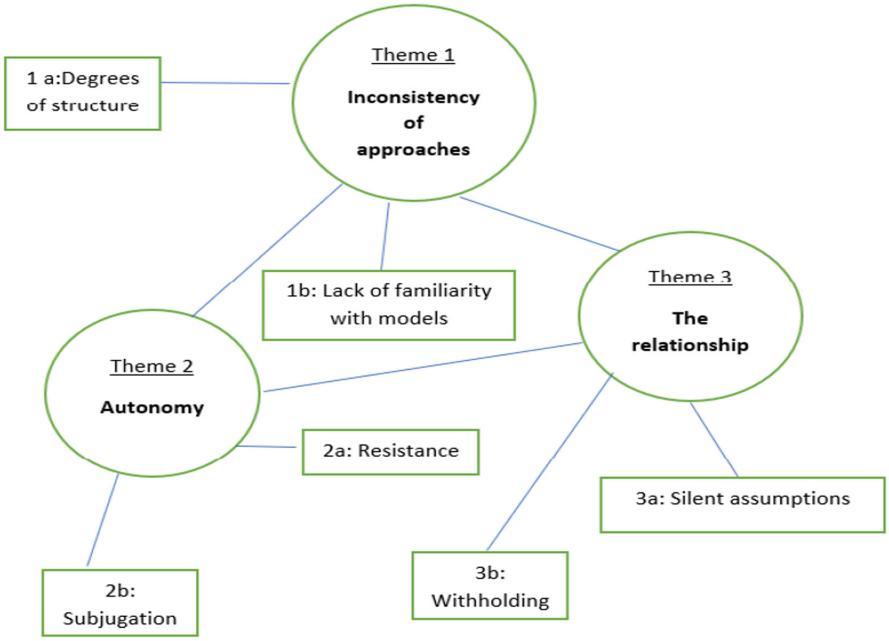
Code	M/F	Practitioner background	Supervising currently	Supervisor training	Accredited supervisor	Context
P1	M	Qualified (no core profession)	No	No	No	VS
P2	F	Trainee (no core profession)	No	No	No	IAPT
P3	M	Qualified (no core profession)	Yes	Yes	No	Education
P4	F	Qualified (no core profession)	Yes	Yes	No	Education (IAPT), PP
P5	M	Qualified (Mental Health Nurse)	Yes	Yes	No	PP
P6	F	Qualified (Social Worker)	Yes	Yes	Yes	Education (CYP-IAPT)
P7	F	Qualified (Counsellor)	Yes	Yes	No	Education (IAPT), PP
P8	F	Qualified (Counsellor)	Yes	Yes	Yes	Education (IAPT), PP
P9	M	Qualified (Mental Health Nurse)	Yes	Yes	Application pending	PP, NHS
P10	F	Qualified (Doctor)	Yes—4 years	Yes	No	Education (IAPT), NHS

Abbreviations: CYP, Children and Young People's IAPT; NHS, National Health Service; PP, private practice; VS, voluntary sector.

TABLE 3 Examples of semi-structured interview questions that informed discussions

Breadth of supervision	e.g., How do you use supervision? e.g., How do you prepare for supervision?
Understanding and awareness of best practice	e.g., How would you define the role of a clinical supervisor? e.g., What model of supervision, if any, do you use and why?
Expectations of supervision	e.g., What do you think about the fact that there is no universally adopted supervision model in CBT? e.g., Is there anything that you would be reluctant to discuss in supervision?

FIGURE 1 Thematic map showing the relationship between superordinate themes



Reflexivity is important in IPA research and, as a CBT supervisor, supervisor trainer, meta-supervisor and supervisee, the lead researcher acknowledged that "our unconscious cognitive errors prompt us to see and value highly what we expect to find or what fits with our pre-existing beliefs" (Dodgson, 2019, p. 220). For example, it was the lead researcher's expectation, based on their own research and extensive supervisory experiences, that there would be evidence of supervisory drift captured in the data. To safeguard against bias, several measures were introduced at different stages during the study. Firstly, questions were designed to elicit open rather than closed answers. Secondly, elaboration of responses was invited during the interviews (e.g., if yes, please explain; if not, please explain) to provide richer data for analysis. Thirdly, when generating codes and themes, the lead researcher deliberately looked for data that did not directly fit with prior expectations. Fourthly, a reflective diary was maintained by the first author at every stage of the study. Finally, member checking was utilised by the author, who emailed a summary of the themes to participants and invited comments. Participants elected not to offer feedback.

Data analysis was largely completed by the first author, with the second author (a psychologist who does not practice CBT) tasked with checking the codes for reliability, before assisting with the creation of a thematic map (see Figure 1). Thematic maps help researchers to understand the relationship between themes and to identify more prominent themes (O'Leary, 2017).

3.5 | Key findings

The analysis produced four superordinate themes in total, three of which, as shown in the thematic map, directly related to the research questions (see Table 4). The fourth theme, "supervisor skillset", was excluded from this discussion as it captured opinions on the perceived qualities of a good supervisor, which was at odds with the emerging overall picture and adds little to our understanding of supervisor and supervisee behaviour or attitudes within supervision (Biggerstaff & Thompson, 2008). As the participants consisted of those with dual roles (supervisors and supervisees) and single roles (supervisees only), some of the subthemes are specific to each role.

3.5.1 | Theme 1: Inconsistency of approaches

Subtheme 1a: Degrees of structure

Overall, the participants' accounts of their experiences suggested strong evidence of supervision following the basic parallel processes of therapy (see Gordon, 2012), such as agenda setting, focusing on specific skills and trying to establish the suitability of clients for various interventions. The level of structure in terms of supervision preparation, primary foci and review of learning varied considerably. Notably, for several supervisees, there was a desire for their supervisors to provide a better

overall structure to sessions or for supervision to be more consistent across different settings. This variability in how one was expected to prepare for supervision was captured by Participant 2, a trainee:

> perhaps not in as much detail [preparing for the workplace supervision session] as I would do for uni, just because my supervisor here doesn't ask as much detail when presenting a client so I don't need to go through everything, I just go straight to the question and give a little bit of background rather than it being quite structured.
>
> (P2)

Participant 2 is not suggesting that one format of supervision is superior to the other, merely that each supervisor has different expectations and rules for how the supervisee should prepare. It was unclear where each supervisor derived their structure from (e.g., a specific model). A complete lack of structure, on the other hand, was a problem for Participant 1 as they voiced some frustration that they would not always get their supervision questions answered as supervision was less structured than they hoped it would be:

> I can sometimes come away feeling that maybe we haven't covered or dealt with what we should have done but I don't really know why.
>
> (P1)

Subtheme 1b: Lack of familiarity with models

Linked to the variance in structure, most supervisors ($n = 7$) were aware of but lacked familiarity with the detail of existing supervision models. For example, Participant 7, a counsellor by background, joked, "*I think Padesky had a valid one but I don't actually know what it looks like.*" If a model was used, it was often in an unstructured way, using bits that they found useful, as explained by Participant 3, a CBT trainer and group supervisor:

> I may have done [using a model as part of supervision], but if I've continued to adopt them in any form, it's in an unconscious manner.
>
> (P3)

Participant 6, one of the few accredited supervisors, seemed confounded by the degree to which the supervision structures available lagged behind those of the therapy models used in cognitive behavioural treatment:

> I find it really surprising actually because firstly we know that supervision is really essential for good practice and to monitor the practice of CBT and we know that models are used as a foundation for evidence-based practice so the fact that there's nothing, no universal model for supervision, is quite shocking.
>
> (P6)

A few of the supervisors reflected that whilst they were introduced to different models during supervisor training, "*no one said this is the one you should use*" (P9). Two of the other supervisors were using an "inhouse" model developed at the University of Cumbria and one, from a counselling background, used elements of different (non-CBT) models, such as Hawkins and Shohet (2000). Whilst several of the supervisors ($n = 4$) had heard of the CBT-based "Newcastle model" (Armstrong & Freeston, 2006), most were unable to articulate a firm understanding of the components or application to their practice. In addition, none of the supervisors mentioned using a supervisor competence measure such as the SAGE (Milne & Reiser, 2014). One of the clearest reasons that was detected for not adopting an established CBT supervision model was their perceived complexity, as Participant 5 (a supervisor and mental health nurse by background) explained:

> ... the ones that become over-complicated with lots and lots of levels and diagrams and lines and things ..... they freak me out a bit anyway cos I can never remember them but they're trying to get things too precise and exact ... I think.
>
> (P5)

Participant 5 seems to be suggesting that the way supervision models are laid out makes it difficult to understand and, subsequently, remember how to use them. For Participant 10, it was the simple structure of the University of Cumbria's 'Wiser Mind' (Harrington, 2020) model that made it part of their supervisory repertoire:

> I find the Wiser Mind model of supervision quite easy to apply and to understand...you know the three domains in terms of the case work and the training domain and the personal development ... it feels it gives me and the supervisee a structure and they quite like it.
>
> (P10)

TABLE 4 Summary of themes

Superordinate themes	Generic subthemes	Subthemes (supervisees only)	Subthemes (supervisors only)
Inconsistency of approaches	Degrees of structure Lack of familiarity with models		
Autonomy	Resistance		Subjugation
The relationship	Silent assumptions	Withholding	

3.5.2 | Theme 2: Autonomy

Subtheme 2a: Resistance

This subtheme captured some evidence of resistance towards supervision models and was epitomised by Participant 1 (a supervisee), who was from more of an integrative background and who was not BABCP accredited, as they cautioned that:

> I think sometimes if you adopt a universal model as a way of doing something, no matter how good that is, you're possibly missing things that could be from elsewhere.
>
> (P1)

Participant 5 gave the impression throughout the interview that they were fundamentally against specific models for supervision. When discussing the possibility of a universal model of CBT supervision being implemented, Participant 5 (a supervisor) stated:

> I don't like it at all….so my answer to that is I'm very pleased that there's no universally adopted model but I think that BABCP still tries to define what supervision is and also what it should be, erm but in the same way as with CBT everybody does it differently and long may it remain so.
>
> (P5)

Neither of these participants said what it was that would be missed in supervision if a model was used to guide sessions. When asked what could be changed about CBT supervision from a regulatory perspective for members to feel more involved in the decision making, Participant 4 (a supervisor) suggested:

> Maybe they [BABCP] could do a little bit more research into that and to get some feedback from people who are supervisors and supervisees and ask what they think would be of benefit, what would they find helpful.
>
> (P4)

On this same topic, Participant 5 concluded that:

> …if I was asked to write that model [a unified supervision model], I would make sure that it was suitably broad to allow for a lot of flexibility in it.
>
> (P5)

Subtheme 2b: Subjugation

The power dynamics in supervision were prominent in two ways. Firstly, some supervisors experienced their supervisees as being implicitly demanding of their expert knowledge, to the extent that they felt they were expected to have all of the answers. Participant 10 voiced frustration with the helpless behaviour of therapists in supervision at times:

> Supervision is not just me telling you what to do.
>
> (P10)

Conversations did not reveal whether these frustrations were ever aired with supervisees, but there was a sense that these were silent assumptions held by both parties about what should happen in supervision. This sense of supervisees lacking agency extended to experienced, qualified therapists, where it was perceived that some did not engage in any CPD or reading of books or journal papers: *"some experienced therapists…they don't even read"* (P10).

Participant 7 voiced similar feelings in relation to trainee therapists:

> Some trainees come and they expect an additional training session.
>
> (P7)

The second expression of subjugation from supervisors was in relation to the strict requirements of CBT training courses, where they were expected to support students whose clients were too complex for short-term CBT or where they were not permitted to teach certain models or interventions or explore the interpersonal aspects of therapy because these did not fit with course curriculum, despite their real-world utility. According to Participant 4, this shapes supervisees' expectations of what supervision will entail and these expectations appear to be resistant to change:

> Some of them can have a very black and white view of…. you're coming to CBT…. present your case…. what are you doing?… What can you do differently with this person? And off you go, so it's quite black and white, and they won't shift from that view.
>
> (P4)

Several participants expressed tension between the competing expectations placed upon them by services (e.g., NHS providers, IAPT) and supervisees. Participant 9, for example, felt that the demands of the organisation often outweighed the needs of the client when cases were brought to supervision:

> I'm currently supervised by my manager and if I'm told to do something that isn't what I've contracted with the client…so like…only offering them six instead of eight sessions, then the organisational normative needs are taking priority over the client.
>
> (P9)

Participant 10 questioned how supervisor competence and effective supervision were to be judged as, to them, this depends on the measure of success that is used. For example, would good recovery rates for clients indicate good quality supervision, or does supervisee satisfaction with what they are getting out of supervision take precedence? For Participant 7, there was too much uncertainty around

the evidence base for the tangible benefits of doing specific things in supervision to follow a specific model:

> There is no evidence base to say do X; therefore, there is no requirement to do X.
>
> (P7)

3.5.3 | Theme 3: The relationship

Subtheme 3a: Silent assumptions

This theme identified a number of assumptions that supervisors and supervisees held about the other party or about hierarchical structures (e.g., accrediting bodies and employers). Supervisees, for example, held silent assumptions about what competent supervision would consist of. The assumption that a supervisor is trained for this role was exemplified by the view of Participant 2, who stated:

> .....To be honest before you told me that you didn't need to [be accredited to work as a supervisor], I automatically assumed that you did, that you would need to, because I wouldn't expect myself to be able to supervise someone off the cuff, I would expect to or I would want some kind of training to do that, in the same way that you have to train to do this role [CBT Therapist].
>
> (P2)

When asked if they knew about their supervisors' credentials, none of the participants said that they had or would ask this outright. As a trainee, it is possible that due to the power dynamic, Participant 2 might have felt uncomfortable asking their supervisor about their credentials. Conversely, according to Participant 1, a trained and accredited supervisor was not seen as necessarily more competent. Participant 1 also seemed to hold a silent assumption suggesting that a good and effective supervisor possessed a mix of training and experience as a therapist:

> You can know a subject really well; it doesn't mean that you can teach it or you can pick up somebody else's feelings about it, kind of thing. You need to be a qualified supervisor and you also need to know about the subject. You need kind of both sides of it, if you like.
>
> (P1)

Participant 4, however, expected an accredited supervisor to have a higher level of skill, owing to the fact that to become accredited one has to engage in additional CPD, extra reading and gain references from supervisees attesting to their competence.

> ...there's certain remits and levels of expectations from somebody who's accredited and not accredited and they can operate quite differently and I think the training and expertise they have as an accredited supervisor seems to be more enhanced.
>
> (P4)

Subtheme 3b: Withholding

This subtheme captured tasks that supervisees avoided in supervision. When asked if they would be reluctant to bring anything to supervision, several participants discussed withholding personal matters and the sharing of therapy session recordings. This fear persisted regardless of how long they had practiced CBT. When prompted to divulge the reasons for not taking video or audio recordings to supervision on a regular basis, Participant 3, who was a CBT trainer, supervisor and supervisee, explained:

> I think there's two answers. I think one of them is the more honest answer probably, and that's there's always that worry that because you've done something for seven years that you should have a certain level of competence and therefore a fear of being crap.
>
> (P3)

Participant 6 (also a supervisor and supervisee) disclosed similar concerns:

> one thing that I don't do very often is I don't record a lot of my clinical sessions to take to supervision and I suppose partly it's time issues, and, you know, in terms of technical issues, you know, it does become a bit of an obstacle but there's also possibly some avoidance on my part because it is exposing.
>
> (P6)

Participant 2 (a supervisee only), a trainee who attended both individual and group supervision, said of the latter:

> I feel a bit more anxious [showing videos to the rest of the group] because I think 'aghh, what are they gonna think?' sort of thing, but it's got easier the more we've done it. It's not as bad as at the start.
>
> (P2)

Other participants described feeling unsafe sharing certain things with their supervisor, especially if this was in case management supervision or if their supervisor was also their line manager. Participant 8, a supervisor on an IAPT course, cited a "*fear of judgment*, *lack of empathy and support*" when reflecting on past experiences working in the NHS, going on to say that:

> I think IAPT hasn't done anyone any favours by being such a business model....it brings the worst out in people.
>
> (P8)

Supervisor behaviour appeared to moderate supervisee fears, such as if they perceived them to be warm and trustworthy or cold and critical.

> ….the supervisory alliance is just as important because if I'm in supervision and I don't feel safe and I don't feel contained and I don't feel I can trust someone with some of my own stuff and don't feel that they will actually deal with it in a sensitive and appropriate and warm way, there's no way that I will disclose anything to … you know… let them know about some of my weaknesses or information that will make me feel more vulnerable and exposed.
>
> (P6)

Given that both supervisees and supervisors (who are also supervisees themselves) reported fears about the perceived consequences of showing recordings of their clinical work to others, this might offer one explanation for drift. If both parties view live supervision as an "exposing" activity, then the supervisor and supervisee may collude to omit or de-prioritise this in supervision. Interestingly, none of the participants spoke about avoidance from the perspective of being a supervisor and how they would manage this with their own supervisees. In addition to this, none of the participants mentioned the use of any supervisory alliance measures, such as the Leeds Alliance in Supervision Scale (Wainwright, 2010), to assess supervisee satisfaction. Finally, whilst the question was not directly asked of supervisors, none disclosed using supervisor competence measures such as SAGE (Milne & Reiser, 2014; Reiser et al., 2018).

4 | DISCUSSION

This is the first UK-based IPA study that sought to capture the lived experiences of CBT supervisors and supervisees. Given the seismic effects that IAPT has had on CBT provision, training and culture since its inception (Kelly & Hassett, 2021; Liness et al., 2019; Liness & Muston, 2011; Turpin & Wheeler, 2011), the aim was to gauge CBT supervisor and supervisee experiences and explore how they made meaning of supervision (Smith et al., 2009). Previous research sampling the routine use of supervision took place pre-IAPT (e.g., Townend et al., 2002) and had indicated that CBT practitioners rarely use active supervision methods. This research sought to understand some of the factors that influence supervisor and supervisee behaviour. An IPA research framework produced three relevant superordinate themes, which cast new light on supervisor and supervisee attitudes towards factors such as expert guidance and accrediting body standards. Overall, the themes indicated that whilst supervision retained an adherence to the general reflexive principles of therapy (Milne, 2008) and showed some evidence of SAGE "front wheel" supervisor tasks (e.g., agenda setting), there were many aspects of expert and accrediting body guidelines that were resisted or omitted for various reasons. From most of the interviews, there looked to be a recognised format for supervision, although the exact content varied depending on the supervisor (e.g., the experiences of Participant 2). Although the research questions were not designed to relate entirely to SAGE, there was little evidence of the "rear wheel" being explicitly targeted in the supervision experiences that were discussed.

In comparing the participant experiences to expert guidance (e.g., Pretorius, 2006), the cognitions and emotions of supervisees were not consistently addressed in a structured way. The subtheme "silent assumptions" captured several unspoken thoughts and feelings amongst both supervisors and supervisees. There were no mechanisms identified for reviewing the quality of supervision or the satisfaction of the supervisee. For example, when asked about the use of self-reflection and the opportunity to explore their own reactions, none of the participants described engaging in any structured forms of self-practice or self-reflection (SP/SR) (e.g., Bennett-Levy, 2019). SP/SR has an expanding evidence base since (e.g., Bennett-Levy et al., 2003) and has been shown to assist in explicitly targeting supervisee cognitions and emotions (Bennett-Levy & Thwaites, 2007). In addition, none of the interviews identified supervision that incorporates a focus on the interpersonal processes involved in therapy, or supervisory relationships, despite issues such as transference and countertransference being recognised in the wider literature (e.g., Azar, 2000; Leahy, 2001; Moorey & Byrne, 2019; Roscoe, 2021a). Some participants discussed unvoiced disgruntlement with aspects of the CBT supervisor role, such as how it is used within IAPT and within their relationships with supervisees. The subtheme "subjugation" captured both the annoyance of Participant 9 at the interference from line management, and the apparent resentment that Participant 10 experienced in relation to what they described as "demanding supervisees". Overall, the findings suggest an uneasy alliance for many where, on the one hand, supervisees are withholding feelings and live access to their work due to fears of judgement and criticism, and on the other, supervisors are feeling subjugated by the demands of supervisees or institutions.

The use of a specific supervision model might help to address such inconsistencies in the application of supervision, yet supervisors and supervisees were largely unfamiliar with specific models, even when they had heard of some. Furthermore, they were not consistently employing these principles in their practice, instead being guided by their own experience (Gyani et al., 2014). Interestingly, all eight of the supervisors in the study had received some form of supervisor training during their career, yet only two of them had gone on to become an accredited supervisor (Participants 6 and 8). Lack of exposure to models is therefore unlikely to explain their absence in supervision. Resistance relating to dysfunctional therapist schemas or difficulty translating the model from the classroom to the real world may be a more likely explanation (Leahy, 2001). The overemphasis within CBT supervision on task alliance might be a disadvantage when supervisors are trying to make sense of their supervisees' and their own reasons for avoiding key supervision tasks (Reiser et al., 2018).

The findings in the present study identified several important reasons why supervisors might instigate drift. Firstly, perceived threats to the autonomy of supervisors were a prominent theme in this research. There was a concern amongst some participants (most notably P1 and P5) that a level of bureaucracy exists in the field and that models and guidelines can stifle, rather than enhance, supervision. It is possible that a supervisor and supervisee who both hold this viewpoint may collude with each other against what they perceive to be too much structure (see Roscoe, 2021b, for examples of this).

In relation to supervisee-initiated drift, despite supervisee avoidance being highlighted in previous literature (Ladany et al., 1996; Yourman, 2003), supervisee cognitions about supervision appear to be going undetected, leading to them engaging in safety-seeking behaviours and avoidance, as verbalised by P3 and P6. Audio and video feedback, a much-neglected component of supervision, appears to heighten supervisee fears. This could be one of the reasons for poor fidelity to supervision best practices such as those outlined by Gordon (2012) and Pretorius (2006). Collusion by supervisors and supervisees was not overtly identified within the interviews; therefore, the reciprocal roles involved in the creation of supervisory drift remain unclear. It is also unclear as to whether the use of a supervision model prevents harm or drift; however, what a model does provide is a shared language that the supervisor and supervisee can draw upon to frame supervision discussions. Models such as the Newcastle Cake Stand (Armstrong & Freeston, 2006) provide a framework for items which may otherwise be overlooked.

4.1 | Limitations

This is the first qualitative study which aimed to explore the lived experiences of CBT supervision and the meanings supervisees and supervisors make from this. Whilst qualitative research does not have the aim of generalizability (Moule, 2018), it is important to recognise the limitations of a small sample size. The divergence amongst the participants' beliefs makes it difficult to establish how representative their supervision is. In addition, the participants were known to the lead researcher and, therefore, selection bias may be a factor. Four of the participants trained at the University of Cumbria, where supervision style and culture may explain some of the responses. It is possible that supervision experience, based on where one is trained, may lead to different expectations around supervision. Furthermore, it is possible that the questions used to frame the semi-structured interviews, to some degree, shaped the direction of the conversations and the topics that were discussed. Indeed, most of the discussions were around the experience of receiving, rather than providing, supervision; therefore, exploration of how supervisors try to prevent drift was not covered. The role of the lead researcher as an "insider-outsider"(Breen, 2007) adds an extra layer of complexity, as Smith and Osborne (2003) aptly state, "Access depends on, and is complicated by, the researcher's own conceptions" (p. 53).

Whilst the data revealed some signs of drift, the interviews did not shed new light on the prevalence of restricted methods (e.g., predominance of case discussion at the expense of role-play). Furthermore, the small sample size did not allow for understanding whether drift is more likely in certain trainees owing to their professional background (e.g., person-centered counselling). It is also of note that Supervision of Supervision (SoS) was not explored in these interviews, a medium that would seem the most likely avenue for addressing supervisee or supervisor-led supervisory drift (Newman, 2013; Grey et al., 2014). Finally, whilst the research captured supervisor and supervisee attitudes at the point of the interview, it would have been useful to include some form of follow-up to see whether the reflection on their practice led to any changes in how they use supervision.

5 | CONCLUSION

The findings from this exploratory study provide new evidence regarding the role that individual experiences and attitudes play in influencing how therapists behave in clinical supervision. This study has found evidence of both members of the dyad holding silent assumptions about supervision, which, if left unspoken, may lead to impasses and ineffective forms of supervision. To quote Ladany et al. (1996), "supervisors cannot help supervisees with concerns they do not know about" (p. 10). In a similar vein, supervisors cannot help themselves if they do not know how to deliberately reflect on the quality of their supervisory practice. The current study may have some transferability (O'Leary, 2017), especially when compared to other research on CBT practitioners' use of supervision (Milne et al., 2009; Roscoe, 2021a; Simpson-Southward et al., 2018; Townend et al., 2002; Weck et al., 2017). Moreover, these findings may help to shed light on some of the reasons why phenomena such as ineffective supervision and supervisory drift continue to occur, despite a range of best practice resources being available to supervisors (e.g., Gordon, 2012; Milne, 2017; Roth & Pilling, 2008). Future research might look to investigate supervisors' perceptions of their competence to deliver active supervision methods and their confidence in addressing interpersonal processes that arise within supervision (Pugh & Margetts, 2020). Little is known about the impact that therapist training, previous professional backgrounds, supervisor training or prior supervision experiences have on the development of supervisor and supervisee beliefs and how these may influence the behaviours described above. To reduce the likelihood of drift occurring, supervisors, supervisees and those that supervise supervision, "meta-supervisors" (Newman, 2013), might also benefit from the introduction of strategies that assist in the detection, formulation and management of drift. There does not currently seem to be a universal platform for CBT supervisors and supervisees to jointly formulate and address beliefs held by either party about supervision. Furthermore, a measure of supervisory drift is required so that supervisors and supervisees know when they

are sailing too far off course, as opposed to retaining some flexibility and autonomy in the ways they practice.

CONFLICT OF INTEREST

The authors have no conflicts of interest with respect to this paper.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available upon reasonable request.

ETHICAL STATEMENT

The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. Ethical approval was granted by the University of Cumbria, reference number 17/59.

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