Student Supervisees' Reported Experiences of Feedback in Clinical Psychology Supervision

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A research report submitted in partial fulfilment of the requirements for the degree of Master of Arts in Clinical Psychology in the Humanities Faculty, University of the Witwatersrand, Johannesburg.

ACKNOWLEDGMENTS

First and foremost I would like to thank my supervisor Aline Ferreira Correia for her patience, support, and infectious enthusiasm for this research topic.

To my family, who were understanding and supportive throughout the research process, I am eternally grateful for the motivation provided.

To the MClin Class of 2014 and my friends who believed in me and helped me stay focused and for the constructive distractions and comforting get-togethers. Thank you for being there for me through every step of the research process.

I would like to thank those that took part in the study and shared their invaluable experiences. I would not have anything to show without your participation and thoughtful responses.

Declaration

I declare that this research report is my own, unaided work. It is submitted for the degree of Master of Arts in Clinical Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

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CHAPTER 1: INTRODUCTION

1.1. Rationale for study

Supervision is considered an integral aspect of clinical training as it facilitates the transition that supervisees make from an educational coursework framework to clinical practice (Bernard & Goodyear, 2009). This process comprises of the supervisor's provision of valuable knowledge to develop the supervisees' skills and provide the space for them to develop into independent, competent practitioners (Bogo, Paterson, Tufford & King, 2011). Supervisors monitor the work of their supervisees, provide clinical skills training, correct missteps, and make judgements about the progress and fate of the supervisee within the profession (Falender et al., 2004). Clinical supervision is a process whereby knowledge is passed from a knowledgeable member of the mental health profession to a developing practitioner. This process facilitates growth in trainee practitioners, and contributes to expanding the footprint of the mental health profession while maintaining its integrity (Bernard & Goodyear, 2009). Supervision is an evaluative relationship where supervisees are provided with feedback to give them a sense of where they are in their clinical development, where their strengths and weaknesses lie, and how effective they are as practitioners (Hoffman, Hill, Holmes & Freitas, 2005; Magnuson, Wilcoxon, & Norem, 2000).

Bernard and Goodyear (2004) define feedback as "the central activity of clinical supervision" (p.30). Although it is considered an important aspect, very little is known about how to express and package feedback in an appropriate and beneficial manner. Supervisors attempt to adhere to standard professional procedures, but note various degrees of difficulty in the relationship, and negative supervisee performance once they have conveyed their evaluations (Claiborn, Goodyear, & Horner, 2001; Falender & Shafranske, 2010; Hoffman et al., 2005; Lehrman-Waterman & Ladany, 2001; Magnuson et al., 2000). Bernard and Goodyear

(2009) indicate that the research that has been conducted on feedback addresses experiences of the process from supervisors' perspectives; it comprises of their ideas and reported experiences of what has worked and what has not, and formulations pertaining to reparation and/or avoiding impasses (Falender & Shafranske, 2010; Hahn & Molnar, 1991; Hoffman et al., 2005; Lehrman-Waterman & Ladany, 2001; Magnuson et al., 2000). Although it is conducive for supervisors to reflect and look for purposeful means to facilitate an optimal supervision environment, their approach is likely to fall short if they do not have a reference from the supervisees' point of view (Kadushin, 1992).

An investigation of supervisees' experiences of feedback will supplement supervisors' experiences and provide a more holistic view of feedback and supervision. Neglecting to converge the two insights will have significant implications on the quality of training and the subsequent effectiveness of trainees in their consultation rooms. Therefore, it is the author's interest to investigate the reported experiences of feedback from the perspective of supervisees. The particular focus of this research is into the reported experiences of student supervisees in the field of clinical psychology. From a developmental standpoint, this cohort will provide insight into positive and negative feedback experiences that they have found to have shaped their professional identities. Furthermore, providing feedback and receiving it is referenced as a difficult process characterised by heightened anxiety, expectations, and detrimental or favourable outcomes (Hoffman et al., 2005). In their exhaustive review of literature into feedback in clinical supervision, Goodyear and Bernard (2009, p.31) assert that, although feedback is an integral aspect of training, "curiously, researchers have given little specific attention to feedback within supervision." The author proposes that this highly arousing transaction between supervisor and supervisee is one that is essentially difficult to talk about within the confines of the supervision space and amongst professionals and the purpose of this

research is to facilitate a discussion and platform for thinking about this instrument of training that has resounding effects on the confidence and competence of trainees.

1.2. Research method

This study follows a qualitative design. The researcher conducted interviews with intern clinical psychologists and community service clinical psychologists who have received clinical supervision from licenced clinicians over the course of their training. The data obtained was transcribed and then analysed using thematic content analysis, which, unlike most quantitative methodologies, highlights the participants' unique, individualised experiences.

1.3. Outline and structure of the study

This paper comprises of four main sections. Chapter 2 consists of the literature review. In this chapter, empirical literature is discussed in detail. A description of the services clinical psychologists provide and the skills trainees are to acquire is provided. In addition, training regulations are covered and the process of supervision is defined and discussed. The chapter concludes with literature regarding feedback that is drawn from different areas within the domain of psychology.

Chapter 3 consist of a discussion of the method employed in this research. In Chapter 4, the results obtained are presented in the form of excerpts that are accompanied by summaries used to highlight the themes from the data. The study is concluded in Chapter 6. The final chapter consists of a discussion of the findings set against the reviewed literature. This chapter will conclude with a discussion of the value of the results and the implications of these findings, the limitations of this study, and suggestions for future research.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The purpose of this chapter is to provide an overview of the literature pertaining to the topic of clinical supervision and feedback. This chapter comprises of the following overviews: a brief introduction to the field of clinical psychology followed by discussions about clinical psychology supervision, and feedback. The field of clinical psychology is rarely defined, and for the interest of this paper, the tasks performed by qualified professionals are highlighted as these are the skills trainees need to acquire, and it is through the provision of supervision that these skills are taught and consolidated (Bernard & Goodyear, 2009). The discussion on clinical supervision highlights the research that has gone into creating and adapting several approaches to supervision such as models that are informed by theoretical paradigms and their implicit techniques, and more evolved models such as the development models applied to supervision practice. Finally, this chapter closes on a review and synthesis of literature on feedback across fields of education, organisational psychology, and clinical psychology.

According to the American Board of Professional Psychology (ABPP) (undated),

> Clinical psychologists provide professional services for the diagnosis, assessment, evaluation, treatment and prevention of psychological, emotional, psychophysiological and behavioural disorders across the lifespan. These services include procedures for understanding, predicting, and alleviating intellectual, emotional, physical, and psychological distress, social and behavioural maladjustment, and mental illness, as well as other forms of discomfort.

In addition, clinical psychologists may provide services directly or support and facilitate the provision of services through supervision, teaching, management, administration, advocacy and similar roles. A candidate inducted into the profession is tasked with navigating through the aforementioned domains of psychometric assessments, psychotherapy (with individuals

[brief and/or long-term], couples, families, and groups), diagnosis and formulation, case management, ethics, and professional practice (Ahmed & Pillay, 2004). Training institutions facilitate the acquisition of the skills through didactic instruction and careful monitoring and modelling of appropriate professional behaviour. In South Africa, training practitioners are required to be formally registered with a higher institution of learning that is recognised by the Health Professions Council of South Africa (HPCSA). In this country, clinical psychology training occurs at a Masters level and the curriculum comprises of coursework, research, and supervised clinical work that intensifies in the internship, which forms the basis of training in the second year (HPCSA, Form 160, 2011).

The HPCSA functions as a governing entity that oversees the execution of training and professional development. The HPCSA thus operates as a gatekeeper for professional and ethical standards of all health professions. The subsidiary of the council, the Professional Board of Psychology, is tasked with enforcing policies and appropriate professional standards. Of specific importance, as highlighted in the HPCSA guidelines (Form 160, 2011), are the rules that stipulate the importance of supervision in the development of a cohort of training professionals. The Professional Board of Psychology (Form 103, undated) stipulates that adequate training occurs in a facility where the trainee is embedded within a multidisciplinary team, where there is a diverse spectrum of cases, and contact with qualified members of the same profession. According to the HPCSA guidelines (Form 105, undated), supervision must be in direct control of at least one full-time registered psychologist with three years of experience (community service included as one of them) in the same category, where the psychologist takes on the responsibility of ‘moulding’ trainees. Under this guidance, the trainee should gradually be given room for independence and greater responsibility. The HPCSA guidelines (Form 105, undated) states that supervision as an activity should constitute 15% of

training process, where the trainee is evaluated and provided with formal quarterly feedback about their progress and shortcomings.

The clinical psychology profession is one that is under the watchful authority of the HPCSA, in South Africa, and others such as the American Psychological Association (APA) in the United States (Ahmed & Pillay, 2004; Bernard & Goodyear, 2009). Members of the profession are enlisted with the duty of maintaining the integrity of practice and the responsibility of grooming future professionals. The above referenced guidelines from the HPCSA provide a starting point for an in depth discussion about the relationship into which a supervisor and supervisee enter.

2.2. Clinical psychology supervision

As a core aspect training, supervision is defined as a directive relationship where a more experienced professional works with a less experienced member of the same profession (Bernard & Goodyear, 2009). The purpose of this relationship is to impart the appropriate professional behaviours through modelling, mutual problem solving, and a provision of objective feedback (Falender & Shafranske, 2008). According to some professionals, supervision plays an integral role in the successful transition from didactic coursework to clinical practice (Atkins, 1981). Furthermore, this relationship is evaluative in nature, and allows for monitoring the quality of services provided to the public (Bernard & Goodyear, 2009).

Supervision can span administrative and clinical work, but these appear to be considered as discreet categories in the literature (Bernard & Goodyear, 2009; Copeland, 1998). The tasks performed by administrative supervisors are in assisting supervisees to navigate bureaucratic organisations such as universities and hospitals, and the task of the clinical supervisor is to focus on evaluating supervisee work in the provision of services to clients. Clinical supervision

comprises of overseeing aspects such as client welfare, the therapeutic relationship, and the clinical interventions implemented. The HPCSA (Form 160, 2011) stipulates that the duty of universities and supervisors is to equip trainees with skills that they can apply in mental health institutions and independent practice. The duties of supervisors are not explicitly delineated by the professional body, as there is likelihood that clinical supervisors may also head departments and training programmes and serve a dual role of an authority figure/employer/superior and supervisor. The supervisor may then have the task of carrying out discipline, and serving as a gatekeeper of the profession as well as a source of guidance. Supervision depends on the creation of an environment of emotional safety constructed in part by the creation of reliable professional boundaries (Bernard & Goodyear, 2009). The existence of dual relationships makes these boundaries unclear (Ellis, 2010; Feltham, 1994). Secondly, dual relationships introduce a conflict of interest. Practical shortcomings such as a limited staffing make these relationships unavoidable, particularly in the South African context (Flanagan, 2014).

In looking at how school counsellors negotiate their roles in schools and colleges where they are mental health practitioners and hired as teachers or tutors, Bond (1992) indicates that it is essential to be clear about boundaries between these roles. Dual or multiple roles may lead to confusion in supervisees and supervisors as their mixed roles also pertain to different ways of conducting themselves and different sets of expectations that might exist within the same frame. One such problem of boundaries is that the process of supervision does not appear to be unlike that of psychotherapy (Bernard & Goodyear, 2009).

There is a sense in which the psychotherapy processes and clinical supervision can be viewed as overlapping, inseparable, and interwoven. From this point of view, the growth of a supervisee can be considered as a gradual unfolding of a new awareness or mastery of new skills and behaviours (Bernard & Goodyear, 2009; Feltham, 1994). In addition, the supervisee is regularly in the same position as the client where he or she relies on the mind and presence

of an objective and neutral other to facilitate a modification in behaviour and a manner of relating to others (Feltham, 1994; Patterson, 1983). The supervision environment is a space whereby supervisees' personal blind spots are highlighted and unpacked in relation to the therapeutic process as they might compromise the overall service provided to a client (Bernard & Goodyear, 2009; Feltham, 1994; Ramos-Sanchez et al., 2002). The line between therapy and supervision is hence a tight one to manoeuvre. The supervisor may need to address the supervisee's issues, whilst maintaining the client's needs in mind (Ramos-Sanchez et al., 2002). The supervisor's task is to maintain professional boundaries by making a strong case for the supervisee to seek personal therapy to address these issues further.

Eagle, Haynes, and Long (2007) give insight into the role a supervisor can hold in their application of Bion's (1962, as cited in Eagle, et al., 2007) notion of containment; more specifically, the containing function of supervisors managing trainees navigating a foreign context. These authors explore the challenges that trainee therapists face in the context of working with a culturally diverse clientele and the accompanying assortment of subjective traumatic experiences. It goes without contention that the anxiety-provoking environment elicits in the trainees a great deal of distress that interferes with their ability to engage with their clients empathically and facilitate therapeutic change. The authors emphasise that it is imperative that supervisors should provide an open space for trainees to share and explore their reactions to their clients' narratives. The supervisees are encouraged to use the supervision space to share personal experiences and honestly express their reactions to the setting and their clients' stories. The supervisors, holding the clients in mind, reflect and help the supervisees to make sense of their anxieties such that they are a capable of approaching similar narratives with less trepidation and a fear of contamination (Eagle et al., 2007).

The supervisors above, engender in the supervisees a sense that openness is beneficial to the learning and therapeutic process. However, it is also strongly suggested that they make use of

their own therapy to better explore their reactions and worries. The supervisees heavily depend on their supervisors' empathic minds and input in the outset of their training, and then gradually wean from the assistance and gradually grow into self-confident therapists (Watkins, 2015). Although supervision is an on-going process, therapists eventually require less directive input from their supervisors and namely use supervision as an exploratory and collaborative environment where two or more minds can actively engage with a case (Stoltenberg & McNeill, 1997). The sensitivity of the supervisor to a supervisee's level of professional development is imperative (Worthington, 1987).

Up to this point, supervision has been defined as "the process in which a senior psychologist teaches, trains, guides and supports a student in the course of his or her practice, with the aim of developing the student's skills and ensuring optimal client or community care." (Pillay & Kometsi, 2007, p.378). For purposes of better understanding supervision it seems imperative to highlight supervision models that inform the practice of supervision. Similar to the practice of psychotherapy, supervisors are known to adopt frameworks that aid them to navigate through the process. Supervision is known to be conceptualised according to a number of theories and models. The approaches to supervision have been collapsed into two main categories: models based primarily on psychotherapy theories, developmental models (Bernard & Goodyear, 2009).

2.2.1. Psychotherapeutic approaches in clinical supervision. The first models to be covered are those where psychotherapeutic approaches (psychodynamic, cognitive behavioural, client-centred) have been extended into the practice of supervision (Bernard & Goodyear, 2009), where the focus of the supervision process is the development of skills that are specific to the psychotherapy approach and the limitations in delivering adequate and effective psychotherapy (Beck, Sarnat & Barenstein, 2008).

The predominant focus for supervision grounded in theoretical approaches is on the development of skills specific to the psychotherapy theory and the areas the supervisee is grappling with in terms of delivering effective psychotherapy (Beck et al., 2008). Supervisors are tasked with teaching supervisees the theories and techniques specific to their theoretical paradigms, monitoring the supervisee's interpersonal skills, and promoting supervisee self-awareness (Fink, 2007; Friedlander, Siegal & Brenock, 1989; Watkins, 2015). The supervisory relationship is conceptualised to mirror the therapeutic relationship and can be a template for future therapeutic encounters (Frawley-O'Dea, 2003). All therapy based supervision models recognise this parallel process and although the technique and the language used to describe the supervisory encounters is different across the modalities, the supervisory relationship is noted to be a crucial vehicle for supervisee development (Barber, Liese & Abrams, 2003; Beck et al., 2008; Berman, 2000; Frawley-O'Dea, 2003; Liese & Beck, 1997; Sarnat, 2012; Skolnikoff, 1997). Supervision informed by psychotherapy approaches is a highly personal task and this model endorses feedback aimed at the supervisee's shortfalls in fundamental interpersonal skills, conflicts from unresolved psychological issues, attitudes, and biases (Sarnat, 2012). According to Frawley-O'Dea (2003), providing feedback that is so highly personal in nature is facilitated by a strong supervisory alliance and a high degree of trust.

Orientation-based models of psychotherapy seem to focus mostly on supervisee blocks in conducting therapy, something perhaps left to a supervisee's therapist, not supervisor. Furthermore, it seems like the models describe an additive, linear process of supervisee development, where a supervisee learns appropriate skills that are added to already existing knowledge and abilities (Gonsalvez, Oades & Freestone, 2002). Additionally, psychotherapy models do not address the changes in a supervisee's abilities over time (Ronnestad & Skovholt, 2003).

2.2.2. Developmental models in clinical supervision. Developmental models of supervision are among the most researched, and currently the most prominent supervision theories in clinical supervision (Stoltenberg & McNeill, 1997). Developmental models typically account for a less linear path in supervisee growth, and instead supervisees are noted to have growth spurts and periods of delay and, at times, to even regress (Gonsalvez et al., 2002). According to the models, supervision needs to be provided in a manner sensitive to the experience and stage of the supervisee. By extension, a supervisor will be required to track the supervisee and implement developmentally appropriate interventions (Stoltenberg, 2005).

This model posits that in the early phases of training, the supervisee enters the therapeutic and supervisory relationship with anxiety and part of the focus of the supervision is in using methods to normalise the apprehension. Supervisees depend heavily on their supervisors who provide more prescriptive interventions – within the dyad there is either the presence of idealisation of the supervisor or disregard for the feedback provided (Bernard & Goodyear, 2009). As supervisees progress they encounter fluctuations in their motivation and confidence – the duty of the supervisor at this point is to take up a more confrontational stance to address the internal impasse; furthermore, within the dyad the former idealisation and disregard for feedback is reported to be replaced by anger and frustration towards the supervisor (Loganbill, Hardy & Delworth, 1982). Following the stage of conflict, is a phase where the supervisee emerges with new understanding, flexibility, and personal security regardless of occasional fluctuations in motivation and confidence (Bernard & Goodyear, 2009).

The process of supervision can also be conceptualised as an experience where the supervisee's focus shifts from their personal conflicts and anxieties and gradually move towards a more reflective and thoughtful mind set (Stoltenberg, 2005). Supervisees are cited to both progress and regress throughout their training, but through adequate supervision, particularly the supervisor's flexibility, the vacillation across skill sets can occur less frequently

and elicit less anxiety in the supervisee (Loganbill et al., 1982). Moreover, the timing of evaluations and feedback needs to be guided by the supervisee's stage and state of development (Bernard & Goodyear, 2009).

Ronnestad and Skovholt (2003) describe professional development as a lifelong process, with beginning practitioners experiencing a high level of anxiety in their work and strong affective reactions toward their supervisors and more experienced members of the profession. Supervisors provide the bulk of evaluation in the early stages of development. Evaluation and feedback experiences have a profound effect on supervisee's early on in their training and criticism, real or perceived, can impact both their self-esteem and subsequent work; explicit positive feedback can have a calming effect at this level. Initially clinicians rely on their supervisors for confirmation, but gradually develop internal motivation and focus and supervisors encourage self-evaluation and self-supervision skills. Furthermore, therapists demonstrate an intense commitment to learn, typically from supervisors in early stages of development, and from colleagues in consultation later in development (Bernard & Goodyear, 2009).

2.3. Feedback in clinical supervision

Feedback is often noted as being the most salient aspect of supervision by supervisees (Bernard & Goodyear, 2009). According to Hoffman et al. (2005), feedback is a vehicle for supervisors to voice their evaluation of supervisees. Feedback often comprises of information regarding the characteristics of a supervisee, such as behaviour and appearance, attitude, and skills. This feedback can be communicated regularly (formative feedback) or during scheduled periods in the year (summative). Formative feedback looks at the supervisee's progress towards professional competence, whereas summative feedback conveys results pertaining to how a supervisee 'measures up' (Bernard & Goodyear, 2009). Formative and summative feedback

should form a consistent core for teaching and learning objectives throughout the course of supervision.

Feedback may be characterised according to the direction of communication. Most of the literature on feedback looks at a linear type of feedback, that is, information communicated from the supervisor to the supervisee (Hoffman et al., 2005; Lehrman-Waterman & Ladany, 2001). Another form of feedback is interactional feedback in which a supervisee gives communication back to the supervisor and a dialogue may ensue. Amongst many responses supervisees may give is the negation of a supervisor's feedback or in acknowledging feedback and providing additional feedback about the supervisor, too. The interactional approach considers implicit messages, such as when a supervisee does not disagree with feedback because he or she is too intimidated to disagree. Alternatively, a supervisor communicates explicit feedback to the supervisee whilst communicating that he or she is committed to the supervisory relationship and the supervisee (Bernard & Goodyear, 2009).

Feedback may be communicated immediately or it may be delayed. Immediate feedback is generally associated with live observation methods. However, there is no official cut-off time to determine whether it is delayed, or not (Bernard & Goodyear, 2009; Falender & Shafranske, 2010). Immediate feedback occurs soon after the experience to which feedback refers (Freeman, 1985). Due to its early communication, immediate feedback allows for the immediate clarification of feedback and adjustment of identified problem areas. On the other hand, delayed feedback opens room for continuous mistake making, which can affect the therapeutic relationship and lead to providing inadequate services to clients.

Supervisors tend to view the communication of feedback as a linear process (Bernard & Goodyear, 2009). Supervisors posit that linear feedback is a vehicle for informing supervisees whether or not they are moving towards competence. Positive feedback refers to instances

where supervisee behaviour is reinforced, and corrective feedback refers to instances where the supervisor notes the supervisee's mistakes and alerts them to things they may have missed. Supervisors need to be conscious of their supervisees' stage of professional development. Supervisees early in development require more positive feedback and affirmation, and more advanced supervisees require a balance of positive and corrective feedback (Abbott & Lyter, 1998). Literature from organisational psychology suggests that there are a number of supervisor types that are different in their provision of positive and corrective feedback, most of which are unable to provide a balance of positive and corrective feedback (Moss & Sanchez, 2004).

The zero-tolerance and micro-manager supervisors are unable to accept mistakes and skilled at finding faults focus on providing corrective feedback and offer little or no positive feedback. There is the nurturing style of the conflict avoider supervisor who often avoids or delays, or distorts corrective feedback. These managerial styles have a number of effects on supervisees, including the reticence to seek feedback and the failure to self-report errors (Moss & Sanchez, 2004).

In a study in the scope of organisational psychology pertaining to the reported experiences of feedback with regards to satisfaction with a supervisor, performance, and motivation levels, it was found that positive feedback was associated with a greater increase in employee motivation than negative feedback (Jaworski & Kohli, 1991). Positive feedback was cited to have a motivating impact on task engagement among preschool children (Anderson, Manoogian & Reznick, 1976), and more motivation in free-choice persistence in undergraduates compared to the no feedback control group (Deci, 1971). Corrective feedback was not observed to lower satisfaction with their supervisors in the Jaworski and Kohli (1991) study of automobile salespeople. Quite unexpectedly, corrective feedback was associated with slightly higher levels of satisfaction with supervisors than when positive feedback was given. Jaworski and Kohli (1991) note that corrective feedback neither had a large impact on

performance as positive feedback nor had a negative impact on motivation. This finding shows that supervisors should be aware that they can provide corrective feedback without worrying about upsetting employees. In addition the authors note that employees are more likely, than not, to hold the expectation that they will be told when they are not performing according to expectations (Jaworski, & Kohli, 1991).

In looking at optimal ways to provide feedback, it is suggested that communicating positive and corrective feedback in an open and non-judgmental manner will engender a pattern of behaviour where the supervisee will begin to seek out help and feedback and become open to evaluation and feedback (Sapyta, Riemer & Bickman, 2005). According to Hillman, Schwandt, and Bartz (1990), this approach to feedback forms the foundation of trust in the relationship. The impact of a positive supervisory relationship was illustrated in a study that examined the bearing of feedback on employee morale. It was found that corrective feedback enhanced rather than threatened employee morale in the context of a strong supervisory relationship (McKnight, Ahmad, & Schroeder, 2001).

According to literature on psychotherapy, feedback is beneficial in therapy when it is provided in the context of a strong client-therapist alliance (Watkins, 2015) According to Claiborn et al. (2001), psychotherapeutic feedback oftentimes arouses emotions in the recipient that can either stimulate or hinder the motivational potential of feedback. In a study where feedback was treated as an intervention and posed against cognitive and behavioural interventions, the feedback condition was associated with more marked behavioural change than the cognitive and behavioural interventions (Claiborn et al., 2001). Feedback was also associated with greater reduction in alcohol consumption for alcoholic clients who completed an alcohol screening measure and had been given feedback as opposed to those who received no feedback at all (Miller, Benefield, & Toningan, 1993). Despite occupying a great space in the psychotherapeutic domain, where feedback can take the form of interpretation, immediacy,

and confrontation (Watkins, 2015) and in effecting client change, there is very little empirical investigation into this area (Claiborn et al., 2001).

In clinical supervision, the lack of feedback from supervisors is the major theme in the literature (Bernard & Goodyear, 2009; Heckman-Stone, 2003). This literature also purports that supervisees find abundant feedback important. Barth and Gambrill (1984) noted that students ranked receiving supervisor observation and feedback as the most effective factor contributing to their skill development. When feedback is absent, mistakes may pass without correction, supervisees may lose positive habits, and inaccurate assumptions may be made (Heckman-Stone, 2003). Freeman (1985) recommended that feedback be well-timed, frequent, objective, credible, balanced, and amongst other things, reciprocal. Supervisors indicated that giving objective feedback was easier to give than subjective feedback that includes supervisee personality and professional behaviour (Hoffman et al., 2005). An additional factor that makes giving feedback easier is when a supervisee is perceived as open and expresses a desire for both positive and corrective feedback. However, another dynamic to consider is that supervisees may fluctuate in terms of their openness and receptiveness to feedback. This highlights the importance of timing feedback well (Hoffman et al., 2005). Timely feedback refers to immediate feedback that is on-going, and comprises both formative and summative evaluations (Bernard & Goodyear, 2009; Heckman-Stone, 2003).

Similarly held positions by organisational psychology and psychotherapy literature is that feedback should be provided within a supportive and trusting relationship (Frawley-O'Dea, 2003; Heckman-Stone, 2003; Liese & Beck, 1997; Sarnat, 2012; Skolnikoff, 1997). However, Bernard and Goodyear (2009) note that some supervisors make protecting the self-esteem of their supervisees their primary objective. In this instance, corrective feedback becomes indirect and difficult to comprehend. Lehrman-Waterman and Ladany (2001) found that students tend to withhold information, including negative countertransferential reactions, personal problems,

clinical errors, and concerns with evaluation when they did not receive adequate feedback. In addition to the anxiety elicited by providing corrective feedback, is the experience of providing feedback that is neither characterised as positive nor negative feedback, for instance, providing feedback about multicultural concerns in cross-cultural supervision relationships (Abbott & Lyter, 1998; Bernard, & Goodyear, 2009; Hoffman et al., 2005; Saptya et al., 2005). This occurrence often results in an impasse in supervision and the difficult feedback tends to result in a less engaged supervision relationship (Hoffman et al., 2005). This feedback is difficult to give and accept, as it is subjective. With this said, it is evident that establishing objective behavioural criteria can help reduce bias and distortion (Heckman-Stone, 2003).

The literature on feedback across various fields in psychology suggests that while feedback, positive and/ or corrective, results in anxiety for the supervisor and the supervisee who receives it, it is desired and it has the potential to change subsequent behaviour in the supervision relationship and translate into therapy. The literature does not fully address the experience of feedback from the viewpoint of the supervisee. Additionally, the literature does not fully address how much feedback is desired by supervisees; this includes how much positive and corrective feedback supervisees are comfortable with. It is also unclear what approach supervisees would like their supervisors to take when providing feedback. Research to date, focuses on the impressions of supervision in general, rather than particular aspects such as feedback, which is referenced as a crucial aspect of clinical supervision. Finally, the literature does not address the supervisee's role in negotiating feedback.

CHAPTER 3: METHODS

3.1. Research aims

This research aimed to explore supervisees' reported experiences of feedback in clinical supervision. Secondly, the researcher aimed to explore the supervisees' reported accounts of the perceived influence of feedback on the supervisory relationship. Thirdly, the researcher aimed to address the supervisees' reported accounts of the influence of feedback on supervisees' clinical skills development.

3.2. Research questions

- *What were supervisees' reported experiences of feedback in clinical supervision?*
- *According to the supervisees' report, what is the influence of feedback on the supervisory relationship?*
- *According to supervisees' report, what is the influence of supervisors' feedback on the supervisees' clinical skills development?*

3.3 Research Design

The choice to use a qualitative approach was informed by the exploratory nature of the research aims (Lewis & Ritchie, 2003). Interviewees were posed with questions intended to explore their responses, impressions, opinions and understandings of the supervision process and the implications of the feedback they had received. Inquiry into the participants' experiences required immersion into details and specifics of encounters they had in supervision. Furthermore, it was central to this study's aims to provide an understanding of feedback from the subjective perspective of participants. Qualitative research distinguishes itself as being staunchly focused on an insider's view, providing in-depth descriptions and understandings of actions and events.

3.4. Sample

The sample comprised of 6 student clinical psychology supervisees, where 3 were intern clinical psychologists in their second rotation and 3 clinical psychologists in community service who were at various stages in commencing or completing their requirements for the year. This group of supervisees was chosen because they are all junior psychologists obliged to attend clinical supervision with an allocated supervisor and they are able to report on their early and recent supervision experiences.

3.5. Procedure

Convenient and purposive sampling methods, with snowball sampling (Teddlie, & Yu, 2007) was the primary strategy to recruit participants. In order to contact with the current supervisees in community services and internship, it was necessary to firstly get in touch with the internship co-ordinator who has access to the email addresses of students and supervisors within the University of the Witwatersrand's Clinical Psychology training circuit.

An email was sent to the internship co-ordinator, (Appendix A) containing details of the study. Trainees on the list were asked to contact the researcher by email or telephonically (Appendix B). A timeline for a convenient time for which they could express their interest to partake in the study and when the interview would be conducted was also provided. The number of trainees interviewed depended namely on whether the interviews sufficiently answered the research questions (by reaching theoretical saturation) and the time constraints pertaining to the deadlines of the research report itself (Fossey, Harvey, McDermott, & Davidson, 2002). The participants forwarded details of other individuals they thought would be interested in the study to the researcher whilst others forwarded the research details to colleagues.

Upon expressing interest via email, the researcher negotiated a convenient time and venue with participants. Subsequent to meeting the participants at their suitable times, they were

provided with the participant information sheet that included a cover letter (containing relevant information pertaining to the study) (Appendix C), and consent forms [interview consent (Appendix D), recording consent (Appendix E)].

Subsequent to obtaining consent from participants, data was obtained in the form of an interview. The interview protocol designed by the researcher comprised of 17 questions and followed a semi-structured format, with the average duration of interviews being 40 minutes. The questions were aligned to the research questions (Appendix F); however, they were open-ended and broad to allow for moment-by-moment, freely expressed, spontaneous responses from participants. The opening three questions in the protocol were aimed at introducing the participant to converse about their general experiences of supervision and the clinical work for which they received supervision. Further questions addressed the participants' understanding of the role feedback plays in supervision and their perception of good and bad feedback – participants were asked to provide examples of their own experiences of good and bad feedback. The next section was appropriate for gaining the participants' perception of factors that make feedback easy or difficult to accept and their preferences of feedback. The following questions were set to contextualise feedback to the supervisory relationship and to determine if there is any relationship between these events and the implication of the event to their training and development. To end off the protocol, participants were asked to reflect on their experience of talking about feedback in clinical supervision and to provide any relevant details they thought had not been covered. The interviews were transcribed by the researcher. For purposes of anonymity, each participant was allocated a pseudonym (*Participant 1, Participant 2, Participant 3*, etc.) and the gender markers of participants and their supervisors were collapsed (to s/he, him/her, etc.).

3.6. Data analysis

Given the exploratory nature of this study, thematic content analysis was used to analyse the data (Braun & Clarke, 2006). A favourable aspect of thematic content analysis is the flexibility that allows for rich and detailed data (Braun & Clarke, 2006). This method is ideal, as the researcher is interested in the underlying understandings, ideas, and conceptualisations of feedback in supervision.

Braun and Clarke (2006) have a step-by-step procedure for performing thematic content analysis. This process begins with the researcher noticing and extracting "patterns of meaning and issues of potential interest" (p.15) and ends with reporting the content and meaning of patterns. It should be noted that these steps do not necessarily follow a linear progression, from one step to the next. Rather, it is an immersive and recursive experience with a lot of revisiting (Braun & Clarke, 2006). The researcher followed Braun and Clarke's (2006) six stages of thematic content analysis that comprise of:

1. Familiarise yourself with the data:

   By virtue of the sample size immersing oneself in the data was not found to be a difficult task. The spaces in between the individual interviews also provided time for reading the data several times before more data was retrieved.

2. Generating initial codes:

   After examining the data, several emerging areas of interest were noted.

3. Searching for themes:

   According to Braun and Clarke (2006, p.82) "A theme captures something important about the data in relation to the research question and represents some

level of patterned response or meaning within the data set." Further examination of the data yielded ideas that were recurring across responses.

4. Reviewing themes:

   The themes that emerge in stage 3 are analysed further and careful attention is given to determine any inconsistencies or further themes that can be teased out.

5. Defining and naming themes:

   This step is characterised by revisiting the last 4 steps and appropriately labelling the themes and assigning them to the elements they represent in the research.

6. Producing the report:

   The final step is to use the themes to spark further conversation and to determine the impact the findings have on previous and new ideas.

3.7. Ethical Considerations

In order to facilitate an honest and critical discussion pertaining particularly to experiences of encounters with senior members of the profession, confidentiality (see Appendix C) was guaranteed to participants. There is a potential for scorn or exclusion or any other kind of detrimental consequences if the certain attitudes are associated with the individual. In addition, to dignify autonomy, the form also explained that participation is voluntary, that he or she may withdraw at any time without any consequences, that their interview transcript would be anonymised, that the interview data is confidential and no identifying information would be shared with anyone else, that they had the right to choose not to answer any questions they did not feel comfortable answering, and that there were no direct risks or benefits to participating in this study.

Provided that the community of clinical psychologists is very small, and with fewer professionals acting in the capacity of supervisors (in universities and hospital settings), potential identifying information such as names and the gender of the supervisor, and supervisee were modified. Additionally, given the face-to-face nature of the interviews, the participants are not anonymous to the researcher. It was incumbent on the researcher to ensure anonymity and confidentiality by removing all identifying information used in the final report (this includes the removal of the names of the institutions they are affiliated to). Furthermore, given that the researcher's supervisor is also a clinical supervisor, the interviewees' identities are unknown to her. For consent to be obtained for recording, interviewees were explicitly informed that only the researcher had access to the audio files.

All participants were informed that the results obtained in the interviews was for use in the final report of this study and that it may be published in journal format, which would be available to the public, and on the World Wide Web via the University of the Witwatersrand library. Furthermore, participants were informed that upon request a summary of the research report would be made available to them.

3.8. Validity and self-reflexivity

To ensure good qualitative research practice several measures were taken into account: peer debriefing and self-reflexivity (Frels & Onwuegbuzie, 2012). Supervision was used as a space for debriefing, where the transcripts and drafts of reports and the adherence to outlined procedures were discussed and feedback was provided. This measure ensures that an external view remains present. One of the significant factors of qualitative research is that the researcher plays a key role in the research process and is therefore unable to be an objective observer in the process.

The researcher's subjective experience during the course of data collection and analysis are thus important (Mruck & Breuer, 2003). The purpose of being reflexive is to account for the extent to which the researcher may have influenced the study. The researcher enters the research with his own preconceptions, attitudes, and beliefs. Furthermore, the interaction between the participant and the researcher may have an influence on the content produced. It was therefore crucial for the researcher to be aware of his characteristics and his demeanour whilst conducting the interviews.

Because the researcher is a supervisee, and relatively new to supervision, participants tended to give didactic input and 'tips' on what to expect in supervision in subsequent training contexts. In addition, the researcher needed to pay careful attention to and document any biases and thoughts about supervision that could have infiltrated or contaminated the responses provided from the initial contact during the interviews to when the data was captured and analysed.

The participants were wary of being identified by previous supervisors as the population of clinical psychologists involved in training is quite small. Interviewees engaged with off-the-record conversations that were relevant and detailed before and after the interviews and this posed difficulties during the analysis of the data and the researcher had to be conscious that he did not allude to or add any of the information that was not within the data, as this would be a violation of ethical conditions and contaminate the data. This also limits the potential avenues for exploration. Furthermore, some participants also assumed that there was an implicit understanding between them and the researcher and some responses were laden with theoretical concepts and jargon as well as vague or brief responses under the presumption that the researcher understood and no further elaboration was deemed necessary.

The response to this on the researcher's part was to fall into these assumptions of understanding without asking for further elaboration for the sake of enriching the data. Additionally, the researcher was also anxious, perhaps more so, than the participants and some interviews were thus brief with limited content.

CHAPTER 4: RESULTS

After applying thematic content analysis to the data, eight broad themes were extracted: 1) relates to what participants understood about the role of feedback in clinical psychology supervision. 2) The general expectations of feedback. 3) Experiences pertaining to instances when feedback was easy to digest 4) and indigestible. 5) The experiences related to feedback conveyed and any change (positive or negative) noted in the supervision relationship, and the effect thereof of feedback on 6) clinical skills. 7) Reciprocating feedback. 8) Reflecting on experiences of feedback. The aforementioned categories are supplemented with examples pertaining to suitable events shared by the participants.

4.1 Role of feedback

Participants reported that the role of feedback is to promote supervisee reflection within a thinking space that promotes reflection and awareness, as well as clinical guidance.

Participant 3: I think it is useful for is that I see feedback as, more than anything else, as being the space to facilitate your thinking.

Participant 5: I think in general the role of feedback, and I think I've said this a lot, it helps you think and make sense of your patients and yourself.

Participant 6: The role of feedback is vital because you need feedback so that you can grow as a person and in terms of your own knowledge.

4.2 Expectations of feedback

Participants expected feedback to be given in the context of a supportive and collaborative supervision relationship, where the content is direct, honest, and resolute. Furthermore, the feedback was expected to be provided alongside an affirmation of their general abilities.

The participant's comment indicates that he/she assumes the learning role and points out that this is a vulnerable position to be in.

Participant 1: It needs to be constructive criticism because you are learning and you will never know everything.

According to *Participant 5*'s comment, supervisors are expected to convey sensitivity to their vulnerability and fragility and, in the same breath, to provide incisive feedback that might contain corrective content. Supervisees thus pose that supervisors should be clear but at the same time should position the feedback such that it is cushioned almost as a suggestion rather than a direct statement of difficulties and areas to focus.

Participant 5: I think I enjoy the more gentle approach to feedback because it's easier to take and I also prefer it to be directive. And when I say "more directive," I don't mean telling you what to do, but pointing to areas where you struggle.

Participants also indicate that the supervisor must be aware of the impact that feedback has and it is suggested that it has the capacity to be destructive. Again, there is a suggestion that feedback should be straightforward but provided with great sensitivity and caution.

Participant 2: So for me I feel that feedback should not destroy your character but it should point out where your weaknesses are in therapy and if someone doesn't pick it up for you it's hard to do it yourself and when you eventually do it might be too late for your patient. So I feel that feedback should be as constructive as possible but it shouldn't destroy your character as a person and therapist.

According to the comments, the participants expect supervisors to be competent in providing the double-edged direct sensitive feedback. Furthermore, the supervisor needs to give feedback that does not hinder independence. One participant is of the opinion that clinical

supervisors should provide feedback that is aimed at growing the supervisee's capacity to engage with work autonomously rather than fostering a reliance on the supervisor's skill sets and opinion. Such an interaction might be one where the supervisor acknowledges the supervisee's lack of knowledge and conveys that in a delicate manner whilst also indicating to the supervisee that they have the potential to grow by recognising and reinforcing constructive self-initiated behaviours and thought processes.

Participant 3: I think it should always be warm and encouraging and I think it should be framed in a manner that ultimately is facilitating your development as opposed to encouraging dependency.

Participants acknowledge supervision to be a relationship. They particularly expect it to be a relationship they can use and if it is a distant one, then it is not useful. Moreover, the supervisor's awareness of the supervisee's needs and the capacity to deliver direct feedback in a sensitive manner facilitates accessibility and confidence in the relationship.

Participant 6: It really comes down to the relationship that you have. Just to emphasise, it doesn't have to be a personal relationship, just their accessibility.

Conversely, participants were asked for their opinion on how feedback should not be and they generally stated that it should not be punitive, unjustifiable, and confusing/ vague.

In this instance, supervisees find that when a supervisor 'thinks out loud' without processing and considering what the supervisee is able to understand at their level of development; this consequently renders the supervisee paralysed and stuck, as exemplified in the quote below from participant 3

Participant 3: How else it should not be done, is in way that facilitates dependency. I think this particular supervisor tended to do two things that always left me very confused. Number

one would say something that probably made sense in the supervisor's mind but made very little sense in my mind and when I would ask more about it for him/her to elaborate s/he wouldn't and say "just carry on."

Supervisees also expect their supervisors to be well-intentioned when providing feedback and expect the content of the feedback to pertain to their room for growth rather than largely focusing on shortcomings. *Participant 4* illustrates this point further and indicates that feedback should not be transmitted as an aggression and it should not elicit anxiety. This could suggest that supervisees are fragile and prone to injury if not managed sensitively.

Participant 1: It shouldn't be negative.

Participant 4: Punitive, uncontaining…

Participants suggest that supervisees require a space that facilitates thinking and to feel heard, even when the supervisor's agenda is to be more directive or finds something else to be pertinent. The supervisee can perceive this as an impingement and be left feeling rejected. This might also point to how directive supervision should be and how much of an active participant the supervisor should be.

Participant 5: So, how I feel it should not be like is a process where your ability to think and make sense of things is shut down. Like "No, no, no don't think about that. It's not that, it's this."

4.3 Factors that make feedback digestible

Participants generally indicated that they could hear feedback if they felt the supervisory alliance was strong, their supervisor approachable, reliable and looking out for the supervisee's best interest, and if the feedback was generally aimed at promoting self-exploration and encouraging thoughtfulness.

Participant 1 highlights that sensitivity and reinforcing skills and emphasising potential, rather than undermining them, builds confidence. *Participant 3* elaborates further on this point.

Participant 1: …sometimes you think that you are doing things wrong and sometimes it's good to hear from people that you are doing something right and that you do have potential and you are not doing everything wrong. So it was nice to hear that at least I'm doing something right.

Participant 3: S/he framed it in such a way that s/he opened up the space for me to think about it and what that did was encourage me to get there slowly. S/he believed I could get there and I did. It is something that has stuck with me forever.

Supervisees respond better to a collaborative space where the supervisor expresses interest and curiosity in their thought process. This is in contrast to a more one-sided interaction where the supervisor speaks alone and out loud and expects the supervisee to engage at his/her accept and engage with content pitched at their level. Below is an excerpt from *Participant 6's* response and an example of moment where feedback was provided in the context of a safe supervisory relationship.

Participant 6: I've had many experiences of when feedback has been easy to accept. I think personally feedback has always been easy for me to take if my supervisor is accessible and s/he can give me feedback where it feels like we are two minds thinking together.

In the below excerpt *Participant 6* demonstrates how a good supervision relationship mitigates vulnerability and the supervisee is more amenable to hearing a more direct or strong message from a supervisor.

Participant 6: like one supervisor in my first rotation, s/he looked at me and s/he said, "No, no! Why did you do that?!" it wasn't a disaster and s/he was just teasing me. S/he was saying

"no" in such a devastated fashion, but it was easy to take it because there was a pinch of humour to it, and we had a good relationship. There was something that was glaring me in the face during a session, and when s/he picked up on it I felt really stupid for not seeing it in the session because it was so obvious. It was so easy for me to take it because there was the relationship there, and after s/he had given a devastated response, s/he said, "Let's think about it."

4.4 Factors that make feedback indigestible

When participants were asked to elaborate on experiences when feedback was difficult to hear, they reported that feedback was difficult to receive if the supervisor's approach was harsh – leaving them feeling interrogated and accused – if the supervision relationship is new or superficial (where the feedback was thought to be provided prematurely), strained, if it was vague or confusing (pitched at a level supervisee's could not understand), where positive and corrective feedback were not balanced, and the lack of safety and warmth in the relationship. Examples from *Participant 1s, Participant 2s, Participant 4s, and Participant 6's* experiences are used.

Participant 6: I think that at all costs it should not leave the supervisee feeling shut down…

When feedback is given without considering the developmental stage of the supervisee (personal and professional), then the supervisee does not understand and it can have a stifling impact (in the same manner as an interpretation made at the wrong time).

Participant 3: It felt difficult to accept something that I could not understand…If I think back to that experience, the only time I found it difficult to accept something in feedback is if something did not make sense, in the sense that I didn't know how to translate it into what I am doing or how to understand it for my own sake.

The quote below raises the issue of balancing a therapeutic and training stance. In this instance, the supervisor is perceived to be engaging with the supervisee as a therapist, but the interaction is one that seems inauthentic and the supervisor comes across as defensive and avoidant of providing direct feedback. Moreover, the supervisee feels that this is a lost opportunity for learning and the supervisor shuts down the thinking space. This is also a further contrast to experiences where the supervisees feel ignored by the supervisor who seems more concerned with providing as many answers and suggestions as possible without taking supervisees' personal needs into account.

Participant 5: When supervisors give roundabout feedback, where they are trying to be containing and it just comes across as pseudo-containment and holding. It doesn't give any clarity to the problem, whereas now what I'm finding is that if something goes wrong in session, because we do transcripts, so if something goes wrong I already know what's gone wrong in session and I feel bad about myself. So instead of giving me this pseudo-containment crap, just tell me that I've gone wrong and I should have done something else there and for me it's more comforting because I know I could've done it and then talk about why it went wrong.

Furthermore, *Participant 1* exemplifies the other extreme, in which the supervisor identified what the core problem between the supervisee and client, it was delivered in a manner that was felt to be an attack, and furthermore as a trainee and subordinate there was no room to respond or an attempt to defend themselves as it can be interpreted as a defence and reluctance to hear feedback or to learn

Participant 1 discussing a case with a supervisor*: So, s/he was like it was all my fault and maybe I was too anxious and I was like, "how can this be my fault?" I couldn't really defend myself and you really can't be defensive because it means that you aren't willing to learn.*

Participant 2 gives an experience of when a supervisor is not working with the supervisee's development level. This supervisee was doing well for his/her level but felt that s/he had plateaued. This suggests that the supervisor needs to challenge the supervisee and promote a new level of competency. This supervisee felt under stimulated in this context because his/her skills were deemed adequate. However, the supervisee also indicates the lack of agency to alert the supervisor to the stasis of his/her development.

Participant 2 describing his/her experience*: I think in my intern year the one feedback I got from that was that I'm doing well and I felt like they were missing out on stuff. Although it was good to hear I feel like they could have helped me out with my weaker areas. So there was an instance where I only got good feedback, but it didn't feel very helpful.*

Supervisees require their supervisors to be aware of their current abilities and shortcomings and to keep this in mind when providing feedback. Supervisees need supervisors to track them appropriately and provide feedback that they can easily make sense of and internalise and then subsequently apply to their work.

Participant 4: I remember the one day s/he kinda stopped me we were going through process notes, and it was about an aggressive patient and s/he was trying to point out some dynamic between the two of us, and s/he was like, "There, that's what I'm talking about! Do you see what I'm saying?" I feel like that can be really difficult to get. I think that part of that was also because s/he was pitching things above my level.

Participant 6 highlights two problems: firstly, working outside a positive supervision relationship and, most specifically, an absent relationship. The second issue raised is that the supervisee feels that the space to think was shut down (the opportunity to think about the dynamic between the supervisee and patient). This also indicates a problem between managerial supervision and clinical supervision. As a manager, the supervisor is concerned

namely about the call being made or not and as a clinician the supervisor would be concerned about the meaning behind a call not being made.

Participant 6's example of an incident with a supervisor: *In my current rotation, my supervisor questioned why I hadn't called a patient. I never, ever don't have a good reason for why something is not done because things for me are always done. So when something is not done, there has to have been an obstacle personally or within the work environment and I can be open about it, I can. My supervisor in this rotation questioned me why I had not seen or contacted a patient […] s/he is completely unavailable, and she doesn't know me, or my work ethic.*

4.5 Effects of feedback on the supervision relationship

Several participants spoke about the effect of feedback on the supervision relationship. Participants typically referenced events that had been damaging and detrimental to the relationship.

When referring to unfavourable feedback events, supervisees reported feeling like the relationship would never be the same and expressed that the supervision space became uncomfortable and reinforced perceptions prior to feedback where it was thought that the relationship cannot work. These participants reported losing faith in supervision and becoming more withdrawn and guarded.

Participant 2 also introduces a new issue pertaining to the applicability of feedback. Supervisees need to see the feedback in action, and working. The more the feedback works in therapy, the more trust is gained and sustained in the supervisor.

Participant 2: …there had been times like with my external supervisor that had not been useful and the feedback was consistently not useful and it changed the relationship with him/her

as a person as well and I didn't not feel like going to supervision and I dreaded it and it wasn't a nice relationship.

Participant 5 provides an example of an instance where the supervision relationship has gone wrong and with no chance of recovery as a result of inappropriate feedback. This exemplifies how powerful feedback can be whether it is provided constructively or negatively.

Participant 5: I felt like my vulnerability was being used against me and the feedback also felt like it was attacking this. It got the hairs on the back of my neck up and the hairs on the back of his/her neck up and the relationship has deteriorated to a point where I don't want see him/her anymore and it has deteriorated to a point where I don't have respect for him/her and whenever I think of him/her I just have yucky feelings inside.

4.6 Effects of feedback on clinical work

Participants reported that they changed their clinical work based on the feedback. Additionally, participants reported that the quality of their work improved. Other participants reported that they felt the feedback they had been given had compromised their work and the confidence they had in their skills. The following quotes illustrate the resounding impact of the feedback on skills and confidence, in both a positive (*Participant 2*) and a negative (*Participant 3*) manner.

Participant 2: That was a turning point for me. I had never been given any negative feedback from a lecturer or anything and this was the first supervisor and person in authority to critique me in such a way. It was hard to accept but I still go back to that now in my Comm Serv year and I look at the notes from that supervisor.

Participant 3: I felt like there was something intrinsically wrong with me and I didn't know where to place this reaction and I felt like I didn't fit in the field and it really broke *my*

confidence…Therapy didn't feel safe and real and I felt incompetent. I felt completely useless in the space because I didn't have any sense of guidance and the fundamentals of therapy became difficult.

4.7 Reciprocating feedback

Participants were asked whether or not they had provided feedback to their supervisors and the majority of participants reported that they had provided feedback to their supervisors; however, this was not always done orally and they felt compelled to provide the feedback of which was not honest and had been filtered. Participants reported that they felt that their feedback would not be taken seriously and that they could not provide transparent feedback because of the differences in power between supervisor and supervisee. Another factor inhibiting feedback to supervisors was whether they were perceived to be receptive or not.

The supervisee suggests that the supervision relationship is not an entirely fair space for honest feedback. More interestingly, is that supervisees require honest feedback from supervisors but it seems like they are not open to giving feedback that is honest in return.

Participant 1: Ja, we had to. It wasn't verbal we would get an evaluation form each quarter and think about how the experience was. Ja, and I feel like even there you can't be really, really honest. Like even when there has been a lot of tension between you and the supervisor you just write good feedback just to avoid because they have to read it and if they read something bad then it's like I don't want to learn and I'm insolent. I don't know what they actually do with it…

Participant 3 highlights when supervisors ask for feedback on their feedback style. This suggest that this supervisor can then adjust the way they pitch the feedback and potentially curb most problems related to supervisees feeling unheard, misunderstood, criticised, or under stimulated. *Participant 5* adds that it is important to have a good working alliance with the

supervisor and that the space opens up room for honesty and perhaps reciprocity. However, establishing a working alliance seems to only be possible over a longer length of time for some supervisees, which is not always possible in the training programmes.

Participant 3: Supervisors usually ask, and my current supervisor asked me, after our first session, if the feedback she had given was helpful to me. And it's nice to hear this because they genuinely want to know if it's helpful and if the space will be of use to you. I have always loved and appreciated how sincere they are about wanting to help. So feedback is really easy to provide to people who would like to hear it and do something about it.

Participant 5: I haven't given direct feedback to my supervisor before. For instance, I suppose I have regarding telling my supervisor that something doesn't make sense and I don't get it. I haven't had relationships for a long enough time to give more feedback.

4.8 Reflecting on experiences of feedback

Participants reported that speaking about their experiences of feedback stirred up different feelings (positive and negative), enabled them to reflect on what kind of input works and what does not work for them, their own progress, and they found it both anxiety provoking and relieving. Participants particularly emphasised the importance of having a space for talking about supervision and feedback, particularly because these are crucial aspects of professional development. The different dynamics, both positive and negative, that arise within the supervision relationship are rarely spoken about and given careful attention.

Participant 2: It's been lovely reliving the experiences. M1 feels like it was a breeze now in comparison to Comm Serv. Also in the M1 year and internship year it feels like your supervisors hold you more and it felt comfortable and when you made mistakes it was easy because they could help you through it and you felt more contained and held. The supervisors are very much like parental figures. In Comm Serv you are left very much to your own devices.

Your supervisors are helpful but they leave the responsibility very much to yourself, just like an adult leaving home. It's been nice to speak about my experiences and the process has even reminded me of supervisors I had forgotten.

Participant 5: I think that this topic is also something that I have thought about before, so it forces you to draw on some unprocessed experiences and try make sense of it, and stuff. I think it's also been nice because I got to think about what's been good for me, and what hasn't. It's also great to know how many different experiences I've had.

Participant 6: It's very nice talking about it, especially in a neutral context, especially because people who have supervision with me aren't here. You get scared to give your true opinion of how things are. For example, when I shared the experience I had with the supervisor with a colleague and the way he responded was nice and I felt heard, but it felt like he was defending the supervisor. There was a defensiveness to it, and being in this context, you're interviewing me and you're not going to give me your opinions and mine feel very important in the process and they don't feel trodden on. Feedback is very crucial to learning in M1 and internship and it's good to talk about it…I think that I haven't put as much thought into feedback and supervision even though it's something that you face so much throughout your career. It's such an integral part of learning and professional growth.

Upon reflecting on the experience of talking about feedback in supervision, supervisees felt that this was an area rarely attended to, which is surprising given the impact the supervision relationship and feedback can have on the development of trainees. Participants also suggested that this is a difficult topic to engage with because of the high emotional content, which points to the intricacies within supervision. Supervisees reported that it is difficult to think about, talk about, and process most of their experiences.

CHAPTER 5: DISCUSSION, LIMITATIONS AND RECOMMENDATIONS

The aim of this study was to examine supervisees' experiences of feedback in clinical psychology supervision. Given that feedback has been largely referenced to be the backbone of training for mental health practitioners (Bernard & Goodyear, 2009), the purpose of this research project was to better understand the reported experiences and perceptions of feedback in general as well as to gain insight into ways in which feedback experiences can impact supervisees, supervisees' clinical work, and the supervision relationship.

The overall findings of this study indicate that participants viewed feedback as an opportunity for supervisors to provide direct but delicate instruction or guidance, rather than to communicate an overt evaluation of the supervisee's performance level. Most participants not only expected to receive feedback, they anticipated feedback to be a positive experience and, interestingly, participants reported more on negative experiences of feedback that resulted in negative consequences for themselves, their clinical work, and relationship with their supervisor. These and other findings are outlined here under.

5.1. Experiences of feedback

The overall findings of the study suggest that participants viewed feedback as an opportunity to learn and grow, particularly through feedback in the form of direct instruction and feedback aimed at promoting self-reflection. Participants also identified a number of supervisor factors and identified the nature of the supervision relationship to have contributed to feedback experiences that were either well-received or difficult to receive.

5.1.1. Role of feedback. The participants predominantly identified feedback as an opportunity to receive direct instruction, promote self-reflection, stimulate professional growth, and, to a lesser extent, to prevent or correct supervisee mistakes. These results align with the literature on feedback in clinical supervision, as feedback is viewed as an opportunity

to transmit knowledge, develop competent mental health practitioners, and to protect the welfare of clients (Hoffmant et al., 2005). It appears that as supervisees, the participants had a desire to learn and grow as clinicians, and they viewed feedback as a vehicle for these opportunities.

5.1.2. Expectations of feedback. The literature on feedback suggests both supervisors and supervisees can be anxious about feedback (Sapyta et al., 2005), however participants held mostly positive expectations and beliefs about feedback. Perhaps this finding indicates that giving feedback need not be so anxiety-provoking an intervention to deliver.

In congruence with Lerhman-Waterman & Ladany (2001), the participants found that feedback and the supervision relationship were mutually reinforcing. Participants voiced expectations about the content of the feedback and the manner in which it is delivered. Specifically, participants expected that feedback would be direct, honest, and clear, a finding that mirrors the theoretical literature on feedback (Bernard & Goodyear, 2009). While supervisors worry about the way in which they couch feedback and how it will be received, it seems that supervisees expect that feedback will be given directly, clearly, and sincerely – rather than for feedback that is talked around, hedged and nestled amongst qualifiers. Supervisees also directly and indirectly expressed that they are very vulnerable and in need of a supervisor to acknowledge this vulnerability and work empathically with it in the supervision space.

They expected supervisors to competently acknowledge and manage their sensitivity while maintaining a resolute and straightforward approach to giving feedback. This finding highlights a balancing act that supervisors have to negotiate. Furthermore, participants expressed an expectation that supervisors would provide affirmation of supervisee skills when providing corrective feedback. While supervisees expect and desire direct and honest communication

about areas in which they should consider making a change, supervisees also expect that supervisors will affirm them and speak to those areas in which they are demonstrating competence. The results also indicated that supervisees expect supervisors to gauge and process their anxiety and provide feedback that is non-confrontational or judgmental as discussed by Eagle et al. (2007). These are approaches ubiquitous to the therapeutic context and raises the dilemma of how much of a therapist a supervisor needs to be for the supervisee.

5.2. Factors that make feedback digestible

The participants' particular thoughts about instances when feedback was either easily received or not well-received indicates that two areas contribute to how feedback is well-received. These areas denote to the supervisor and the supervision relationship.

Participants who perceived their supervisors' manner positively found feedback easy to receive, and when they perceived their supervisors to be harsh and punitive it was difficult for them to receive feedback. Supervisees are therefore sensitive to the way in which supervisors conduct themselves and convey information. What seems to be particularly important is that it is not necessarily what is said that has the most impact, rather how it is said, or even more it may increase the chances of receiving and the message and incorporating it as discussed by Lester and Smith (1993). Moreover, supervisors who were perceived to work through the feedback together with a supervisee, or validated and normalised the supervisee's clinical work, helped supervisees to hear feedback. If feedback came across as vague, harsh, or pitched above the level a supervisee could understand, it was considered to be indigestible. Therefore, it appears that how a supervisee will hear feedback is influenced by circumstances that extend beyond the content of the feedback. Allen, Szollos and Williams (1986) discuss this occurrence and report that supervisors may be inconsistent in their demeanour as their roles span the

domains of evaluator and mentor, and even in the capacity of an employer and thus supervisors may have to monitor their own reactions and conduct around supervisees.

Participants viewed feedback as a unidirectional event and they did not readily identify themselves as playing a role in feedback that either went well or was difficult to take. In looking at literature that describes factors that were identified to influence accepting feedback (Hoffman et al., 2005), supervisee openness was seen as a factor that contributed to favourable outcomes after feedback was given, whereas supervisees who were deemed defensive were likely to have negative experiences of feedback (Bernard & Goodyear, 2009; Hoffman et al., 2005).

Interestingly, participants in this study expressed that they wanted to give feedback to their supervisors but they were concerned about being considered as guarded and others referenced the inherent power dynamics in the supervisory relationship to have dampened their intentions to express their concerns. It seems that the participants in this study tended to feign openness such that their supervisors, who in some feedback events act as gatekeepers of the profession, would not render them inflexible and difficult to train. This implies that there are latent factors to take into consideration when addressing feedback events and the supervisory relationship.

In light of this study, participants also tended to readily identify supervisor factors rather than supervisee factors in addressing how feedback events were handled. It can be assumed that supervisees are more sensitive to supervisor factors, while possessing limited insight into the role they play within the supervision dyad when formulating their perception of feedback events. Previous findings have indicated that supervisors refer to supervisee qualities, such as openness to feedback and the supervision relationship, when framing their view of feedback events (Hoffman et al., 2005). This implies that both supervisors and supervisees may possess

limited perspective about the role they play in contributing to feedback events that are either favourable or not.

The supervisory relationship was a contributor in how supervisees received feedback. Over the course of several supervision relationships, supervisees noted that having strong supervision relationships with their supervisors made it easier for them to hear feedback as stated by various authors such as Frawley-O'Dea (2003) and Heckman-Stone (2003). As indicate by Lehrman-Waterman and Ladany (2001) the difficulties in the supervision relationship were considered to contribute to experiences where it was difficult for supervisees to receive feedback.

Participants who described feedback events that were positive mentioned them in relation to a strong supervision alliance. It may be, then, that positive supervision experiences create safety, trust, and an emotional bond between supervisor and supervisee that helps the supervisee hear and receive feedback, even when it is corrective, positively. This finding mirrors previous research that suggested the supervision relationship was a moderator variable in how supervisees responded to feedback (McKnight et al., 2001).

In the context of a supervision relationship that was already considered to be positive, participants were struggling with their clinical work, and they received feedback from supervisors that they had not responded well to a clinical issue, the positive response to the feedback was attributed to the manner in which the supervisor delivered the feedback. This finding that the supervision relationship is integral in how feedback is received, aligns with the theoretical literature on supervision such as the supervision models based on psychotherapy approaches, which posit that feedback can serve to increase the strength of a supervision relationship if done in a constructive and appropriate manner (Barber, Liese & Abrams, 2003; Beck et al., 2008; Berman, 2000; Frawley-O'Dea, 2003; Liese & Beck, 1997; Sarnat, 2012;

Skolnikoff, 1997). In this study, participants who had described the quality of the supervision relationship as warm, supportive, and affirming were overwhelmingly more likely to detail feedback events that went well.

Supervisees nestled in a strong supervision alliance reported experiences where they felt their supervisors were inviting them to collaboratively think about their blind spots in relation to cases. The supervisees were able to engage with the supervisor and subsequent changes were seen in the therapy that benefited the client. Supervisors' reactions seem to have be cushioned by the safety of the working alliance with the supervisee. Thus, in the context of a strong supervision relationship, supervisors need not filter and monitor themselves as much and may provide authentic responses. Supervisees are able to respond well to a supervisor's feedback that occurs within the context where there mutual understanding between the supervisee and the supervisor that predates the feedback. Furthermore, a supervisor can be candid in their approach to feedback but the supervisee has to feel that, over and above the transparency, they were nevertheless working towards the same goal and adhered to the objectives of supervision, which are to broaden the supervisee's awareness. The finding that about strong supervision relationships mirrors those of McKnight et al. (2001), who found that feedback, specifically corrective feedback, in the context of a strong supervision relationship enhanced, rather than threatened, employee self-esteem.

As mentioned previously, supervisees attributed positive perceptions of feedback to the supervision relationship, as well as the manner in which supervisors delivered the feedback. Supervisors who were perceived to validate, affirm, and advocate supervisee growth, also seem to have involved their supervisees in a dialogue about the feedback and created conditions in which supervisees were able to hear the feedback and, most importantly, to incorporate it successfully into their clinical work. It seems, then, that supervisors who are able to create

favourable conditions for supervisees to hear feedback may be fostering conditions that contribute to the development of a strong supervision relationship (Worthington, 1987).

Participants perceived that positive feedback experiences resulted in improvements in their clinical work. It thus seems that a strong supervision relationship not only impacts how supervisees receive feedback in that moment, it allows supervisees to change in the clinical work, which is one of the prime goals of feedback (Barber, Liese & Abrams, 2003; Beck et al., 2008; Berman, 2000; Bernard & Goodyear, 2009; Frawley-O'Dea, 2003; Liese & Beck, 1997; Sarnat, 2012; Skolnikoff, 1997). Moreover, participants not only made a change to their clinical work as a result of positive feedback moments, they viewed their clinical work and personal skills as having improved because of the feedback. This result corresponds with that from a study from organisation psychology literature by McKnight et al. (2001), in which workers reported improved work, self-esteem, and morale following feedback that was given in the context a strong supervision alliance/relationship.

5.3. Factors that make feedback indigestible

In stark contrast with feedback experiences that have gone well, participants detailed feedback events that did not go well and negatively impacted them personally, their clinical work, and the supervision relationship. In the same vein as the positive feedback experiences, the pattern that emerged in negative feedback events emphasises the important role of the supervision relationship in how supervisees receive feedback. Participants consistently described feedback experiences with negative effects to have occurred in the context of a strained supervision relationship. It, thus, seems like a poor supervision relationship may make it more likely for supervisees to perceive feedback in a negative light. Supervisees also reported that they found feedback difficult to make sense of and integrate if their supervisor did not take

their level of development into consideration (Worthington, 1987). Supervisees were at a loss when feedback was pitched in a manner they could not understand.

5.4. Effects of feedback on the supervision relationship

Participants who described feedback experiences with negative consequences noted interpersonal difficulties in the supervision relationship, which subsequently contributed to their negative reactions to the feedback. The participants' noted that the manner in which their supervisors conducted themselves, such as being harsh, inconsistent, and providing little rationale for feedback, was linked directly to supervisee experiences of being left unsettled and confused. *Participant 6* particularly highlighted the importance of a stable supervision frame as feedback can be provided in the context of insufficient evidence or without the awareness of supervisee circumstances. Furthermore, negative feedback experiences occurred when the administrative responsibilities of the supervisor interfered with clinical work.

It seems, then, that the participants in this study are very sensitive to overt and covert communication from their supervisors. Specifically, a tenuous supervision relationship was considered to be associated with increased guardedness, anxiety, and vigilance on the part of supervisees. Their increased arousal in strained relationships is likely to contribute to further miscommunication/misinterpretation and friction between the supervisor and supervisee so much that it is difficult to consider any reparation in the relationship. Supervisees give insight into the possibility for damage that comes with feedback that is more directive and corrective, without the accompanying validation and affirmation of the supervisees competence in spheres that are directly or indirectly linked to the area(s) feedback addresses and out of touch with the supervisees' competency. In Hoffman et al. (2005), supervisors reported that they were reluctant to give feedback when they perceived the supervision relationship to be strained, which indicates a reciprocal process where the supervisee and supervisor act out within the

dyad and exacerbate dissatisfaction and a degree of animosity between them. Participants who received personal and mainly corrective feedback reported becoming despondent and self-conscious about all of their clinical skills as the feedback they were provided was perceived to encompass competence in all clinical spheres. The results also indicate how easy it is for feedback to injure and alienate supervisees when their anxieties and vulnerabilities are not taken into account.

5.5. Reflecting on experiences of feedback

The participants considered partaking in the study as a reflective exercise and mostly reported that they had found the process helpful. It seems like talking about experiences of feedback helped and prompted participants to define the role of supervision and feedback in the supervision relationship. It might even be that supervisors and supervisees might benefit from the findings in the study, as the results suggest that reflecting on experiences of feedback resulted in greater clarity regarding expectations and beliefs about feedback and the role that supervisors and supervisees play in shaping the experiences.

To a lesser degree, given that participants had discussed feedback experiences that were unfavourable, the participants reported re-experiencing negative emotions and memories. Even though several months or years had passed since the negative experience the participants still experienced raw emotions and memories. This account may give insight into the extent to which such supervision experiences can affect supervisees and subsequently the implications of these experiences on clinical work and the supervision relationship.

Alongside the recapitulated negative experiences, participants expressed that the process of discussing their supervision experiences was anxiety provoking in one instance and another was that it left them with a great sense of relief and better understanding of their own reactions and that of their supervisors. Perhaps this indicates that the initial anxiety experienced by the

participants limited their capacity to fully reflect on supervision in a manner in which they externalised and implicated their supervisors as being the sole member in the dyad that is accountable. The participants' responses and reflective capacity (the ability to process the supervision relationship as an encounter where both the supervisee and supervisor contribute to dynamics within the relationship) indicate how emotive the supervision experience is and particularly how crippling and detrimental a relationship that does not contain anxiety as addressed by Eagle et al. (2007). In lesser detail, but of great importance, the actual interviewing process seemed to have functioned as a neutral space for some participants.

Participants had reported that they had not provided feedback directly to their supervisors and usually shared unfavourable experiences with peers. This leaves one to wonder if a negative supervision cycle might be broken if supervisees are more forthright about their concerns or reactions to the feedback. Additionally, it might be that supervisees may need to convey their feedback in a resolute and sincere manner that they expect from supervisors. It is evident that supervisees hold an equal stake in the supervision relationship and in the process. Interventions proposed by supervisors may not meet supervisee expectations and might be perceived negatively, however it should be incumbent on supervisees to be more active in the relationship such that they achieve their goal of professional and personal growth. This statement leads on to the implications of the results found in this study on training. The focus of this following section is to attempt to integrate fractures related to accountability and reciprocity in the supervision relationship.

5.6. Implications

This section of the paper is an ambitious attempt to weave all the findings together and provide suggestions based on the results. The points to be covered are related to the expectations of feedback that supervisors and supervisees bring into their relationship.

It was previously mentioned that supervisees from this particular study expect to be given feedback and they conceptualise feedback as an intervention employed to promote growth and clinical skills development. This implies that supervisors should not approach feedback with trepidation. Supervisees are also sensitive to the manner in which feedback is couched and supervisors should therefore reflect on the content of their feedback; their approach needs to be a combination of corrective and affirming feedback.

Supervisees in this study emphasised the importance of a supervision relationship built on mutual respect and direct, sincere communication. Furthermore, supervisees enter supervision with certain expectations in mind and marked anxieties and vulnerability. In order to build rapport and establish a connection with supervisees, supervisors could engage in goal setting in their initial encounter so that they can establish a common aim to underscore their relationship. Supervisors can further tie in the goals with the supervisees' expectations of feedback and have a conversation about what kind of feedback they find easy to receive. Furthermore, supervisors may engage in a dialogue with supervisees after providing feedback to them. Supervisors can demonstrate that they are willing to meet supervisee expectations. A dialogue about feedback could mitigate confusion or misinterpretation so that the supervisee can incorporate the feedback appropriately and apply it accordingly to their work. Most importantly, supervisors could engage with supervisees directly about the way they may have perceived the feedback, and to use this open channel of communication to monitor the supervision relationship and impact on clinical work. In demonstrating concern about supervisee expectations and meeting them, supervisors are likely to gain buy-in from the supervisee and supervisees may identify that that they are accountable to participating in supervision and feedback events.

This study has highlighted that supervisees welcome and appreciate feedback, but they set a high bar for supervisors as they expect feedback to be direct and honest and to also build their

self-confidence at the same time. While supervisees defer most of the responsibility of keeping the supervision relationship harmonious to their supervisors, it may be prudent that supervisees take on the responsibility of initiating a discussion about their own goals if supervisors do not initiate a conversation early on in supervision. The literature suggests that supervisors may hold the same expectations for supervisees to communicate effectively and honestly (Bernard & Goodyear, 2009; Hoffman et al., 2005). Supervisees in this study expressed that they found it difficult to address their supervisors directly because of the power differential in the relationship. This is a factor that cannot be avoided and perhaps supervisees need not see this as a deterrent as supervisors may look to supervisees for honest feedback so that they can better communicate with them. By extension, supervisors may reinforce the importance of bidirectional communication and stipulate the importance of reciprocal feedback in strengthening the supervision relationship and subsequently facilitate favourable feedback experiences.

Participants from this study reported that they experienced different emotions during the interview, namely gaining insight into their experiences of feedback and supervision, anxiety, and gratitude. The interviewing environment was considered a neutral and non-judgmental space for them to share their experiences in the same light as peer discussions about supervision. It might be incumbent on training institutions to provide supervisees with a neutral space where they can discuss supervision outside of the training setting and immediate surroundings of supervisors. In creating a separate space for thinking about supervision and feedback, supervisees can discuss and perhaps clarify any confusion about the role of feedback and the part they play in the relationship as well as communicating their preferences amongst themselves so that they may have a clearer picture about their role in supervision and perhaps play a more active role within their supervision relationship.

Training institutions should supplement their didactic coursework with an introductory element related to supervision, conduct, and goals so that trainees are aware of the expectations stipulated by the HPCSA and their training institution. This can serve as a point for initial discussion in a pre-supervision context so that supervisees may enter the supervision space with more insight into the process of supervision and the purpose of feedback – which is to communicate the overall impression of a supervisee's work based on discrete moments during supervision (formative feedback) and an aggregated impression (summative feedback) (Bernard & Goodyear, 2009). It also seems pertinent to address the fact that clinical supervision is not a given skill for clinical psychologists, and perhaps this training should be made available as a matter of urgency as well as the practice of supervision should be regulated as the practice of clinical psychology is (for instance where Board exams need to be written to become an accredited supervisor).

In sum, supervisees and supervisors should have a baseline agreement about the events and goals of supervision. Engaging in a dialogue and reaching a consensus about expectations and parameters that both participants can work within may lead to a more open supervision relationship, which could then, in turn, facilitate adequate delivery and acceptance of feedback and strengthen the supervision relationship. With this said, supervisees from this study also implied that supervision is an intricate relationship where differing and even incompatible personalities converge or clash. Thus it is important to note that some supervision relationships may be strained because of the dynamics the supervisor and supervisee bring into the context. The nature of the supervision encounter may exacerbate intrapersonal and interpersonal difficulties. Training institutions are mostly understaffed and supervisees and, to a lesser extent, supervisors cannot always choose people they intrinsically fit with and thus it may be important that a supervisor and/or supervisee openly communicate difficulties within the relationship and perhaps consult with a neutral party about approaching this encounter.

5.7. Limitations

5.7.1. Sample. This study aimed to obtain supervisees who were completing their community service as they were developmentally in between the role of a trainee and qualified professional. This population had also been exposed to several supervision relationships and experienced different intensities of supervisory input and thus made an ideal group to address about their experiences of feedback in supervision. However, 3 individuals from the target group became participants. Adjustments were made and intern psychologists were approached to participate as they had also experienced several kinds of supervisory input in the period the interviews were conducted. 3 people from this group responded to the request for participation. The total sample size did not yield adequate theoretical saturation and a further validity check could not be done to ensure that saturation had been reached or not.

Furthermore, the participants in this study were all initially trained at the same academic institution and, although they asked for this identifying factor to be removed from identifying data, they represented a specific theoretical paradigm and thus the results obtained in this study may only be representative of supervisees specifically versed in one paradigm, which can limit generalisability.

5.7.2. Limitations based on the interviewer's identity. As mentioned earlier in the Chapter 3, the fact that the researcher is a supervisee, and relatively new to supervision, participants tended to assume the role of providing the interviewer with details about their training experiences and particularly what he should expect in subsequent years (the quantity of supervision, the types of supervisors) and reflecting very little on these experiences and how they have made sense of them. The interviews were further complicated by an assumption that the interviewer was well-versed in psychological jargon and the participants did not elaborate any further when referring to theoretical concepts and particularly how they have come to

understand them according to their own subjective experiences. Anxiety was observed to be an overwhelming and present feeling between the interviewer and interviewees and this was noted to comprise the capacity to reflect and expand on experiences. Furthermore, the participants were cautious about the content they relayed as they worried about supervisors they had crossed paths with identifying them through their examples they provided.

5.8. Recommendations

It appears that the participants were worried about being identified by their supervisors, which may account for those that did not participate at all. Perhaps a more conservative method such as the interviews being conducted by a researcher of a different profession may be used where supervisees need not worry about specific accounts or experiences being identified. Using a quantitative approach where participants can be invited to fill in rating scales or scales designed to elicit their experiences of supervision and feedback in a more structured and sterilised manner might contribute to more participation.

The results obtained in this study suggest that supervision is a relationship that requires reciprocity and communication for ideal outcomes to emerge. Therefore, future studies can incorporate both the experiences of supervisors and supervisees to adequately determine if supervisors' expectations parallel those held by supervisees.

This study aimed to investigate several components that were influenced by feedback: the supervisory relationship and supervisee clinical skills. Future studies may address one of the areas to narrow the focus. The results obtained are based on supervisee perceptions of encounters in supervision, rather than actual event(s). This is why perhaps different methodologies should be implemented when researching this topic, such as Conversation analysis, in which you see the interaction between supervisor and supervisee as it happens moment-by-moment and not a report based on the memory they have of the occurrence(s).

Finally, supervision is aimed at enhancing supervisee clinical skills such that they can provide adequate services to clients. This study and others tend to focus on the supervision dyad rather than the triad (even though the client is not physically present in the room they occupy a significant amount of thinking space in supervision) and it might be interesting to find an ethically sound way to speak to clients about their experiences of therapy and whether this mirrors reported events in the supervision relationship where feedback may have been well-received and applied in the therapy.

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APPENDICES

Appendix A: Email to internship co-ordinator

Dear Prof Smith,

My name is Kgabe Molepo and I am studying Masters in Clinical Psychology, in the School of Human and Community Development, at the University of the Witwatersrand, Johannesburg. I am conducting research for the partial fulfilment of my degree. I would like to invite students currently fulfilling their community service duties to participate in my research entitled: *Student Supervisees' Reported Experiences of Feedback in Clinical Supervision*. I would like to ask for your assistance in broadcasting the attached invitation to the relevant students.

Feedback is considered as an integral component of the clinical supervision process; however, very little research has been done, and the limited amount of empirical literature that does exist focuses namely on supervisors' experience of delivering feedback and the subsequent problems they may encounter. Therefore, the aim of this research is to explore supervisees' reported experiences of feedback in clinical supervision; to explore their accounts of the reported effect of feedback on the supervisory relationship; and to address the reported effects of feedback on supervisees' clinical skills development. As community service students have had more than one supervisory relationship they can provide information about preferences they may have acquired and reference experiences in varied detail.

I ask that you please circulate the participant invitation I have attached to the email to students in their community service year and internship. Given time constraints, participant recruitment will take three weeks and the interviews will be conducted over the course of four weeks. Should you have any queries please contact me via email, or you may contact me by phone at 073 432 9676. You may also contact my supervisor, Mrs Aline Ferreira Correia, telephonically at 011 717 4527 or via email at Aline.FerreiraCorreia@wits.ac.za, if you have any further queries or concerns.

Appendix B: Participant invitation

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

Dear Sir/ Madame:

My name is Kgabe Molepo and I am studying Masters in Clinical Psychology, in the School of Human and Community Development, at the University of the Witwatersrand, Johannesburg. I am conducting research for the partial fulfilment of my degree. I would like to invite to participate in my research entitled: *Student Supervisees' Reported Experiences of Feedback in Clinical Supervision*.

Feedback is considered as an integral component of the clinical supervision process; however, very little research has been done, and the limited amount of empirical literature that does exist focuses namely on supervisors' experience of delivering feedback and the subsequent problems they may encounter. Therefore, the aim of this research is to explore supervisees' reported experiences of feedback in clinical supervision; to explore their accounts of the reported effect of feedback on the supervisory relationship; and to address the reported effects of feedback on supervisees' clinical skills development. As community service students have had more than one supervisory relationship, I believe that they can provide information about preferences they may have acquired and more detailed experiences.

Participation in this research will entail an interview by myself, at a time and place that is convenient for you. The interview will last for approximately 45 minutes to 1 hour. With your permission, the interview will be recorded in order to ensure accuracy. Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. All of your responses will be kept confidential, and no information that could identify you will be included in the research report. The interview material (digital audio recordings and transcripts) will not be seen or heard by any person outside research supervision—they will only be processed by my supervisor and me. You

may refuse to answer any questions you prefer not to, and you may choose to withdraw from the study at any point.

If you would like to partake in this research, please contact me via email at kgabe70@gmail.com or you may contact me telephonically at 073 432 9676. Additionally, you may contact my supervisor, Mrs Aline Ferreira Correia, telephonically at 011 717 4527 or via email at Aline.FerreiraCorreia@wits.ac.za

Kind Regards,

Kgabe Molepo

Appendix C: Participant Information Sheet

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

Dear Sir/ Madame:

My name is Kgabe Molepo and I am studying Masters in Clinical Psychology, in the School of Human and Community Development, at the University of the Witwatersrand, Johannesburg. I am conducting research for the partial fulfilment of my degree. I would like to invite you to participate in my research entitled: *Student Supervisees' Reported Experiences of Feedback in Clinical Psychology Supervision.*

Feedback is considered as an integral component of the clinical supervision process; however, very little research has been done, and the limited amount of empirical literature that does exist focuses namely on supervisors' experience of delivering feedback and the subsequent problems they may encounter. Therefore, the aim of this research is to explore supervisees' experiences of feedback in clinical supervision; to explore their accounts of the perceived effect of feedback on the supervisory relationship; and to address the effects of feedback on supervisees' clinical skills development. As community service students have had more than one supervisory relationship, I believe that you can provide information about preferences they may have acquired and reference experiences in varied detail.

The interview will last for approximately forty-five minutes to one hour. With your permission the interview will be recorded in order to ensure accuracy. Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. There are no direct risks or benefits to participating in this study.

All of your responses will be kept confidential, and no information that could identify you will be included in the research report. Your identity as a participant will be only known to myself and my supervisor. The audio recordings and the transcriptions will be in electronic

format and password protected in a password protected computer. Only my supervisor and I will know the passwords and will have access to these files. To protect confidentiality, your name or other personal identification data will not be used in any reports. Instead, pseudonyms will be used. Some of the information that you provide could be quoted in the research reports, however, all the identifying material will be disguised.

The Master's dissertation resulting from this research will be available in the library of the University of the Witwatersrand, which offers access to material on the world-wide web. The findings will also potentially be published in scientific journals. If you wish to have access to the results, you may request so by contacting me.

Prior to participating in the study it is required that you complete the attached consent form. This will be kept separately from the rest of the data for the purpose of confidentiality. The consent form will only be made available to the University authorities should a random audit process require this.

If you have any questions, please contact me via email at kgabe70@gmail.com or you may contact me telephonically at 073 432 9676. Additionally, you may contact my supervisor, Mrs Aline Ferreira Correia, telephonically at 011 717 4527 or via email at Aline.FerreiraCorreia@wits.ac.za

Kind Regards

Kgabe Molepo

Appendix D: Participant Consent (Interview)

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

Please check the box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation in this interview is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I understand that any information given by me may be used in future reports, articles or presentations by the researcher and supervisor, but no information that may identify me will be included, and my responses will remain confidential. ☐

4. I understand that I may refuse to answer any questions I would prefer not to. ☐

5. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature

Appendix E: Participant Consent (Recording)

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

Please check the box

1. I understand that the audio recordings and transcripts will only be processed by the researcher and supervisor. ☐

2. I understand that all audio recordings will be stored after the research is complete. ☐

3. I understand that any information given by me may be used in future reports, articles, or presentations by the researcher and supervisor, but no information that may identify me will be included, and my responses will remain confidential. ☐

4. I understand that no identifying information will be used in the transcripts or the research report. ☐

_____ _____ _____

Name of Participant Date Signature

Appendix F: Interview Protocol

1. How would you describe your general experience with clinical supervision?
2. What types of supervision have you had in your clinical training?
3. Would you say that there are similarities and differences between the different types of supervision or supervisors that you have been exposed to? (Ask for concrete examples)
4. What do you think the role of feedback in clinical supervision is?
5. How do you think feedback should be in the context of training as a clinical psychologist? (Ask for concrete examples)
6. How do you think feedback should not be? (Ask for concrete examples)
7. Have you had experiences when feedback was easy to accept? What makes feedback easy to accept? (Ask for concrete examples)
8. Have you had experiences where feedback has been difficult to accept? What makes feedback difficult to accept? (Ask for concrete examples)
9. What kind of feedback do you prefer? (Ask for concrete examples)
10. What kind of feedback don't you prefer? (Ask for concrete examples)
11. Have you always received feedback that you have deemed useful to you? (Ask for concrete examples for when useful and/or irrelevant)
12. Do you believe the type of feedback you have received has an influence on your relationship with your supervisor?
13. What influence do you think this shift may have had on your clinical training?
14. Have you provided feedback to your supervisor?
15. What, if at all, makes it easy or difficult for you to give feedback to your supervisor?
16. How was it talking about your experience with feedback in clinical supervision?
17. Is there anything else you would like to add regarding your experience of feedback in clinical supervision that we haven't covered?