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# The Training and Supervision of Individual Therapists

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## 1 INTRODUCTION

This chapter is structured to explore aspects of what it can mean for a student to study and train as an individual therapist. Core elements of academic study, personal development, professional practice, clinical supervision and personal therapy can be largely similar, but there will be differences of focus in theoretical approach, organisational provision and structure (part-time regular weekly meetings; blocks of days; full-time etc.) and continuing changes are likely in costs and funding. Additionally, in recent years, there has been a significant shift towards professional training at degree level, whether at first degree or postgraduate levels. This emphasis on academic training highlights the impact of research findings, some of which will have been initiated through current masters and doctoral training programmes, and their potential for influencing evolving practice. All therapy training in the UK acknowledges the needs of professional registration as required by professional lead bodies, some details of which are addressed below.

There has been a substantial body of individual therapy research published in the UK and North America in recent years. This has enabled mental health providers to demonstrate and provide evidence for how and why therapy ‘works’ in practice (Norcross and Wampold, 2011a, 2011b), a necessary resource in arguing for the funding and provision of professional therapy services in the UK through the NHS, GP practices, Employer Assistance Programmes (EAPs), third-sector voluntary agencies and private practitioners.

A significant recent development has been the UK government funded initiative, Improving Access to Psychological Therapies (IAPT), which has affected ways in which mental health and well-being might be addressed by professional practitioners through the provision of 'treatments' aimed at alleviating psychological distress. This has had an impact on the British Association for Counselling and Psychotherapy (BACP), British Association for Behavioural and Cognitive Therapy (BABCP) and other professional body guidance on training programmes, with consequent changes in how training programmes might be structured. This has led to pressures for a paradoxical shift away from recent trends towards integration of psychotherapy approaches, and into a separation of therapeutic models as definable 'treatments' for specific conditions.

The trend towards 'medicalising' psychological distress into specific evidence based treatments validated through randomised controlled trials (RCTs), regarded as the 'gold standard' for recommendation and funding of NHS treatments by National Institute for Clinical Excellence (NICE), has led in the first instance to a focus on cognitive-behavioural therapy-based (CBT) approaches that are readily measurable using quantitative statistical analysis of patient outcomes. This initial focus has been additionally informed through the development of Skills for Health *National Occupational Standards for Psychological Therapies*. This was the first time that the skills applicable across the 'talking therapies' profession had been systematically itemised. With the aim of recognising skills across theoretical perspectives, a structure was defined that moved away from an integration of psychological approaches, separating key principles of practice into humanistic, psychodynamic, CBT and family and systemic therapies.

## 2 SELECTION

Students are selected for training as individual therapists according to an evolving set of criteria. These relate largely to the potential for development as a psychological therapist. Broadly, they can be seen to fall into three categories: knowledge and skills; personal qualities; and reflective capacity. The first two of these may be assessed in one form or another for entry to a higher education or further education course in any subject. In the case of students applying to study an undergraduate course in most academic subjects, for example, knowledge and skills are both assessed through the state examinations system, and personal qualities are evidenced in the UK through the personal statement made on the Universities and Colleges Admissions Service (UCAS) form. What makes therapy training so different is the need to assess aspects of the individual that cannot be evidenced solely through the written application, and so trainers have necessarily developed ways to identify students who have a good chance of succeeding.

One method might be to invite up to four candidates to a selection event. Whilst demanding of staff time, this procedure is usually evaluated positively by candidates and associated with low attrition rates over time, as trainers learn from experience. The selection process should be two-way. To this end, current therapy student representatives can be asked to offer attendance at the

selection event in order to answer questions 'from the horse's mouth' about their training experiences. The student representative may spend ten to fifteen minutes with candidates, while the interviewing tutors withdraw. This aspect of the selection process would not be assessed, and the student representative should not offer feedback to staff concerning individual applicants.

The selection event can be divided into several activities designed to assess different aspects of the candidates' suitability for training, which might involve the following:

1. A group discussion where the candidate group is asked to self-time for 20 minutes, to discuss three topics; the precise topics are less important than how the individual engages both with reflection and with the other group members. However, tutors are also interested to hear the level of their thinking about the topic. Topics may be deliberately ambiguous, in order to encourage creativity and engagement; an example is 'Is therapy compatible with personal faith?' Tutors may use a proforma that is scored numerically; the precise numerical score is used as a guide only, and this is compared with other aspects of the selection process at the end of the selection event, in a staff meeting.
2. A second aspect of the selection process is therapy skills practice, in which tutors assess candidate readiness to see clients from the start of the course (a usual entry requirement for therapy trainings is a Certificate in Counselling Skills, which will also involve observation and assessment of skills). The format should enable candidates to demonstrate skills of opening and closing of the session, time keeping, listening skills including use of creative silences, reflection of both content and affect, paraphrasing (used sparingly), use of open questions (which further the client's focus and reflection), empathic engagement, and also the ability to work with nonverbal phenomena.
3. While some candidates are engaged in skills, others will be asked to attend a face-to-face interview. This is usually conducted by two staff members, one of whom scribes in order to leave the other free to engage in a meaningful conversation with the candidate. This also means that there are two perspectives on the interview process, since interviewers might have strong feelings about an applicant that are best explored through collegial reflective practice before making recruitment decisions. Most trainers use a series of questions that have evolved over several years' experience together with reference to scholarly writings. These might include: what led the candidate to apply for this particular course; skills, experience and personal qualities including what aspects of self-learning might usefully be developed during training; life events that might have contributed to the candidate's capacity to self-reflect; previous counselling training undertaken and the impact of undertaking this; what client groups the candidate might feel drawn towards or would wish to avoid, and whether plans are in place for the practice part of the course (a potential student's readiness to engage actively with prospective practice agencies being a vital personal skill); how the applicant deals with stress; and the degree of reflection on the potential impact of training and personal change on immediate and wider relationships.

Trainers may find that their views about particular applicants are influenced by their experiences during the selection process. Strong feelings can result as part of the interpersonal dynamics engendered by being in a highly emotionally charged setting. A meeting of tutors at the end of each selection event provides the opportunity to challenge collegially and reflect on strongly held views, and to consider carefully those candidates about whom it might be more difficult to make a selection decision. It is sometimes helpful to arrive at an overall score out of 10 for each candidate, with an understanding that, for example, all of those scoring 8 and above are 'appointable'. This is especially helpful if decisions are not going to be made on a first come, first served basis

but on the basis of selecting the 'best of the bunch'. Those with lower scores, including 6 and 7, may be held on a waiting list, but 5 and below may result in a rejection. When a decision is made to reject a candidate, this must be done with sensitivity, with a personal letter that sets out their strengths as observed together with reasons that recruitment was felt not to be the right course of action at this point in time.

Below we present three fictional applicants. As with all potential trainees, each has unique features that need to be recognised and acknowledged within the selection process. Some key factors that might emerge from these examples are discussed later on in this chapter.

### Box 23.1 Sylvia: No formal qualifications, access to higher education

It is important for both applicants and trainers to be mindful of how intimidating such a thorough process of selection for counselling and psychotherapy training might be to someone who has real potential to develop as an excellent therapist, but who does not have a formal, 'high-flying' academic or professional background. The first fictional applicant, Sylvia, who has completed an Access course, said about her interview, 'It's almost intimidating, coming into the building; it's something that I know is important for me to pursue, and it feels do-able even though I'm struggling sometimes to overcome the sense of "what am I doing here?"'

She made the assumption that other students would be more in tune with what is required academically. She talked of early experiences of 'not succeeding' that had felt as if she was letting her parents and herself down, and of losing contact with friends who had passed their exams, 'the rest of the world that is going on ahead of you' (here Sylvia made a non-verbal gesture of something tumbling over, up and away). Such experiences add to the investment, but also to the stakes associated with selection processes. However, sensitive interviewing can help applicants connect with their belief that they can succeed.

### Box 23.2 Agymah: business school graduate

Our second fictional person is a Ghanaian man, Agymah, who 'wished to give something back, knowing that others were less fortunate'. Very self-assured, he held his teachers in high regard, owning a focused attention to study and diligence towards measurable success. His evident strength of religious belief was a source of grounded assuredness, yet leading to a dependency on the judgement and 'advice/guidance' of respected others. Ambivalent towards self-determination, he readily assumed responsibility in business terms, enabling him to reflect on the different meanings of 'advice' and 'authority'. Respectful of others, he said that family relationships were centrally important to him, and although he had left his wife and family in his home country Ghana, the use of Skype ensured a daily link. He disclosed

that, as a child, he had been sent away from home to boarding school and acknowledged his distress when remembering this time.

Evidently deferential towards the interviewers, his expressed need was to offer advice and guidance to others. Academic study, qualifications and status seemed centrally important. When experiencing 'doubt' he relied on his pastor's judgment/permission. The notion of 'autonomy' was difficult for him. The interviewer observed the self-determination necessary for him to have arrived in the UK – Agymah avoided responding to this, but acknowledged his responsibilities as a business person, accepting advice from family whilst making his own decisions and that 'the buck stops here'.

On qualifying he would return to Ghana, where there was a distinct need for professional counsellors. He knew a Ghanaian counsellor 'who studied with you', admiring her qualities, 'her smiling face ... she would never make me feel cross – if so, I would probably say sorry ... as it would be likely to have been my own fault'. It was not easy for Agymah to own vulnerability, to recognise that he too had feelings. A client who was 'a mother' would be challenging, he felt likely to defer to the 'mother' role rather than relate to her as his client. It would be difficult to work with a distressed child, reminding him of his family and his own emotional struggle on being sent away to boarding school, acknowledging difficulty in being away from his family. Evidently with much that he might add to a training group, those involved in selection decisions would be mindful of what Agymah might teach them as well as the potential gift to the learning of others that he might offer on his journey towards professional status.

### Box 23.3 Emma – psychology graduate, '2.1'

The third applicant, Emma, with a first degree in 'very scientific' studies, for the last five years has been with a high-street retail chain as a graduate trainee in their management team. Finding this role no longer satisfying or able to engage her interest, she sees her initial drive in studying psychology hadn't helped her understand 'what makes people tick' and 'didn't know much about the human mind', her degree 'didn't tell me who I am' and that this didn't make others the way they are.

Emma disclosed the emotional challenge of life experiences and occasions of grief, separation and loss. Support from her employer provided counselling through an Employee Assistance Programme (EAP) that enabled a 'surprising' shift. The counsellor 'listened to my story', 'it was wonderful and scary ... like walking the edge of a plank ... should I fall into the water or not? It taught me that I don't know much.' She had recognised problematic behaviour without having an explanation. Aware of a 'split' in different aspects of self, she 'needed to join them up'. Her 'crack-up' (as she termed it) was not so much about an event but rather a challenge to who she was, to her sense of identity. Mentioning 'new insight', she acknowledged the fragmented 'bits' of self: a thinking

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brain, an emotional experience that didn't quite synthesise, and a wish for greater emotional literacy. Offered the notion by one interviewer of a provisional self that might yet contain instructions for 'assembly', Emma felt both 'radical uncertainty' and some excitement in not knowing how the assembled 'form' might evolve. To what extent do most people experience times of challenge to their sense of mental health and well-being? Here Emma has openly disclosed such times to her interviewers, perhaps understanding that her own path might offer insight into others' sense of confusion and challenge to find greater meaning in everyday life.

### 3 MODELS OF TRAINING

#### 3.1 Psychodynamic approaches

Training in psychodynamic and psychoanalytic therapy varies considerably in length and in the degree of integration between the three main elements of theory, supervised practice and personal therapy. As the terms 'psychodynamic' and 'psychoanalytic' are often confused, it may be helpful here to draw a distinction between them: psychoanalysis typically involves sessions four or five times a week, while psychoanalytic psychotherapy is less frequent, usually two or three times a week; psychodynamic therapy is more likely to involve once or occasionally twice-weekly sessions. Trainees are usually expected to have personal therapy at the same frequency as their intended practice. Seeing a therapist for multiple sessions each week has clear cost implications and is largely confined to private practice, while the NHS and voluntary-sector organisations usually offer weekly psychodynamic therapy.

A further distinction involves the theoretical breadth and depth of trainings. Psychoanalytic trainings in Britain typically follow a Freudian, Kleinian or Independent route (see Chapters 2, 3, 4 and 5), focusing on the theoretical and clinical thinking of major figures within these schools. The Independent school includes the work of British object relations theorists such as Winnicott, Fairbairn and Guntrip. There are significant contemporary developments in theory and practice in all these schools, so that although the work of their founding figures remains central, it is continually being elaborated. Analytical psychology, which is the name given to Jungian therapy to distinguish it from psychoanalysis deriving from Freud and his followers, has separate trainings among which several 'schools' are again identifiable. Psychoanalytic trainings are mainly offered by private psychotherapy associations, whereas psychodynamic trainings, which are more likely to refer to theories across all the psychoanalytic schools, are also offered in these settings and by the NHS and some universities.

Understanding and applying theory in practice is considered very important in psychoanalytic and psychodynamic trainings. Students are typically asked to discuss theoretical reading as a means to gaining insight into their practice and conversely to consider their clinical work in the light of relevant theoretical perspectives. Besides psychodynamic concepts, the range

of theory explored may include developmental perspectives and increasingly, psychodynamic trainings link theory to findings stemming from infancy studies and recent neuroscientific research on intersubjective brain development (Wilkinson, 2010).

The early psychoanalysts, Freud, Jung, Adler and their associates, had no training other than their medical background and the intense self-analysis which their clinical work led them to undertake. However, it quickly became normal practice for would-be analysts to seek a 'training analysis' for themselves with one of the established practitioners, and this personal work was seen as the central factor in professional development. This remains the case, and psychoanalytic and psychodynamic trainings today typically require students to be in therapy throughout the training period so that they can develop reflexive self-awareness and become more alert to transference and countertransference within the therapeutic relationship. The supervision of clinical practice with an experienced practitioner is another key element in psychodynamic training, and often involves attention to the fine detail of interactions with clients through the use of verbatim accounts of therapy sessions. Supervision is the place where theory and practice come together in understanding the client's history, their internal world and its manifestation in the dynamics of the therapy.

#### 3.2 Humanistic approaches

Humanistic approaches to individual therapy (e.g. person-centred, gestalt, existential) are fundamentally centred within the existential-phenomenological tradition, a paradigm of thinking that describes how making sense of being and living is an essentially individual enterprise. No-one else can perceive the world in the same way because others' experiencing of being can only be uniquely contextualised and processed through *their* embodied minds, seeing the world and making best sense of it through the moment-by-moment experience of 'being'. This can be experienced by trainees as fundamentally challenging to their sense of meaning and negotiation of relationships with significant others. Essential to the existential-phenomenological core of this approach, which also informs much of contemporary relational analytic theory, is the necessity for practitioners to be continually mindful of their own existential 'reality' and how reflection on moment-by-moment experiencing can effect unfolding change in perception of self and others.

This fundamental root of approaches in the humanistic tradition can be seen as centred upon establishing a trusting and professionally intimate therapeutic relationship, where each is negotiating good-enough meanings in the dialogic exchange. On occasion these might be momentarily be experienced as phenomena that transcend everyday experiencing, variously described as 'relational depth' (Wiggins, Elliott and Cooper, 2012), 'transpersonal' (see Chapter 19) or 'spiritual' (West, 2011) – potentially transformational for the client, and also the therapist.

One common misperception is to conflate humanistic and person-centred schools of thought. While person-centred therapy is one of the many versions of humanistic therapy, it is by no means the only one. It is inaccurate, for example, to assume that all humanistic therapists strongly reject the idea of transference and countertransference.

### 3.3 Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) evolved from the Behaviourist school and is an approach that was seen to offer a useful way of applying a formulated structure to treatment. A key feature of CBT is that it is based on scientific principles of experimentation and measurement, focusing on the individual in their environment: thoughts and images, mood, behaviour and physical reactions are each addressed, sometimes through between-session homework and the keeping of a diary. This approach can be seen as a little prescriptive to some potential trainees; for others, however, this can be very reassuring. Training in CBT programmes will encourage active and collaborative negotiating of therapeutic tasks and processes. More recent developments emphasise the importance of the interpersonal relationship, enabling trust and 'compassion' (see Chapter 12) and, increasingly, the notion of 'mindfulness' (see Chapter 17), a capacity to clear the mind of extraneous thoughts, attending to in-the-moment bodily sensations, such as breathing, tasting and a capacity to be 'still'.

It is important that the reader engages in a more detailed consideration of the therapeutic approaches within these broad paradigms, which may be found described elsewhere in this volume.

### 3.4 Pluralism and its evidence base

Challenges to the proliferation and fragmentation of theories of psychology and the promotion of discrete models of practice, or 'schoolism', have led in recent years to initiatives towards integration across competing theories of individual therapy. This move has also been developed through the Society for Psychotherapy Integration (SEPI) and notions of transtheoretical practice. Training providers have attempted to reflect this trend with diplomas, degrees and masters level courses in integrative and pluralistic therapy (see Chapter 20).

The move towards theoretical integration and pluralism has gained considerable ground on the basis of evidence that no single model of therapy is necessarily more successful than any other. Numerous articles and research papers on competing theories informing approaches to counselling and psychotherapy cite the well-used notion of the 'dodo bird verdict', that 'all must have prizes' and that no one therapy model in itself has any clear advantage over others. This finding has encouraged the development of pluralistic trainings without a particular theoretical allegiance, but based rather on the view that no single perspective can be privileged over others (see Chapter 21). Cooper and McLeod distinguish between a 'pluralistic perspective', which is 'the *belief* that there is no, one best set of therapeutic methods' (2011: 7, italics in original), and 'pluralistic practice', which 'refers to a specific form of therapeutic *practice* which draws on methods from a range of orientation[s], and which is characterised by dialogue and negotiation over the goals, tasks and methods of therapy' (2001: 8, italics in original). They point out that *pluralistic belief* and *pluralistic practice* may be independent from each other. They acknowledge the

close similarity with integrative and eclectic approaches, but specify that pluralism, in their understanding, potentially embraces an infinite number of perspectives and practices and is fundamentally concerned with negotiating and tailoring practices to the needs of individual clients.

In spite of this tendency towards integration and pluralism, the continuing requirement of NICE in the UK for evidence-based treatments has promoted research aimed at demonstrating that individual therapies 'work' for specific symptoms. Consequently, protocol-based and symptom-focused therapies evidenced by the 'gold standard' of randomised controlled trials continue to proliferate, particularly in the IAPT services of the NHS. Training in these therapies is normally only available to practitioners already holding an initial qualification in counselling, psychotherapy or a core health profession. Training in the recently developed model Counselling for Depression, for example, is open only to experienced person-centred or humanistic counsellors.

A considerable body of work in the USA has explored what works in the integration of individual therapeutic and psychoanalytic modalities, where North American researchers have demonstrated a different view of 'what works' in terms of the elements present in successful therapy outcomes irrespective of model. Common factors such as the therapeutic alliance, client motivation, the structuring of therapy and the role of the therapist, as well as ongoing feedback from client to therapist, have been shown to be major influences on the successful outcome of therapy. Norcross and Wampold (2011a: 99) encourage individual therapy training programmes 'to provide competency-based training in the demonstrably and probably effective elements of the therapy relationship'. According to research cited by Norcross and Wampold (2011a), these include the therapeutic alliance, empathy and client feedback (demonstrably effective) and goal consensus, collaboration and positive regard (probably effective). Norcross and Wampold (2011b) highlight consistent evidence that reinforces what therapists have always intuitively understood: that therapeutic relationships which are responsive to individual clients rather than to symptoms, lead to successful therapeutic outcomes. Building on this work, Mozdierz, Peluso and Lisiecki (2011) emphasise the need for training in individual therapy to avoid 'silos' of learning such as theoretical models and skills in isolation from each other, and to integrate understanding of the common domains of therapy with both linear and non-linear thinking. Non-linear thinking has long been known to underlie the kind of therapeutic listening and presence which enables practitioners to attune to clients emotionally and symbolically, and developing this capacity is a significant aspect of most therapy trainings.

In the UK, trainings accredited by BACP are based on their Core Curriculum, which specifies the competencies therapists need in key domains of knowledge, skill and application. These domains are: the professional role and responsibility of the therapist; understanding the client; the therapeutic process; and the social, professional and organisational context for therapy. The competencies described in each domain are generic and may be elaborated distinctively by training courses in accordance with their particular philosophy. This competency-based approach allows for the integration of a common factors perspective

on 'what works' in therapy with different theoretical models and encourages pluralistic or trans-theoretical thinking. The recent Subject Benchmark Statement for Counselling and Psychotherapy (Quality Assurance Agency for Higher Education, 2013) also impacts on therapy trainings in higher education at undergraduate and postgraduate levels. It is likely that professional bodies will soon endorse a requirement for all initial counselling trainings to be at least at NVQ level 6 or honours graduate equivalent, and psychotherapy trainings at level 7 or postgraduate.

The other major professional body in the field, the United Kingdom Council for Psychotherapy (UKCP), does not specify a training curriculum since it acts as an umbrella organisation for nine modality-based colleges, each determining its own training requirements. This way of structuring psychotherapy training and practice tends to maintain allegiance to single modalities and to mitigate against integration and pluralism in practice, although the Humanistic and Integrative College (HIPC) aims to integrate different perspectives within the humanistic paradigm and other approaches, such as cognitive analytic therapy (CAT). It is usual for trainings leading to registration with the UKCP to specify a theoretical approach in the title which practitioners may use, for example psychodynamic psychotherapist or cognitive-behavioural psychotherapist.

A helpful way of thinking about professional training as induction into a community of practice is suggested by Lave and Wenger (1991). They distinguish between closed communities in which adherence to orthodox practice is inculcated, and more open communities which allow 'legitimate peripheral participation' (1991: 35). The periphery is a legitimate position to occupy, since it allows a critical perspective and the possibility of fresh thinking. Since learning is an inherent aspect of many social practices, the critical encounter of learners (who may include experienced practitioners as well as trainees) with established theory and practices offers an opportunity for the professional group as a whole to be transformed. Trainings which value the mutual learning of students and teachers through reflexive critical educational practices have the potential to foster a similar approach to therapeutic practice, in which there can be recognition of the intersubjective nature of the therapeutic encounter (Macaskie, Meekums and Nolan, 2012).

#### 4 CULTURAL COMPETENCE

Most therapy trainings include sessions intended to develop awareness and competence in working with clients of different cultures. While the relationship between therapist and client is accepted as being central to all approaches, an emphasis on the intersubjective recognition of the other implies that ethical relating demands of therapists that they willingly engage with the 'otherness' of clients as individuals who are both shaped by, and participate in shaping, their culture(s). Individuals are subjects with their own experiences and values, equally important to our own, and not merely objects in *our* cultural worlds. This recognition is a radical counter to the tendency we often have to objectify the other and their culture. However, the complex ways in which we identify and belong to cultural spaces require a

highly developed sense of our own multiple identities, how they may change over time and how we perform them in particular settings.

'Culture' here is used to include reference to aspects of difference and identity such as 'race', gender, class, sexual orientation, age, ability, language and spirituality, to name perhaps the most salient. This is not intended to deny the importance of issues related specifically to each of these dimensions of being human, but to highlight the ways in which they intersect (Chantler, 2005). A person is never 'just' female, or black, or middle-class, but some or all of these and more, and how she lives these ways of being herself in various situations will be partly to do with her relationships with others, whose own multiple identities interact with hers.

In a training setting, for example, the way one individual presents and performs who she is will inevitably be influenced intersubjectively by the presentation and performance of other students, tutors, the training institution itself, and the professional and educational cultures in which they are located. How people are positioned as belonging to particular groups may be thought of as an active process of 'minoritisation' (Chantler, 2005), which draws attention to the power relations between dominant and minority social groups that are often ignored by a focus on individual cultural identity.

White suggests that notions of identity in Western culture are typically associated with 'the construction of an encapsulated self, one that emphasises norms about self-possession, self-containment, self-reliance, self-actualisation, and self-motivation' (2007: 137). These values are inherent in some therapeutic approaches and may be uncritically assumed by therapists who have not worked to develop cultural self-awareness and competence in working transculturally. Awareness of dominant values is especially important, as White (2007) argues:

These contemporary Western social and cultural forces that promote isolated, single-voiced identities actually provide the context that generates many of the problems for which people seek therapy. (White, 2007: 137)

However, it might also be suggested that an individual's identity can be seen as a more socially interactive framework, which is less individually focused as it implies belonging to a group – albeit fluidly constructed through contextually driven social practices.

Narrative therapies (see Chapter 18) seek to help clients question and re-author stories which keep them trapped in narrow or self-defeating identities. Whatever the therapeutic approach, it is essential for trainees to learn to recognise what kind of stories clients tell about themselves, and what kind of stories the model they are learning constructs about clients. Models of therapy, like any other theories, are situated in their time and cultural context and if we are to be really open to clients we need to have the tools to critique the assumptions underlying our model/approach, thus allowing them to evolve. All therapeutic theories are historically situated and influenced by the class (usually middle to upper), gender (often male) and dominant cultures (mainly European and American) of their authors. Therapists need to be able to recognise and deconstruct these influences on their

theoretical understanding. This is a complex task in training, and one which all three of the fictional applicants will need to engage with. Our fictional applicant, Agymah, coming from a West African country, may face a dual task of learning theories which derive from Western cultural norms that have influenced his education and to some degree colonised his own culture, but which emphasise an isolated self that may be in contrast to his more family-oriented values. He may also find it unusual at first to facilitate clients' self-determination rather than offering advice and guidance. He speaks with respect for the authority of gifted teachers who have inspired him in the past; now he will join a learning community where teachers and students are all potentially engaged in transforming their knowledge and practice through challenge and critique. Emma, the psychology graduate, is also joining a new kind of learning community where two kinds of knowledge, cognitive and emotional, are valued. In her first degree, cognitive knowledge was based on scientific experiment and theory, while now she will be challenged by the radical uncertainty of synthesising cognitive knowing with emotional intelligence and the experience of 'not knowing'. Sylvia has experienced not succeeding in the school system and the educational and social categorising that often follows from that, and she needs a deep sense of self-belief to help her enter the cultural world of the university and professional training. While she may need support to engage with academic practices, it will be surprising to her to find that her tutors value her personal authority, derived from her own experiencing.

Therapeutic approaches which emphasise cultural awareness have been variously labelled multicultural, transcultural and intercultural, and the usage of the authors referred to is followed here. Within the North American context much has been written since the early 1980s on the concept of culture and the development of multicultural counselling competencies. However, the separation of multicultural from general professional competence is critiqued by Collins and Arthur (2010) who adopt a broad definition of culture and argue that 'all encounters are, on some level, multicultural interactions' (Collins and Arthur, 2010: 204). These authors therefore propose the term 'culture-infused counselling' to denote the recognition of culture at the heart of therapy. They suggest a framework organised around the working alliance, the collaborative aspect of the therapeutic relationship that enables client and therapist to agree on goals and methods and to develop a bond that can withstand relational difficulties. In such a framework, the personal cultural identity of counsellor and client, built up from personal, contextual and common factors, can intersect with core competencies of cultural awareness in relation to self and other within a culturally sensitive working alliance.

Lago (2011) provides helpful ways of thinking about cultural issues in the UK therapy context, which overlaps with but is distinct from North American experience; he argues that therapists need to extend their empathic capacity in order to develop transcultural competence. For Lago, competence depends on seven domains:

- personal and professional or therapeutic relational qualities;
- primary knowledge and understanding of how diversities, 'isms' and power operate and affect us;

- knowledge and understanding of specific communities local to the therapist and from which their clients may come;
- awareness of our own cultural origins and identity, communication style and influences on our thinking such as the media;
- professional competencies such as the ability to work with interpreters, learn key words in relevant languages, work with groups and critique the values underpinning theoretical models from a transcultural perspective;
- professional commitment to ongoing development and learning; and
- understanding the impact on clients of the therapeutic context and environment. (Adapted from Lago, 2011: 12–14)

This last domain might be extended to include the training context, which impacts on students in certain ways according to its ethos and their expectations, and previous experiences of education and training. Therapy training in a university context, for example, may reinforce an academically inclined student's expectations of developing theoretical knowledge and research competence, and the discovery that it also requires reflexivity, self-disclosure and a more personally engaged way of writing essays may come as a shock, particularly to our fictional applicant Agymah. Some students (such as Sylvia), may find training disempowering if it re-activates past experiences of being devalued or humiliated in an educational setting, and trainers need to be able to help students recognise, name and challenge the impact of such experiences.

Training courses in individual therapy often have an obvious majority of white female students and teachers, which reflects a similar predominance in the profession as a whole. It is easy for whiteness to be ignored because it is felt to be 'normal', with consequent blindness to the way it reinforces the structural power inherent in the role of therapists. Trainings that include and seek to understand the experience of 'minoritised' (Chantler, 2005) students, therapists and clients are essential if therapy is to offer more than just a reflection of European cultural assumptions and values. However, a counselling training curriculum that recognises but does not just rely on examples of the diversity within the student group, would also reflect the trainers' ability to create opportunities for students to reflect on the cultural implications of counselling theories and practices, and of their own experience and behaviours. Transcultural competence will remain an abstract idea unless it is made real and alive by challenging cultural norms in the student group and by encouraging reflection on the experience of students themselves.

## 5 SUPERVISION FOR TRAINEES AND EXPERIENCED PRACTITIONERS

To meet the current training requirements of BACP and the Professional Standards Authority for Health and Social Care (PSAHSC) for 100 hours of supervised clinical practice pre-registration, trainees would normally accrue a minimum 12.5 hours' supervision before qualifying. Students are usually expected to arrange clinical supervision external to



the training programme, acting autonomously in making contact with their supervisor, preferably from a catalogue of supervisors recommended by the training centre who will have met prerequisite criteria for inclusion.

However, in some agencies, particularly NHS settings, clinical supervision may be provided by a placement line manager or other colleague. This is a dual relationship that can present potential difficulties. In these cases it might be advisable for students to have access to someone else as a consultant in order to talk through any organisational issues that arise. Students are expected to make contact with a supervisor before beginning practice and to agree arrangements for individual supervision. This may be in the ratio of supervision to client hours recommended by BACP of not less than 1 to 8; however, some trainings require more intensive supervision. Opportunities for group supervision that might be offered by the placement agency are deemed extra. Supervision would be increased proportionately if, as she or he progresses, a student were to see more clients.

Trainees should plan ahead of supervision: what might they want from each session? Which client(s) do they want to discuss? Are there other issues that need addressing such as developing skills, awareness of countertransference, or the relationship with the agency where they are practising? They need to keep a log of supervision sessions, updating a record of which client was presented and when, being careful to code their entries to maintain confidentiality. Supervisors are usually expected to complete reports on their supervisees, for example using a pro forma containing a series of questions pertinent to key developmental stages in the training.

The welfare and well-being of the client/patient, their social context and worldview, and the personal and professional development of the therapist/supervisee are the collegial, ethical and educational purposes of clinical supervision. The supervisory process helps reconstruct and present relational scenarios, contemplated in shared reflection in order to clarify confusion, understand process and foster insight; it enables the deconstruction of clinical material contained within the therapist's narrative, and encourages further clarity arising from the relational dynamics enacted between practitioner and supervisor.

Supervision ... stands at an interface between disciplines. Its task is to enable learning but not necessarily to teach directly. Its task is to enable internal shifts of perception and awareness in order to understand patients and their internal world and yet not become therapy. (Driver, 2005: xvi-xvii)

Crook Lyon and Potkar (2010: 16) offer a description of the *supervisory working alliance* as a 'collaboration for change' that involves the supervisor and supervisee's mutual agreement and understanding on three distinct aspects:

- the tasks and goals of the supervision;
- the tasks of the supervisor and supervisee; and
- the emotional bond.

These aspects are echoed in many texts on supervision practice and processes and research published in the UK and North America (see, for example, Hawkins and Shohet, 2012),

which recognise the notion of a supervisory emotional bond that facilitates the interpersonal co-creation of meaning.

Supervision in the training context has a different emphasis, recognised in the literature as necessarily intrinsic, clearly described in Hawkins and Shohet's (2012) 'Developmental Process Model'. The needs of the 'novice' at 'Level 1' are acknowledged as an integral stage of therapist development and as the training experience progresses, students experience an extension in their developmental process. Individual external supervision is additionally seen as being centrally important in the evaluation of trainees' fitness-to-practise. Observations and assessments of indicative use of the supervisory relationship made within periodic supervisors' reports are a necessary indication of practice development and can serve as arbiter towards meeting professionally qualified status.

With accumulating clinical practice hours, trainee and novice practitioners' supervision can change in character towards a more open-ended 'consultative' frame, increasingly relaxed in the process of discovery around clinical storied events. With accumulating experience the supervisory learning process can become more collegial and a space for mutual professional exploration. Comfort with indwelling in clinical material can promote ease in contemplating discomfort within therapeutic and supervisory frames. Ward and House (1998) elaborate a four-stage developmental supervision process model facilitating reflective dialogue, which they name as: *contextual orientation*; *trust establishment*; *conceptual development*; and *clinical independence*. The degree to which this process is enabled, however, depends on a level of awareness, experience and learning-to-date in order to develop sufficient insight, without which therapists may carry an 'afterimage' of dissonance and unresolved meaning.

An effective supervisory alliance within training and practice can enable a shift towards resolution of some of these dissonances, through learning accruing from trust in the reflective process and experienced at a level beyond stage-four *clinical independence* (Ward and House, 1998). Each may dwell in hovering free-floating attention, jointly contemplating the felt experience and exploring new perceptions rather than seeking immediate answers or meanings. The learning experience of mutual discovery can help perception and understanding of some new territory. It may be particularly useful for a supervisee to know that the other (the supervisor) was both witness to, and facilitator of, an unfolding moment of insight and the co-creation of new meaning – this experience arising from the supervisory alliance and within a mutually reflective space. This may open up access to the experiencing of parallel process (Doehrman, 1976), a form of insight arising when aspects of the therapeutic relationship become re-enacted, echoed in the supervisory relationship. These phenomena can also be experienced and noted in training group supervision.

Managing this 'matrix' of relational complexity and empathic understanding is a challenge for both supervisor and supervisee; enabling conscious engagement with the 'unconscious imagination' of countertransference phenomena 'is therefore key not only to the successful therapeutic process, but also its supervision' (Wilkinson, 2010: 165).

Michael Carroll's (1996) *Counselling Supervision: Theory, Skills and Practice* and Hawkins and Shohet (2012) *Supervision in the Helping Professions* each offer generic

perspectives on clinical supervision that directly acknowledge ideas of Elizabeth Holloway, Francesca Inskipp and Brigid Proctor, Steve Page and Val Wosket, and others in drawing together 'integrative' approaches towards clinical supervision. Carroll (1996) describes a format within which practitioners (from 'novice' trainees through to 'journeyman', 'independent craftsman' and 'master craftsman') might develop and explore supervisory practice. This structure incorporates

- the purposes of supervision: managing the client welfare and supervisee professional development;
- the functions of supervision: educative (formative), supportive (restorative) and administrative (normative);
- the generic tasks of supervision: evaluating and enabling a learning/teaching relationship, monitoring professional and ethical issues and administrative tasks, to counsel and consult;
- managing the supervisory process through: pre-assessment; assessing; contracting for supervision; engaging in supervision; evaluating supervisee, supervisor, the supervision process; terminating the supervisory relationship.

Carroll (1996) emphasises that these be seen as 'a guide' in balancing between supervision that would otherwise be either 'overmanaged' or 'understructured'. The former removes all spontaneity while the latter can result in chaos, especially for beginning supervisees.

Checklists, frameworks and methodologies are at our service and useful when they guide us, not when they imprison us. (Carroll, 1996: 89)

Carroll's words are prescient when sometimes the only clinical supervision provided for talking therapies in some contexts can be overly focused on case management, or checking-in on the client treatment process, but allows little (if any) time for reflection on therapeutic relational processes.

Supervision within organisational contexts can bring added relational complexity, where management dynamics, external funding, interpersonal- and dual-relationships can each add considerable challenge to professional and ethical practice. Whilst each of these influences might be seen as outside of the therapeutic frame, they can impose a dis-abling impact on effective interpersonal engagement (Nolan and Walsh, 2012).

Practitioners may require supervision as container for their clinical work within a particular professional modality or context, and as described elsewhere in this handbook. Examples might include the specific supervision demands of 'safeguarding' when working with vulnerable adults or with children and issues of child protection; strategies within art therapy or dance movement therapy; case formulation in specific psychological approaches such as psychodynamic practice, person-centred work or CBT theories; or within time-limited solution-focused or NHS IAPT structured 'treatments' that have a specified format: each might need a way of working that requires specific supervisor skills, experience and training.

Anecdotal discussions between practitioners, along with research findings emerging from North America and the UK over the last 25 years, indicate that the espoused modality of the therapist may not necessarily be what is actually being practised in the therapy room, and that

most practitioners will incorporate theories and ideas from across a breadth of psychological perspectives in order to best serve their clients or patients in their struggle towards sufficient meaning and purpose. Critically important here is the question of the level of client care and support that is possible through clinical supervision practice which might otherwise be unable to effectively recognise or support what is meaningful within the therapeutic frame. Whilst perceptions within supervision are seen as being echoed from the therapy frame, the interpretations of meanings are dependent on theoretical orientation, individual world-view, and insight into in-the-moment countertransference and parallel processes. When therapist and supervisor have differing perspectives on, or access to, each of these factors the effective managing of clinical material presented in supervision can become either (1) an informing challenge to all parties, or (2) problematic to the supervision process.

Hawkins and Shohet (2012) link practice across seven process model modes, integrating developmental levels where supervision integration can progressively inform the maturing practitioner's practice with purpose and potential across differing therapeutic approaches. This means working with 'an open mind and an open heart' whilst managing symptom treatment and being mindful to support the persons with whom we are working, 'the human beings who are communicating through these symptoms' (Hawkins and Shohet, 2012: 250–1).

In response to an apparent dearth of supervision research in the UK (Wheeler and Richards, 2007) the Supervision Practitioner Research Network (SuPReNet) has encouraged international cooperation on research projects. The BACP website hosts a link to this group (SuPReNet, 2013) which encourages supervision research projects and is accumulating sessional evaluation on supervisees' experience of supervision.

For the trainee the experience of the tutor–student relationship, with tutor as educator, mentor and practitioner-connoisseur, is therefore centrally important. This relationship helps to facilitate student learning through the modelling of skills practice and sharing of professional experience and wisdom, particularly when tutors share instances from their practice experience as illustration of theoretical ideas and challenges, dilemmas and insights into clinical practise. It is a joint learning enterprise, where the tutor will also gain insight from trainees and which recognises the student's life experiences, their wisdom and their facilitating 'presence'. This latter element of emerging self-awareness becomes an increasingly evident feature that has, after all, led to their selection success and which reflects:

- a substantial commitment of financial and emotional resources;
- trust in risking shifts in personal life and worldview;
- humility that avoids 'knowing' yet sustains curiosity and the chance of learning something more from each other.

## 6 CONTINUING PROFESSIONAL DEVELOPMENT

Continuing Professional Development (CPD) is a requirement of all practising healthcare professionals including individual therapists, and involves providing evidence of yearly

updated activities that have supported practice. Good practice within training organisations may offer guided support for students in maintaining a work-based learning log of therapy-related activity, comprising training days/courses, workshop attendance and placement support work. Some training organisations and self-facilitating counselling practitioner groups offer post-qualifying workshops as CPD opportunities; professional bodies also provide workshops and conferences on international research findings and current professional practice.

## 7 REGULATION OR REGISTRATION?

Individual therapy is currently an unregulated profession in the UK. This means that there is no single recognised training curriculum or level of qualification for practitioners, and in fact there is no generally agreed definition or legal power to determine who may or may not be described as a 'counsellor' or 'psychotherapist'. This situation has led to concerns about quality assurance, ethical practice and the safeguarding of clients. Since the 1970s, there have been several attempts to set up a regulatory system that would be legally enforceable, but none of these has been successful. Most recently, the UK government proposed in 2007 that counselling and psychotherapy should be regulated by the Health and Care Professions Council (HCPC) (previously entitled the Health Professions Council (HPC)), which already regulates psychologists and arts therapists. Arguments were made from various sections of the profession against this proposal on the grounds either that statutory legislation was unnecessary and the voluntary registers already established by professional bodies such as BACP and UKCP were sufficient to ensure a means to address unethical practice, or that the HPC was an unsuitable organisation to regulate therapists. At the same time there was considerable support in principle for the idea of statutory regulation, and BACP in particular took the decision to support the government's proposal.

However, after the UK election in 2010, the Coalition Government decided to take no further action and the proposal for statutory regulation was dropped. Instead, the Health and Social Care Act (2012) encourages voluntary registers of therapists as the best way to deal with quality assurance and good practice in a diverse professional field. It therefore falls to the professional organisations to create a framework for training and to work with a body responsible for the quality assurance of voluntary registers. Both BACP and UKCP are working in collaboration with the PSAHSC (previously the Council for Healthcare Regulatory Excellence). BACP is one of the first organisations to pilot the PSA's Accreditation Scheme for Assured Voluntary Registers.

It is important to be clear at this point in the discussion about terminology. To summarise, regulation of the profession of individual therapy is now set to be a voluntary, not a statutory process. It will involve practitioners becoming registered via the BACP or UKCP registers which, in turn, will be 'assured' by becoming accredited by the PSA. This is confusing enough, but the term 'accredited' has further meanings. BACP accredits training courses that meet their rigorous criteria, and it also accredits therapy services and individual practitioners.

Individual accreditation is conferred on practitioners who have made a successful application and completed a minimum of 450 hours of supervised practice. Some accredited practitioners go on to become senior accredited practitioners after more than six years of accreditation. UKCP, however, does not use the term or the process of 'accreditation' and simply registers graduates of its trainings.

BACP has established a register of counsellors/psychotherapists since its position is that it is not possible to distinguish between these two titles in any generally acceptable way. The BACP Register of Counsellors and Psychotherapists (previously UK Register of Counsellors and Psychotherapists (UKRCP)) is open to the following categories of practitioners:

- (a) Graduates of a BACP accredited training course;
- (b) Graduates of a non-accredited course who successfully complete an online Certificate of Proficiency;
- (c) Practitioners who are currently accredited or senior accredited members of BACP.

The minimum experience required for entry to the register is that required by BACP accredited courses, currently 100 hours of supervised practice. Since the register is accessible to newly qualified practitioners, registration is seen as the point of entry to the profession, as it is in nursing or social work. The individual accreditation scheme already operated by BACP for many years will now be seen as a way of marking a further degree of experience and competence. Individual accreditation as a counsellor/psychotherapist by BACP will continue to require a minimum of 450 hours of supervised practice.

Psychotherapists and psychotherapeutic counsellors registered with the UKCP are in a different situation, though many practitioners in fact hold both UKCP registration and BACP accreditation. The UKCP, which is made up of modality-based constituent colleges each with its own training standards and courses, has long maintained its own register, consisting of graduates of trainings that fall under the auspices of its colleges. This is expected still to be the case under the PSAHSC. However, UKCP registration as a psychotherapist has always required a longer initial training and more practice hours than BACP accreditation. It seems likely that this discrepancy between BACP and UKCP registers will continue under the new system of assured registers. UKCP has recently started to offer an independent route to registration in addition to the route via membership of a constituent college.

The aim of assured registers is firstly to protect the public by ensuring that practitioners are appropriately trained and that an accessible complaints procedure is in existence. A related aim is to enhance employment opportunities for registered practitioners, since increasingly employers will make registration as an essential requirement for recruitment.

It is likely that the development of assured registers will have an impact on training courses. For example, the proposed entry routes to the BACP register of counsellors/psychotherapists give a clear advantage to graduates of BACP accredited courses, which will make them more attractive to potential trainees. Courses which are not accredited may find it harder in future to recruit students and may cease to be viable.

Further information on the development of the registers is available from the BACP and UKCP websites: [www.bacp.co.uk](http://www.bacp.co.uk) and [www.psychotherapy.org.uk](http://www.psychotherapy.org.uk).

## 8 THERAPY RESEARCH AND TRAINING

Therapists and trainees can feel alienated from the world of research, resulting in a defensive rejection (Meekums, 2010). However, we have also found that students can find conducting a research investigation personally transformational and can help enhance practice. Many features of counselling and psychotherapy education and practice are in themselves useful research skills, for example: reflexivity at every stage of the process; curiosity; searching the literature; interviewing and attentive listening skills that encourage relational ease, making probing questions possible; creative techniques that elicit information at the edge, or outside of, immediate awareness; management of audio and video recordings, their accurate transcription towards understanding and analysis, including 'listening between the lines'; writing up case summaries; and presenting ideas to others. The use of research modalities that inform IAPT services is mentioned earlier in this chapter.

Some trainees who may have previously studied scientific subjects (e.g. Emma, one of our fictional applicants), and who may struggle at first with a different view of reality (ontology) and ways of knowing (epistemology), can often find motivation in wanting to understand more deeply what makes us human. Personal crises and subsequent personal therapy can be a motivating factor for this shift, sometimes challenging previous self-beliefs about strength and vulnerability. Emma, a psychology graduate, learned through this process that she did not 'know much about the human mind'. In working with students whose background is in scientific study, it is important to acknowledge the need for synthesis of these two aspects of self and differing ways of knowing. It would be a mistake to assume there is a need to throw out left-brain, linguistic, mathematical and analytic thinking in order to nurture more right-brain, embodied and affective/creative ways of knowing. Trainers would aim to nurture and celebrate the capacity to think, and to do so with emotional literacy. However, they would also need to avoid both the rigidity that comes from a positivist assumption of certainty, and any 'woolly' reactions to this that run counter to the systematic enquiry necessary for both therapy and research. Rather, there should be a need to cultivate a willingness to suspend certainty, and to remain open to new possibilities; what Emma, our fictional applicant, described as a 'radical uncertainty'.

## 9 CONCLUSION

In this chapter on training and supervision we have presented a summary of some current thinking on the evolving nature of counselling and psychotherapy training in the UK. We have also considered what this might involve for the trainee, having arrived at the decision to follow a personally challenging investment of time, emotion and financial cost, who is

prepared to dwell within others' confusion and the pursuit of what it means to be human. It could be helpful to take time at this point to reflect on your initial thoughts on reading this chapter – perhaps in answer to questions such as:

- What really excites you now about the prospect of training? What is the drive that leads you to this demanding process?
- What might feel scary to you?
- What do you think might be difficult and a challenge?
- What do you think will be fun and enjoyable?

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## CONCLUSION