

**A Thesis Submitted for the Degree of PhD at the University of Warwick**

**Permanent WRAP URL:**

<http://wrap.warwick.ac.uk/163292>

**Copyright and reuse:**

This thesis is made available online and is protected by original copyright.

Please scroll down to view the document itself.

Please refer to the repository record for this item for information to help you to cite it.

Our policy information is available from the repository home page.

For more information, please contact the WRAP Team at: [wrap@warwick.ac.uk](mailto:wrap@warwick.ac.uk)

# **Online Working in Clinical Psychology: Supervision and Acceptance and Commitment Therapy**

Holly Millard

This thesis is submitted in partial fulfilment of the requirements  
for the degree of Doctor of Clinical Psychology

Coventry University, Faculty of Health and Life Sciences  
University of Warwick, Department of Psychology

April 2021



## Contents

List of Tables and Figures .....	5
List of Appendices.....	6
List of Abbreviations and Symbols .....	7
Acknowledgements .....	8
Declaration.....	9
Summary .....	10
<b>Chapter One: Health, Social, and Intervention-Specific Outcomes of Online Acceptance and Commitment Therapy for Chronic Primary Pain: A Narrative Synthesis .....</b>	<b>11</b>
<b>Abstract .....</b>	<b>12</b>
Chronic Pain .....	13
<i>Chronic Primary Pain</i> .....	13
<i>Impact of Chronic Pain</i> .....	13
Acceptance and Commitment Therapy.....	14
Online Therapy.....	14
Evaluation of Previous Literature Reviews.....	16
Rationale for Current Systematic Review .....	16
Aims of Current Review .....	17
<b>Methods.....</b>	<b>17</b>
Systematic Literature Search.....	17
<i>Search Process</i> .....	17
<i>Search Terms</i> .....	18
<i>Search Strategy</i> .....	18
Inclusion and Exclusion Criteria.....	19
<i>Initial Screening</i> .....	19
<i>Specific Inclusion and Exclusion Criteria</i> .....	20
Classification of Studies .....	21
Assessment of Methodological Quality .....	22
Characteristics of Studies .....	23
<i>Location</i> .....	23
<i>Design and Aims</i> .....	23
<i>Sample</i> .....	24
<i>Intervention</i> .....	25
<i>Outcome Measures</i> .....	26
Analytic Review Strategy .....	36
<b>Results.....</b>	<b>37</b>

Intervention-Specific .....	37
Relationship to Pain.....	38
Mental and Physical Health .....	39
Quality of Life and Daily Functioning .....	41
Self-Efficacy .....	42
Critique of Included Studies.....	42
<b>Discussion.....</b>	<b>45</b>
Limitations .....	46
Clinical Implications .....	47
Future Research Recommendations .....	48
<b>Conclusion .....</b>	<b>49</b>
<b>References .....</b>	<b>51</b>
<b>Chapter Two: Online Supervision during the Covid-19 Pandemic: Perspectives of Trainee Clinical Psychologists and Clinical Supervisors. ....</b>	<b>66</b>
<b>Abstract .....</b>	<b>67</b>
<b>Context .....</b>	<b>68</b>
Research Purpose and Significance .....	68
Supervision Models .....	70
Online Supervision .....	71
Previous Literature .....	72
Rationale and Research Question .....	74
<b>Method.....</b>	<b>75</b>
Research Design.....	75
Procedure.....	75
<i>Ethical Considerations .....</i>	<i>75</i>
Participants .....	76
<i>Recruitment .....</i>	<i>76</i>
<i>Eligibility Criteria .....</i>	<i>76</i>
<i>Participant Characteristics .....</i>	<i>77</i>
<i>Materials .....</i>	<i>78</i>
<i>Interview Procedure .....</i>	<i>78</i>
Data Analysis .....	78
<i>Reflexivity .....</i>	<i>79</i>
<b>Results.....</b>	<b>80</b>
Context Influences the Content .....	84
Effects on the Mechanics of Supervision .....	85
Process Differences – Us .....	87

Process Differences – Me.....	93
<b>Discussion.....</b>	<b>97</b>
Limitations .....	101
Clinical Implications .....	102
Future Research Recommendations .....	103
<b>Conclusion .....</b>	<b>104</b>
<b>References .....</b>	<b>105</b>
<b>Chapter Three: A Reflection on the Research Journey: Working Towards a Position of Safe Uncertainty .....</b>	<b>112</b>
<b>Introduction.....</b>	<b>113</b>
Reflective Practice.....	113
Unsafe Uncertainty .....	114
Unsafe Certainty.....	116
Safe Certainty.....	118
Safe Uncertainty .....	119
My Personal Learning.....	120
Future Directions .....	121
<b>References .....</b>	<b>123</b>
<b>Appendices .....</b>	<b>127</b>

## List of Tables and Figures

<b>Table 1.</b> Search Terms .....	18
<b>Table 2.</b> Inclusion and Exclusion Criteria .....	20
<b>Table 3.</b> Key Characteristics of the Literature .....	27
<b>Table 4.</b> Development of Outcome Measure Groupings .....	36
<b>Table 5.</b> Inclusion Criteria .....	76
<b>Table 6.</b> Participant Demographics .....	77
<b>Table 7.</b> Six Phases of Reflective Thematic Analysis .....	79
<b>Figure 1.</b> PRISMA Flow Diagram (adapted from Moher et al., 2009) .....	21
<b>Figure 2.</b> Thematic Map.....	81
<b>Figure 3.</b> Thematic Map with Subthemes and Links .....	83
<b>Figure 4.</b> Seven-Eyed Model (Hawkins & Shohet, 2012).....	100
<b>Figure 5.</b> Safe Uncertainty Positions (Mason, 1993) .....	114
<b>Figure 6.</b> My Experience of the Four Safe Uncertainty Positions .....	114

## List of Appendices

	Page
A	Author Guidelines for the Journal of Pain and Symptom Management 127
B	Certificate of Ethical Approval (Systematic Literature Review) 136
C	Diagnostic Criteria for Chronic Primary Pain from ICD-11 (World Health Organisation, 2020) 137
D	Caldwell et al. (2011) Process of Quality Assessments Outline 138
E	Quality Assessment Scoring – Principal Assessor 139
F	Quality Assessment Scoring – Second Assessor 143
G	Inter-Rater Reliability Coefficient (Kappa) Scoring 147
H	Author Guidelines for The Clinical Supervisor 148
I	Certificate of Ethical Approval (Empirical) 153
J	Informed Consent Form 154
K	Participant Information Sheet – Trainee Clinical Psychologists 156
L	Participant Information Sheet – Clinical Supervisors 160
M	Debrief Form – Trainee Clinical Psychologists 164
N	Debrief Form – Clinical Supervisors 166
O	Research Poster – Trainee Clinical Psychologists 168
P	Research Poster – Clinical Supervisors 169
Q	Interview Schedule – Trainee Clinical Psychologists 170
R	Interview Schedule – Clinical Supervisors 171
S	Quality Checklist for Thematic Analysis (Braun & Clarke, 2006, p.96) 172
T	Evidence of Coding Stage of Analysis – Trainee Clinical Psychologist 173
U	Evidence of Coding Stage of Analysis – Clinical Supervisor 175
V	Additional Quotes to Support Themes 177

### **List of Abbreviations and Symbols**

ACT	Acceptance and Commitment Therapy
BABCP	British Association for Behavioural and Cognitive Psychotherapies
BAME	Black, Asian, and Minority Ethnic
BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
DCP	Division of Clinical Psychology
ICD-11	International Statistical Classification of Diseases and Related Health Problems 11th edition
IMMPACT	Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials
$\kappa$	Cohen's Kappa Inter-Rater Reliability Coefficient
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
N	Total Number of Participants
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
RCT	Randomised Controlled Trial
SLR	Systematic Literature Review
UK	United Kingdom
UKCP	United Kingdom Council for Psychotherapy
USA	United States of America



### **Acknowledgements**

Firstly, thank you to all of the supervisors and supervisees who took part in this research project, choosing to share their experiences and learning. I have really valued your time and commitment to the research whilst managing difficult and unusual circumstances.

Thank you to Dr Tom Patterson and Dr Carolyn Gordon, my research supervisors, for containing my anxiety, steering me in the right direction, and continually reminding me to rest. Your reassurance, reflections and helpful suggestions have been invaluable. I would also like to thank my appraisal tutor, Dr Lesley Harrison for her continued encouragement and support throughout the course.

A huge thank you to my cohort, journeying through the past three years with you has been filled with ups and downs and our WhatsApp group has been a source of comfort, laughter, reassurance, and inspiration. I wouldn't be at this point without each and every one of you.

Thank you to my close friends and family for your never-ending support and kindness. In particular, thank you to my Mum and sister for the weekly care packages and cards, they always managed to encourage and uplift me. Thank you as well to my Dad for his humour and reassurance during our weekly video calls. Mum and Dad, you have always been my champions and never stopped believing in me, we did it!

Finally, thank you to my husband, Sam. I wouldn't have made it through the last year without your incredible support. Thank you for always walking beside me, through the laughter, tears, and late-night chocolate runs. Though this first year of our marriage may not have been what we expected, there is no one else I would rather have by my side.

Deuteronomy 31:6

### **Declaration**

This thesis has been submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology at the Universities of Coventry and Warwick. The work presented has been completed and written by myself and has not been submitted for any other qualifications or to any other institution. This thesis is an original piece of work, which has been conducted under the supervision of Dr Tom Patterson (Coventry University) and Dr Carolyn Gordon (Coventry University).

Chapter One of this thesis has been written in preparation for submission to the Journal of Pain and Symptom Management (see Appendix A for author guidelines), and Chapter Two has been written in preparation for submission to the journal, The Clinical Supervisor (see Appendix H for author guidelines).

Word Count (excluding tables, figures, references, and appendices)

Chapter One: 7,755 words

Chapter Two: 8,403 words

Chapter Three: 2,861 words

Total: 19,019 words

## Summary

This thesis is comprised of three chapters. Chapter One is a narrative synthesis of twelve studies exploring the health, social, and intervention-specific outcomes of online Acceptance and Commitment Therapy for chronic primary pain. Identified outcomes were grouped into five categories: *Intervention-Specific*, *Mental and Physical Health*, *Relationship to Pain*, *Quality of Life and Daily Functioning*, and *Self-Efficacy*. The findings indicated the value of therapist involvement being a part of such interventions and the contribution of this to health and social outcomes, as well as improvement in psychological flexibility across the studies. The results also highlighted the importance of incorporating exercises that increase psychological flexibility into online Acceptance and Commitment Therapy programmes.

Chapter Two is an empirical qualitative study exploring online supervision during the Covid-19 pandemic and describes the perspectives of eleven Trainee Clinical Psychologists and eleven Clinical Supervisors. Reflexive thematic analysis generated four main themes which highlighted the impact of online supervision on both practical and process aspects. A perceived reduction in nonverbal communication, endings, and emotional connection was highlighted by both supervisors and supervisees in comparison to their experiences of face-to-face supervision. An impact on the supervisory relationship and the capacity to cultivate a reflective space was also noted. Clinical implications in relation to training and practice are explored.

Chapter Three presents a reflective account of the research process and the author's experience of safe uncertainty during this process. The safe uncertainty model is used to guide the reflective process and demonstrate key points of learning. Additionally, the author considers the parallel experiences between themselves and participants alongside the wider impact of the Covid-19 pandemic context.

## **Chapter One**

### **Health, Social, and Intervention-Specific Outcomes of Online Acceptance and Commitment Therapy for Chronic Primary Pain: A Narrative Synthesis**

This paper will be adapted for submission to the Journal of Pain and Symptom Management  
(see Appendix A for Author Guidelines)

Overall Chapter Word Count at Submission (excluding abstract, tables, figures, and  
references): 7,755 words

### **Abstract**

The present review sets out to critically evaluate empirical evidence regarding the health, social, and intervention-specific outcomes for online Acceptance and Commitment Therapy for chronic primary pain. Four databases (PsycINFO, CINAHL, Medline, and Web of Science) were systematically searched using search terms guided by the aim of the review. The search resulted in twelve studies which met the inclusion criteria. A narrative synthesis of the included studies was completed. Outcomes were grouped into five categories: *Intervention-Specific, Mental and Physical Health, Relationship to Pain, Quality of Life and Daily Functioning, and Self-Efficacy*. The findings highlighted the improvements found in psychological flexibility across the studies and the possible mediating impact that this can have on mental health and quality of life. Additionally, therapist involvement was shown to increase health and social outcomes. These results highlight the importance of incorporating exercises that focus on the development of psychological flexibility into online Acceptance and Commitment Therapy interventions as well as considering the therapist's role within online treatment programmes. Future research recommendations are also discussed.

## **Chronic Pain**

Chronic pain is defined as a persistent pain which is experienced for over three months (Mills et al., 2019). Chronic pain is said to affect 13-50% of adults in the United Kingdom (Mills et al., 2019) and is the leading cause of disability worldwide (Smith et al., 2019).

### ***Chronic Primary Pain***

Within the latest version of the ICD-11 (International Statistical Classification of Diseases and Related Health Problems 11th ed.) the new term chronic primary pain has been added. Chronic primary pain is defined as a disease in itself and not the symptom of an underlying condition (ICD-11; World Health Organization, 2019). Additionally, the recently published National Institute for Health and Care Excellence (NICE) guidelines for chronic primary pain describe predominant features of disability and distress and that chronic primary pain is primarily influenced by biological, psychological, and social factors (NICE, 2021). The new chronic primary pain term replaces terms such as chronic idiopathic pain or persistent somatoform pain disorder (Smith et al., 2019). It is hoped that the introduction of this new term will shift the focus in the patient treatment journey from finding a cause of the pain to managing its impact (Smith et al., 2019; Treede et al., 2015).

### ***Impact of Chronic Pain***

There are many known effects of chronic pain (including chronic primary pain); individuals who have experienced significant, long-term pain are more likely to experience mental health difficulties, problems with sleep, decreased quality of life, and impaired functionality in daily activities (Fine, 2011). When interviewed, individuals living with chronic pain reported that it resulted in interference with physical functioning, professional life, relationships and family, social life, sleep, and mood (Hadi et al., 2019). Additionally, living with chronic pain can result in lost or reduced work opportunities, Breivik et al. (2006) reported that 61% of individuals questioned were unable to work outside of their home environment as a result of their chronic pain.

## **Acceptance and Commitment Therapy**

The most recent NICE guidelines indicate that Cognitive Behavioural Therapy (CBT) or Acceptance and Commitment Therapy (ACT) are the appropriate psychological therapies to use when working with chronic primary pain (NICE, 2021). A third wave therapeutic approach, ACT is focussed on increasing psychological flexibility by exploring openness, awareness, and engagement (Feliu-Soler et al., 2018). For individuals experiencing chronic pain, the focus is not on reducing pain or uncomfortable emotions but rather on improving an individual's functioning and reducing the interference of pain (Hann & McCracken, 2014). In ACT interventions, this involves supporting the person to develop or increase their psychological flexibility to facilitate moving towards personal values and goals in the presence of potentially interfering thoughts and feelings (Hayes et al., 2006). Committed action is then encouraged to build patterns of behaviour that continue to facilitate values-based living (Bailey et al., 2016).

Multiple studies have explored the effectiveness of ACT for chronic pain (McCracken & Gutierrez-Martinez, 2001; McCracken et al., 2013; Scott et al., 2016), Wetherell et al. (2011), found that ACT can improve outcomes associated with depression, pain-related anxiety, and pain interference with equivalent efficacy to a CBT treatment group. Additionally, Wicksell and colleagues (2008) compared treatment as usual to an ACT-based intervention, demonstrating better results in the ACT-based intervention for multiple health and social outcomes, including life satisfaction and depression (Wicksell et al., 2008). Further analysis indicated significant indirect effects of psychological flexibility in relation to life satisfaction (Wicksell et al., 2008).

## **Online Therapy**

Online or internet-based therapy is increasingly more widely used across mental health services as an alternative to face-to-face sessions (Amichai-Hamburger et al., 2014); this was increasingly seen during the Covid-19 pandemic as much service provision transitioned to remote delivery (NHS England, 2020). Online therapy can increase

accessibility and cost-effectiveness and has been demonstrated to improve treatment adherence for chronic medical conditions such as chronic pain (Mariano et al., 2019).

Acceptance and Commitment Therapy has been shown to be effective when delivered online and has demonstrated some advantages over face-to-face interventions for depressive symptoms (Lappalainen et al., 2014; Pots et al., 2016). Equally the use of online ACT has been shown to result in a greater reduction in anxiety symptoms when compared to alternative online treatments (Kelson et al., 2019). More generally, the effectiveness of online ACT interventions for mental health has been widely supported throughout relevant literature (Kelson et al., 2019).

Both CBT and ACT are recommended as appropriate interventions for chronic primary pain; understanding the efficacy of online CBT may increase understanding of the possible effectiveness of online ACT. Internet-based Cognitive Behavioural Therapy has been shown to decrease pain symptoms and activity limitation (Bender et al., 2011). However, online CBT does not consistently demonstrate a reduction in depression and anxiety symptoms (Bender et al., 2011). This may in part be due to the focus of CBT on pain symptoms with less consideration given to the wider psychosocial effects of chronic pain. These conclusions are similar to the results seen in face-to-face CBT for chronic pain; effects on pain, disability, and mood are small and not consistently sustained over a long period of time (Eccleston et al., 2009).

There is a limited but growing body of research exploring online ACT in relation to chronic primary pain, which will form the focus of the current review. A recent feasibility trial demonstrated that online ACT was linked to a significant reduction in pain interference, anxiety, and depression (Gentili et al., 2021). In contrast, Trompetter et al. (2015a) highlighted that there was no significant difference in anxiety and depression symptoms between control groups and online ACT for individuals living with chronic pain.



## **Evaluation of Previous Literature Reviews**

Previous reviews have primarily focussed on the efficacy of face-to-face delivered ACT for chronic pain (Hann & McCracken, 2014; Veehof et al., 2011; Williams et al., 2020) rather than exploring online ACT. A review of 10 studies examined the effects of acceptance-based therapies which included both ACT and mindfulness-based approaches and demonstrated there was a small effect on pain intensity (Veehof, et al., 2011). However, it is suggested that focussing solely on pain intensity may not be the most appropriate outcome for acceptance-based interventions as they focus primarily on increasing psychological flexibility (Veehof et al., 2011). The Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials' (IMMPACT) recommendations for clinical trials in chronic pain advise that studies exploring the effectiveness of chronic pain treatments should consider at least four main outcomes; pain intensity, physical functioning, emotional functioning, and participant ratings of overall improvement (Dworkin et al., 2008; Turk & Dworkin, 2004). Consideration of additional health and social outcomes is also recommended.

The findings of a more recent review (Williams et al., 2020) suggest that face-to-face ACT for chronic pain may not be effective, though the authors also highlighted that existing studies were too low quality to gain accurate estimates of effectiveness (Williams et al., 2020). However, the review included studies of both chronic primary and chronic secondary pain; NICE guidelines suggest that ACT is most appropriate for chronic primary pain because of the potentially medically unexplained source of pain and the importance of acceptance (NICE, 2021). Furthermore, the review focussed on pain intensity and distress outcomes and did not explore wider health and social outcomes such as quality of life and impact on daily functioning.

## **Rationale for Current Systematic Review**

Previous reviews of the use of ACT in the treatment of chronic pain have concentrated on a narrow range of primarily symptom-focussed outcomes, such as pain

intensity and distress. These reviews have failed to consider additional intervention-specific outcomes (such as change in psychological flexibility) or other relevant health and social outcomes. It is argued here that consideration of such outcomes in addition to symptom or pain reduction may be more appropriate for evaluating the impact of acceptance-based interventions, given the focus of ACT on facilitating acceptance of and adjustment to chronic pain.

In addition, there is currently no published review that explores outcomes for online ACT for chronic primary pain. As chronic primary pain is a relatively recent diagnostic term, previous reviews have not focussed on this diagnosis. An existing proposal for a meta-analysis to explore online ACT for chronic pain has been registered, however, a potential limitation of this review is its restricted scope whereas the current review may offer a more comprehensive analysis by exploring a wider range of studies and health, social, and intervention-specific outcomes.

### **Aims of Current Review**

The current review therefore sets out to address this gap in the literature using a narrative synthesis approach to examine the impact of online ACT on health, social, and intervention-specific outcomes for chronic primary pain. The review seeks to address the following question, designed using the PICO framework: “What are the health, social, and intervention-specific outcomes of online ACT for chronic primary pain?”.

## **Methods**

### **Systematic Literature Search**

#### ***Search Process***

A systematic search of the literature for studies exploring online ACT for chronic primary pain was completed in March 2021, following receipt of ethical approval from Coventry University Ethics Committee (Appendix B). Four relevant databases containing articles within psychology, health, and medicine were searched: PsycINFO, CINAHL,

Medline and Web of Science. Alerts were established within the databases until the 31<sup>st</sup> March 2021. Additionally, the reference lists of included articles were reviewed for any relevant articles.

### **Search Terms**

**Table 1.** *Search Terms*

<b>PICO</b>	<b>Main Concept</b>	<b>Synonyms</b>	<b>Location</b>
Problem	Chronic Primary Pain	Chronic pain	Title
		Pain	Abstract
		Pain syndrome	Key words
		Complex Regional Pain syndrome	
		Pain management	
		Long-term pain	
		Persistent pain	
		Idiopathic pain	
		Unexplained pain	
Intervention	Online therapy	Online	Title
		Online intervention	Abstract
		Computers	Key words
		Computerised	
		Computer assisted therapy	
		Internet	
		Internet-based therapy	
		Remote therapy	
		Remote intervention	
		Digital therapy	
		Digital intervention	
	Acceptance and Commitment therapy	Acceptance-based	Title
		ACT	Abstract
		Relational frame theory	Key words
		Third wave approaches	

Table 1 summarises the search terms used, these were organised using the Problem, Intervention, Clinical Population, Outcome framework (Schardt et al., 2007) and included the main concepts and additional synonyms. The terms were searched for within the Titles, Abstracts, and Key words lists of articles within the mentioned databases.

### **Search Strategy**

Boolean logic was utilised within the search strategy. Accordingly, words (e.g. 'AND', 'OR' and 'NOT') and symbols (e.g. an asterisk '\*' to replace characters in a word so that

multiple variations can be searched) linked key words into search statements (Ridley, 2008).

The following Boolean strategy was used:

*(chronic primary pain OR chronic pain OR pain OR pain syndrome OR Complex Regional Pain syndrome OR pain management OR long-term pain OR persistent pain OR idiopathic pain OR unexplained pain) AND (online therapy OR online intervention OR online OR computer\* OR computer assisted therapy OR internet OR internet-based therapy OR remote therapy OR remote intervention OR digital therapy OR digital intervention) AND (acceptance and commitment therapy OR acceptance-based OR ACT OR relational frame theory OR third wave approaches).*

## **Inclusion and Exclusion Criteria**

### ***Initial Screening***

Two stages of screening were applied to screen relevant articles. Firstly, titles, abstracts and key words were screened and included if they were: (a) written in English; (b) peer-reviewed, empirical studies; (c) full text was available; (d) focussed on chronic pain; (e) reported online ACT-based interventions. Secondly, full text articles were evaluated against the specific inclusion and exclusion criteria (Table 2).

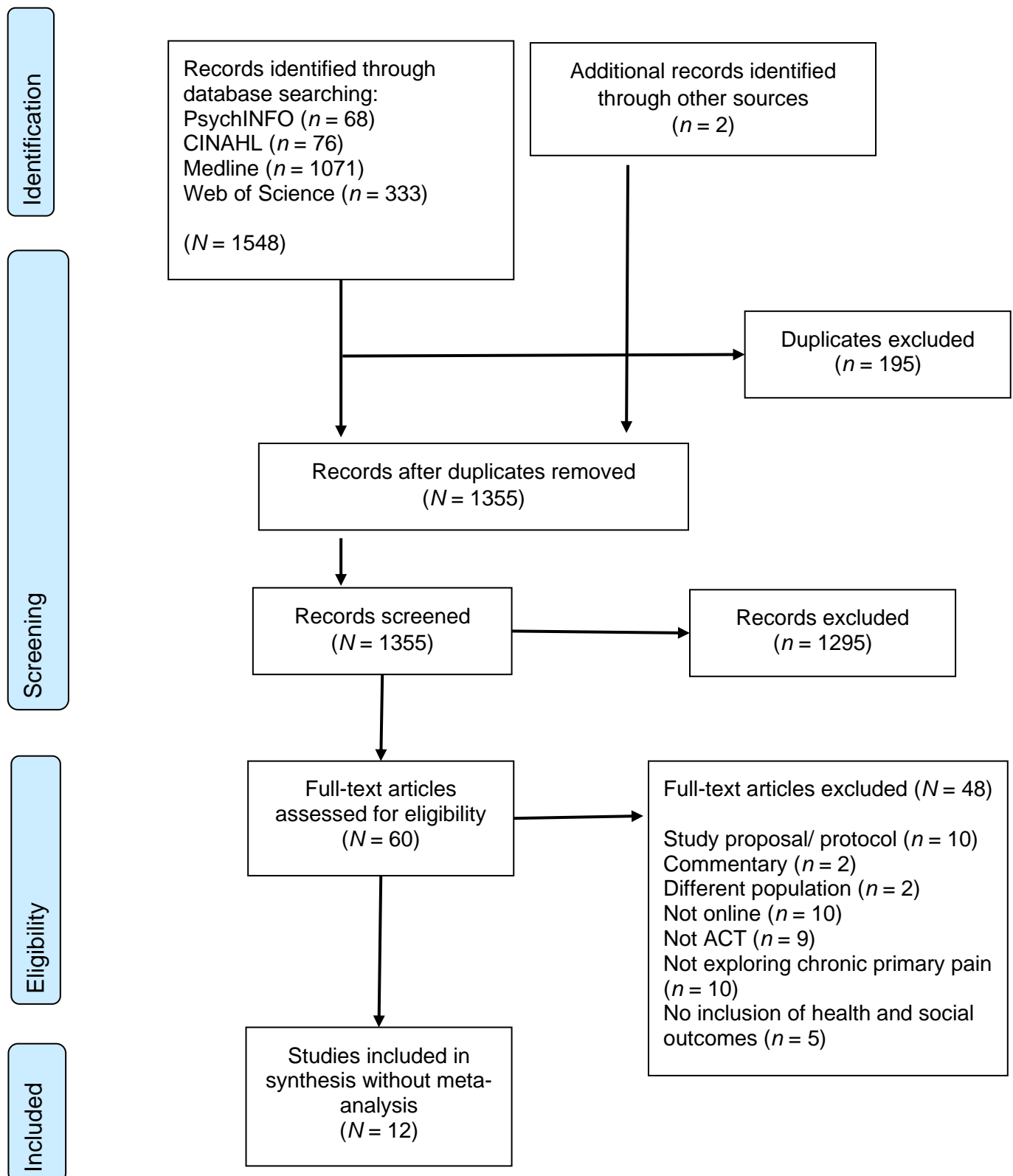
### ***Specific Inclusion and Exclusion Criteria***

**Table 2.** *Inclusion and Exclusion Criteria*

<b>Criteria</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
Problem (P in PICO)	Chronic primary pain or unspecified chronic pain diagnostic criteria met by the majority of participants	Chronic secondary pain related to another medical condition e.g., diabetes or arthritis
Intervention (I in PICO)	Online ACT	Face to face ACT or alternative interventions e.g., CBT
Methodology	Quantitative, qualitative & mixed method studies	
Clinical population (C in PICO)	Adults, aged 18 years+	
Outcomes (O in PICO)	Pain-based outcomes e.g. pain change or pain interference AND Intervention-specific outcomes e.g. acceptance, psychological flexibility, or values AND Health and social outcomes e.g. mental health, daily functioning, social functioning, or quality of life	Outcomes related solely to physical health or symptoms

The inclusion and exclusion criteria were guided by the research question and PICO framework. No restrictions were placed on the type of online ACT-based intervention, for example, group interventions, therapist led interventions etc. In order to facilitate consideration of the widest range of research available, studies were not required to have a control group design or comparator criteria. Studies were included if they evaluated ACT-based interventions for chronic primary pain using intervention-specific, health, and social outcomes and met the other inclusion criteria. Chronic primary pain diagnostic criteria had to be met by over 50% of the participants to suggest that the intervention was exploring ACT online for chronic primary pain (diagnostic criteria for chronic primary pain can be seen in Appendix C).

# Classification of Studies



**Figure 1.** PRISMA Flow Diagram (adapted from Moher et al., 2009)

The 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses' (PRISMA; Moher et al., 2009) flow diagram (Figure 1) was used to record the screening and selection process. In total, 1,550 articles were identified through database searches and screening reference lists. The initial screening removed 195 duplicate articles and an additional 1,293 for not meeting the initial screening criteria. Consequently, 62 articles were reviewed using the inclusion and exclusion criteria, 48 were removed for reasons such as not focussing on predominantly chronic primary pain, no inclusion of health and social outcomes and not using an ACT-based intervention. In total, 12 studies met the inclusion criteria and were retained for quality assessment.

### **Assessment of Methodological Quality**

The 12 selected studies were assessed for methodological quality. Using a structured, valid quality assessment can add to a systematic review and avoid bias by supporting reasoning and judgement about quality (Dixon-Woods et al., 2007). Studies were evaluated using the Caldwell framework (Caldwell et al., 2011). This framework is frequently used within clinical and health psychology reviews and is applicable across quantitative and qualitative research methodologies (Caldwell et al., 2011; Hobbs, 2015)

Studies were assessed against 18 criteria (Appendix D). For each criterion, studies were rated as; 0, if criterion was not met; 1 if the criterion was partially met; and 2 if the criterion was fully met. The overall score was then calculated by totalling the scores for all 18 criteria, resulting in a score between 0 and 36. Any papers scoring below a midpoint of 18 would be excluded for not reaching a satisfactory level of methodological quality. All of the papers screened scored between 25 and 35 ( $M = 32.6$ ) and were therefore deemed to be good quality and eligible for inclusion in the review (Appendix E).

To increase the reliability of the quality assessment, a second researcher independently rated all articles with the same assessment criteria (Appendix F). Any areas of significant divergence in scores were discussed together and agreement was reached on the interpretation of those assessment criteria. Inter-rater reliability analyses using the Kappa

statistic were then conducted. The overall Kappa coefficient was  $\kappa = .907$ , with individual Kappa coefficient scores ranging from  $\kappa = .824$  to  $\kappa = 1.0$  (Table 3; Appendix G). This demonstrates moderate to strong patterns of inter-rater reliability (McHugh, 2012).

## **Characteristics of Studies**

### ***Location***

Table 3 presents the characteristics of the 12 studies. Five studies were conducted in Sweden (Buhrman et al., 2013; Gentili et al., 2021; Ljótsson et al., 2014; Rickardsson et al., 2020; 2021), three were completed in the Netherlands (Trompetter et al., 2015a; 2015b; 2016), and the remaining papers were conducted elsewhere including; Australia, (Scriven et al., 2019) Germany (Lin et al., 2017), Singapore, (Yang et al., 2017), and the United Kingdom (Scott et al., 2018).

### ***Design and Aims***

The research aims were wide-ranging; some explored the feasibility, acceptability, and preliminary effects of an online ACT-based intervention within a particular context (Rickardsson et al., 2020; Scott et al., 2018; Trompetter et al., 2015a; Yang et al., 2017), and other papers aimed to explore the efficacy and long-term effects of a digital ACT-based intervention (Buhrman et al., 2013; Gentili et al., 2021; Ljótsson et al., 2014; Scriven et al., 2019). Additionally, a selection of papers sought to compare an online ACT-based intervention with an alternative intervention (Lin et al., 2017; Rickardsson et al., 2021). The two remaining papers aimed to explore the relationships between factors such as psychological flexibility and psychosocial domain factors on pain interference and health and social outcomes (Trompetter et al., 2015b; 2016).

The majority of the studies were quantitative in design, with two studies presenting mixed method designs (Rickardsson et al., 2020; Scriven et al., 2019). Seven of the studies were randomised controlled trials (Buhrman et al., 2013; Lin et al., 2017; Rickardsson et al., 2021; Scott et al., 2018; Trompetter et al., 2015a; 2015b; 2016). All of these studies used a control group within the designs. The control groups included waiting lists (Lin et al., 2017;



Rickardsson et al., 2021; Trompetter et al., 2015a; 2015b; 2016), treatment as usual (Scott et al., 2018), a moderated discussion forum (Buhrman et al., 2013) and expressive writing group (Trompetter et al., 2015a; 2015b; 2016).

### **Sample**

All of the studies employed purposive sampling; seven of the studies recruited self-referred participants (Gentili et al., 2021; Lin et al., 2017; Ljótsson et al., 2014; Rickardsson et al., 2021; Trompetter et al., 2015a; 2015b; 2016), four of the studies recruited from clinical samples (Buhrman et al., 2013; Scott et al., 2018; Scriven et al., 2019; Yang et al., 2017) and the final study used a combination of a clinical and self-referred sample (Rickardsson et al., 2020). Across all studies the participants were self-selecting or voluntary.

For the purposes of consolidating the extracted information, the Trompetter et al. (2015a; 2015b; 2016) papers were considered as one sample as the studies used the same data and describe different analyses of this. Subsequently, of the ten papers, sample sizes ranged from 21-303 ( $M = 96.1$ ) participants, with more females ( $n = 747$ ) than males ( $n = 214$ ). All papers apart from Ljótsson et al. (2014) reported participant age with the mean age across the remaining nine studies calculated as 48.58 years.

There was not a consistent method of assessing or categorising chronic pain across the studies. Of the six studies who reported pain duration in years the average was 13.6 years (Buhrman et al., 2013; Gentili et al., 2021; Lin et al., 2017; Rickardsson et al., 2020; 2021; Scott et al., 2018), with reported pain locations varying from widespread, generalized pain to more specific back, limb, or face pain. Ljótsson et al. (2014) focussed solely on Fibromyalgia and did not explore other experiences of chronic primary pain. None of the studies specifically mentioned chronic primary pain as a diagnostic category.

Three of the studies described pain experience using specific diagnostic clusters (Gentili et al., 2020; Rickardsson et al., 2020; 2021) including *Nociceptive*, *Nociplastic*, *Headaches*, and *Other/Unclear*. For the purposes of this review and the focus on chronic

primary pain, *Nociplastic*, *Headaches*, and *Other/Unclear* were considered as chronic primary pain categories. Additionally, the *Neuropathic* and *Nociceptive* categories were assumed to potentially contain participants who may also be experiencing chronic primary pain, as research demonstrates that individuals with a Neuropathic or Nociceptive pain experience are four times more likely to also have Fibromyalgia or another widespread chronic pain experience (Haliloglu et al., 2014).

Finally, the Trompetter et al. (2015a; 2015b; 2016) studies used alternative categories to classify specific pain experiences, with the majority of their participants falling into the *Other* or *None* categories. These two categories, where the cause of pain was unclear or unidentified, were assumed to be likely to contain participants with chronic primary pain. Fibromyalgia in these three studies, was also a separate category which comprised 20.2% of participants; Fibromyalgia sits within the current chronic primary pain classification (World Health Organisation, 2019).

### ***Intervention***

The online ACT interventions were delivered across a variety of platforms. Eleven of the interventions evaluated were self-directed and delivered digitally through an online platform, website, or smartphone application (Buhrman et al., 2013; Gentili et al., 2021; Lin et al., 2017; Ljótsson et al., 2014; Rickardsson et al., 2020; 2021; Scott et al., 2018; Trompetter et al., 2015a; 2015b; 2016; Yang et al., 2017). Scriven et al.'s (2019) intervention was delivered by a therapist via video conferencing and was the only group intervention. The average length of the interventions was 8.15 weeks, with a range of 4-12 weeks. For the eleven studies that were self-directed, regular therapist contact was described; most of this contact was in the form of weekly feedback via email or secure messaging (Gentili et al., 2021; Lin et al., 2017; Ljótsson et al., 2014; Rickardsson et al., 2020; 2021; Trompetter et al., 2015a; 2015b; 2016). For two of the studies therapist contact was face-to-face for the first and last session followed by weekly email contact for the majority of the intervention (Scott et al., 2018; Yang et al., 2017).

### ***Outcome Measures***

A wide range of outcome measures were used to evaluate the efficacy of the interventions. The majority of primary outcomes were focussed on pain interference and impact (Gentili et al., 2021; Lin et al., 2017; Ljótsson et al., 2014; Rickardsson et al., 2020; 2021; Trompetter et al., 2015a; 2015b; 2016; Yang et al., 2017) with two focussing on chronic pain acceptance (Buhrman et al., 2013; Scriven et al., 2019) and one paper using feasibility outcomes (Scott et al., 2018). Secondary outcome measures were diverse and included a range of intervention-specific, health, and social outcomes as well as participant satisfaction with the intervention. Further details regarding all of the outcomes and the grouping of these is explored in the results and Table 4.

**Table 3. Key Characteristics of the Literature**

Author, Year of Publication, Country of Origin, Quality Assessment Rating (QR) and Kappa Score ( $\kappa$ )	Aims (* relevant to current study)	Research Design and Sampling method	Sample Characteristics Number of Participants	Pain Characteristics	Data Collection and Analysis	Intervention	Key Findings
Buhrman, M., Skoglund, A., Husell, J., Bergström, K., Gorddh, T., Hursti, T., Bendelin, N., Furmark, T., Andersson, G. (2013)  Sweden  QR = 33/36, 91.6% $\kappa$ = .824	Aim: To investigate if a guided internet-based ACT intervention could be beneficial for patients with chronic pain.	Quantitative Randomised Controlled Trial  Purposive sampling, clinical sample	N = 76 iACT n = 38 control group n = 38  Age: 49.1 years (M)  Gender: Female 59.2% Male 40.7%  Education level: University education 43.4% Completed A Levels (equivalent) 47.4% Completed GCSEs (equivalent) 9.2%  Sick leave: 82.9% (n = 63) 17.1% (n = 13)	Pain duration: 15.3 years (M)  Pain location: 72.4% generalized pain Back pain 9.2% Neck, head pain 6.6% Shoulders, arms 3.9% Hips, legs, feet 7.9%	Online questionnaires (pre and post intervention)  Primary outcome: CPAQ  Secondary outcomes: HADS CSQ MPI PAIRS QOLI  ANCOVA	IACT: Length: roughly 7 weeks  Online portal intervention  Seven chapters including Life values, Willingness and Thoughts and emotions. Written exercises and audio tracks. Weekly therapist contact via videoconferencing  Control group: Moderated online discussion forum	Treatment adherence: 39.5% (n = 18)  CPAQ: Significant effects between groups in favour of the treatment group [ $F(91, 73) = 6.0, p = .017$ ], with medium effect size, $d = 0.41$ . No improvement or deterioration at six months.  HADS: Significant effects between groups on the HADS-anxiety scale [ $F(1,73) = 5.88, p = .018$ ] and HADS depression scale [ $F(1,73) = 6.87, p = .01$ ] for treatment group. Effect sizes were small $d = 0.18$ and $d = 0.44$  QOLI: No significant effect  PAIRS: No significant effect  CSQ: Significant effect on the CSQ catastrophizing scale [ $F(1,73) = 6.10, p = .016$ ] and CSQ praying and hoping subscale [ $F(1,73) = 9.46, p = .003$ ] in favour of the treatment group. Effect sizes medium to small, $d = 0.51$ and $d = 0.28$ .  MPI: Significant effect on the MPI interfering subscale [ $F(1,73) = 9.49, p = .003$ ] and MPI affective distress subscale [ $F(1,73) = 5.08, p = .027$ ] in favour of the treatment group. Small to medium effect sizes, $d = 0.56$ and $d = 0.3$

<p>Gentili, C., Zetterqvist, V., Rickardsson, J., Holmstrom, L., Simons, L. E., &amp; Wicksell, R. K. (2021)</p> <p>Sweden</p> <p>QR = 35/36, 97.2% κ = 1.000</p>	<p>Aim: To evaluate the immediate and long-term effects of smartphone app, ACTsmart on pain interference, and other health and social outcomes.</p>	<p>Quantitative Pilot trial</p> <p>Purposive sampling, self-referred sample</p>	<p>N = 34</p> <p>Age: 44.3 years (<i>M</i>)</p> <p>Gender: Female 88% (<i>n</i> = 30) Male 12% (<i>n</i> = 4)</p>	<p>Pain duration: 20.4 years (<i>M</i>)</p> <p>Pain diagnosis type: Nociceptive: 35% Neuropathic: 3% Nociplastic: 29% Headaches: 3% Other or unclear: 9% Unspecified diagnosis: 21%</p>	<p>Questionnaires via app Pre and post (3, 6, and 12-month follow-ups) intervention</p> <p>Primary outcome: PII</p> <p>Secondary outcomes: PIPS VQ ISI PHQ-9 GAD-7 EQ-5D-3L</p> <p>Pain intensity: rated using numeric rating scale 0 (no pain) to 10 (worst imaginable pain)</p> <p>Intent-to-treat approach using linear mixed-effects model</p>	<p>ACTsmart: Length: 8-week intervention, recommended daily access</p> <p>Smartphone based intervention</p> <p>Four sections with psychoeducation, texts, exercises, and values (delivered by text, audio, pictures, and animations)</p> <p>Therapist contact via secure message feedback, weekly</p> <p>No control group</p>	<p>Attrition: Withdrawal 3% (<i>n</i> = 1) Attrition 6% (<i>n</i> = 2)</p> <p>Treatment adherence: 90% (<i>n</i> = 28)</p> <p>Pain interference: Significant linear effect from pre-treatment to posttreatment (<i>p</i> = .000) No significant changes from posttreatment to 12-month follow-up</p> <p>Significant liner effect of time from pre-treatment to posttreatment for all secondary outcomes</p> <p>Large effect sizes seen in the primary outcomes (<i>d</i> = -1.01) and secondary outcomes of avoidance (<i>d</i> = -1.34), value obstruction (<i>d</i> = -1.02) and anxiety (<i>d</i> = -0.67)</p> <p>Medium effect sizes for value progress (<i>d</i> = 0.78), depressive symptoms (<i>d</i> = -0.63) fusion (<i>d</i> = -0.67), and insomnia (<i>d</i> = -0.47)</p> <p>Small effect sizes for pain intensity (<i>d</i> = -0.44), and health related QoL (<i>d</i> = 0.16)</p>
<p>Lin, J., Paganini, S., Sander, L., Lüking, M., Ebert, D. D., Buhrman, M., Andersson, G., &amp; Baumeister, H. (2017)</p> <p>Germany</p> <p>QR = 31/36, 86.1% κ = .852</p>	<p>Aim: To examine the effectiveness of a guided and unguided ACT-based internet intervention (ACTonPain) for individuals with chronic pain in comparison to a waiting-list control group.</p>	<p>Quantitative Three-armed Randomised Controlled Trial</p> <p>Purposive sampling, self-referred sample</p>	<p>N = 303</p> <p>Age: 51.7 years (<i>M</i>) Range: 20-86</p> <p>Gender: Female: 84.1% (<i>n</i>=254)</p> <p>Education level: No school qualification: 0.3% (<i>n</i> = 1) Basic secondary school: 11.9% (<i>n</i> = 36) Middle secondary school: 35.4% (<i>n</i> = 107) Grammar/ technical grammar school: 53.3% (<i>n</i> = 158)</p>	<p>Pain duration (months): 114.45</p> <p>Pain location: Back 34.1% (<i>n</i> = 103) Head, neck 23.5% (<i>n</i> = 71) Shoulders 5.6% (<i>n</i> = 17) Other 36.8% (<i>n</i> = 111)</p> <p>Type of pain: Constant pain with little</p>	<p>Questionnaires</p> <p>Primary Outcome: MPI</p> <p>Secondary Outcomes: BPI PHQ-9 GAD-7 SF-12 AAQ-II CPAQ</p> <p>Pain intensity rated using 11-point numeric rating scale (0 = no pain, 10 =</p>	<p>ACTonPain:</p> <p>Length: Roughly 8 weeks (60 minutes a week)</p> <p>Same intervention for guided (<i>n</i> = 100) and unguided (<i>n</i> = 101) groups consisting of an introduction and seven modules</p> <p>Therapist involvement for guided group only, via email feedback after completion of each module.</p> <p>Control group: Waiting list (<i>n</i> = 101)</p>	<p>Attrition: <i>Guided ACTonPain</i>: 40% <i>Unguided ACTonPain</i>: 60%</p> <p>Intention to treat analysis was significant between time 0 and time 1 and between time 0 and time 2</p> <p>Primary outcome: Pain interference was significantly lower in the guided ACTonPain group than the control group. No significant differences were found between the two ACTonPain groups or between unguided ACTonPain and the control group</p> <p>Secondary outcomes: Pain acceptance significantly higher in guided ACTonPain</p>

			Occupational status: Unemployed: 4.3% ( <i>n</i> = 13) Student 4% ( <i>n</i> = 12) Self-employed/ employed 57.6% ( <i>n</i> = 174) Retired 34.1% ( <i>n</i> = 103)	fluctuations 36.1% ( <i>n</i> = 109) Constant pain with large fluctuations 33.4% ( <i>n</i> = 101) Pain attacks, no pain in between 13.2% ( <i>n</i> = 40) Pain attacks, pain in between 17.2% ( <i>n</i> = 52)	pain as bad as you can imagine)  Participants' satisfaction  Participants' rating of overall improvement  Intervention adherence  Intention to treat analysis, MANOVA with repeated measures and further post hoc analyses		compared for control group across all time points Depression symptoms significantly reduced in unguided ACTonPain compared to control group  No significant differences in remaining secondary outcomes.  No significant differences regarding participant satisfaction  Guided ACTonPain more effective across outcomes in comparison to waiting list
Ljótsson, B., Atterlöf, E., Lagerlöf, M., Andersson, E., Jernelöv, S., Hedman, E., Kemani, M., & Wicksell, R. K. (2014)  Sweden  QR= 31/36, 86.1% κ = 1.000	Aim: Evaluate the efficacy and acceptability of an ACT based internet- delivered treatment for individuals experiencing fibromyalgia. Specifically focussing on the impact on additional health and social outcomes.	Quantitative Open pilot trial  Purposive sampling, self- referred sample	<i>N</i> = 41  Age: not stated  Gender: 100% Female  No other characteristics provided	All participants had fibromyalgia diagnosed by a doctor  Year since diagnosis 9.2 years ( <i>M</i> )	Online questionnaires  Primary outcome: FIQ  Secondary outcomes: PDI SF-12 HADS FSS PIPS TIC-P  Dependent samples t-tests & multiple linear regression	IACT: Length: 10 weeks  Self-directed ACT intervention based on ACT manual for face-to-face treatment. Five treatment steps  Therapist contact was via internet approximately one message per week.  Access to online, closed, discussion forum to share with other participants.  No control group	Attrition: <i>n</i> = 4  Significant decreases across all measures from pre to posttreatment and from pre- treatment to follow-up  Primary outcome: Large effect size from pre-treatment to posttreatment <i>d</i> = 0.71 and large effect size from pre-treatment to follow-up <i>d</i> = 0.96  Secondary outcomes: Moderate to large effect sizes from pre- treatment to post-treatment and pre- treatment to follow-up <i>d</i> = 0.62-1.63  No significant improvements from posttreatment to follow-up.
Rickardsson, J., Zetterqvist, V., Gentili, C., Andersson, E., Holmström, L., Lekander, M., Persson, M., Persson, J.,	Aims: Evaluate preliminary effects of iACT treatment on pain interference and additional	Mixed methods Open pilot and feasibility study  Purposive sampling	<i>N</i> = 39 <i>Clinical sample n</i> = 15, <i>Self-referred sample n</i> = 24  Age: <i>Clinical sample</i> 35 years ( <i>M</i> )	Pain duration: <i>Clinical sample</i> 7.6 years ( <i>M</i> ) 0.5-29.0 years range  <i>Self-referred</i> <i>sample</i>	Online questionnaires via online platform and semi-structured telephone interviews  Primary outcome: PII	Internet based ACT on online platform  Length; 10 weeks  40 episodes of content (15 minutes length), 4 to be completed per week	Attrition: <i>Clinical sample</i> During treatment <i>n</i> = 5 3-month follow-up <i>n</i> = 8 12-month follow-up <i>n</i> = 1  <i>Self-referred sample</i> During treatment <i>n</i> = 6

<p>Ljótsson, B., Wicksell, R. K. (2020)</p> <p>Sweden</p> <p>QR = 32/36, 88.8% κ = 1.000</p>	<p>health and social outcomes</p>	<p>Clinical and self-referred sample</p>	<p>18-64 years range</p> <p><i>Self-referred sample</i> 42.4 years (<i>M</i>) 24-60 years range</p> <p>Gender: <i>Clinical sample</i> Female <i>n</i> = 13 Male <i>n</i> = 2</p> <p><i>Self-referred sample</i> Female <i>n</i> = 22 Male <i>n</i> = 2</p> <p>Education: <i>Clinical sample</i> Up to 12 years <i>n</i> = 7 12-15 years <i>n</i> = 3 15 years+ <i>n</i> = 5</p> <p><i>Self-referred sample</i> Up to 12 years <i>n</i> = 7 12-15 years <i>n</i> = 1 15 years+ <i>n</i> = 16</p>	<p>16.2 years (<i>M</i>) 3.0-59.0 years range</p> <p>Pain diagnosis: <i>Clinical sample</i> Nociceptive <i>n</i> = 4 Neuropathic <i>n</i> = 1 Nociplastic <i>n</i> = 4 Headaches <i>n</i> = 1 Other/unclear <i>n</i> = 5</p> <p><i>Self-referred sample</i> Nociceptive <i>n</i> = 8 Neuropathic <i>n</i> = 1 Nociplastic <i>n</i> = 7 Headaches <i>n</i> = 0 Other/unclear <i>n</i> = 8</p>	<p>Secondary outcomes: PIPS VQ SF-12 HADS ISI</p> <p>Chi square, Mann-Whitney U, and t-tests, linear mixed-effects for repeated measures</p>	<p>Therapeutic support secure messaging system. Additional phone support available</p> <p>No control group</p>	<p>3-month follow-up <i>n</i> = 7 12-month follow-up <i>n</i> = 2</p> <p>Significant improvements on pain interference, psychological inflexibility, value progress and obstruction. QoL, depressive symptoms, pain intensity, anxiety, and insomnia from pre to posttreatment</p> <p>Primary outcome: Effect size was medium</p> <p>Secondary outcomes: Effect sizes small to medium</p> <p>No significant effect of times across time points was found signifying stability of improvements</p>
<p>Rickardsson, J., Gentili, C., Holmström, L., Zetterqvist, V., Andersson, E., Persson, J., Lekander, M., Ljótsson, B., &amp; Wicksell, R. K. (2021)</p> <p>Sweden</p> <p>QR = 33/36, 91.6% κ = .824</p>	<p>Aim: To evaluate the efficacy on iACT for chronic pain in comparison to a waitlist control group.</p>	<p>Quantitative Randomised Controlled Trial</p> <p>Purposive sampling, self-referred sample</p>	<p><i>N</i> = 113</p> <p>Age: 49.5 (<i>M</i>)</p> <p>Gender: Female 75% (<i>n</i> = 85) Male 25% (<i>n</i> = 28)</p> <p>Education: Up to 12 years 28% (<i>n</i> = 32) 12-15 years 24% (<i>n</i> = 27) 15 years+ 48% (<i>n</i> = 54)</p> <p>Employment status: Full time working/studying 36% (<i>n</i> = 41)</p>	<p>Pain duration: 18.1 years (<i>M</i>)</p> <p>Pain diagnosis: Nociceptive <i>n</i> = 42 Neuropathic <i>n</i> = 7 Nociplastic <i>n</i> = 13 Headaches <i>n</i> = 12 Other/unclear <i>n</i> = 12</p>	<p>Questionnaires</p> <p>Primary outcome: PII</p> <p>Secondary outcomes: PIPS VQ EQ-5D GAD-7 PHQ-9 ISI</p> <p>Pain intensity – numeric rating (0- no pain to 10 - worst imaginable pain)</p> <p>Intention to treat approach, multilevel</p>	<p>Internet based iACT treatment (<i>n</i> = 57)</p> <p>Length: Eight weeks</p> <p>Brief 10-minute daily microlearning interactions with content consisting of text, audio, and illustrations.</p> <p>Weekly therapist feedback sent by text message Phone support available</p> <p>Control group: Waiting list (<i>n</i> = 56)</p>	<p>Attrition: <i>N</i> = 13 <i>iACT condition</i>, <i>n</i> = 11 Post assessments completed by 88% (<i>n</i>=100) 12-month follow-up completed by 65% (<i>n</i>=37)</p> <p>Significant outcomes for iACT from baseline to posttreatment for pain interference, depressive symptoms, pain intensity and insomnia.</p> <p>Primary outcome: Large effect size, (<i>d</i> = 0.99). 32% reduction in pain interference posttreatment</p> <p>Secondary outcomes: Small effect sizes for insomnia (<i>d</i> = 0.39) and QoL (<i>d</i> = 0.49)</p>

			Part-time working/studying 24% ( $n = 27$ ) Temporary sick leave 20% ( $n = 23$ ) Permanent sick leave 24% ( $n = 27$ )		linear models, effect sizes and Chi tests		Moderate effect sizes for depressive symptoms ( $d = 0.68$ ), anxiety, ( $d = 0.62$ ), value progress, ( $d = 0.63$ ), and value obstruction, ( $d = 0.69$ )  Large effect sizes for pain intensity, ( $d = 1.2$ ) and psychological inflexibility ( $d = 1.0$ ) Average reduction in pain intensity of 29% and change in psychological inflexibility of 23% for iACT condition.
Scott, W., Chilcott, J., Guildford, B., Daly-Eichenhardt, A., & McCracken, L.M. (2018)	Aim: Explore the feasibility of online ACT for patients with chronic pain in the UK.	Quantitative Randomised Controlled Trial  Purposive sampling, clinical sample	$N = 63$  Age: <i>ACT online</i> 47.26 years ( $M$ ) <i>Control</i> 43.84 years ( $M$ )  Gender: <i>ACT online</i> Female $n = 21$ Male $n = 10$ <i>Control</i> Female $n = 19$ Male $n = 13$  Ethnicity: <i>ACT online</i> White $n = 24$ Black $n = 4$ Asian $n = 2$ Mixed/Other $n = 1$ <i>Control</i> White $n = 27$ Black $n = 1$ Asian $n = 1$ Mixed/Other $n = 3$  Education: <i>ACT online</i> $n = 14.5$ years ( $M$ ) <i>Control</i> $n = 15$ years ( $M$ )  Employment status: Full-time employment $n = 19$ Employment part time (due to pain) $n = 11$	Duration: <i>ACT online</i> 7.25 years ( $M$ ) <i>Control</i> 5.63 years ( $M$ )  Primary pain location: <i>ACT online</i> Head, face, or mouth $n = 1$ Neck $n = 4$ Upper shoulder/limbs $n = 1$ Chest region $n = 1$ Lower back/spine $n = 11$ Lower limbs $n = 3$ Pelvic region $n = 3$ Anal/genital $n = 1$ Widespread pain $n = 6$  <i>Control</i> Head, face, or mouth $n = 5$ Neck $n = 2$ Upper shoulder/limbs $n = 4$ Chest region $n = 0$ Lower back/spine $n = 8$	Online questionnaires  Primary outcomes: Feasibility outcomes  Secondary outcomes: PGIC BPI Interference subscale WSAS PHQ-9 CPAQ-8 EQ CAQ-8  Pain intensity and pain-related distress Numeric scale (0 - no pain to 10 - extremely intense pain)  Independent samples t-tests, Mann-Whitney U-test and chi-square tests and linear mixed effects regression models	Internet based ACT treatment ( $n = 31$ )  Length: 10-12 weeks Eight online sessions. Online sessions consisted of videos guiding through exercises and information.  Therapist contact: initially face-to-face to establish rapport and introduce model. Final face-to-face session to review and set long-term goals Weekly written feedback from therapist  Control group: Treatment as usual ( $n = 32$ )	Attrition: 76.2% ( $n = 48$ ) completed 3-month assessment 77.8% ( $n = 49$ ) completed 9-month follow-up  PGIC: 56.5% of ACT online group reported being much improved at 3-month follow-up compared to 20% of control group. 27.3% of ACT online reported being much improved at 9 months compared to 15.4% of control group.  Secondary outcomes: Less than small effect sizes for pain intensity and distress ( $d = 0.19$ ) and ( $d = 0.10$ )  Small effect size for pain interference ( $d = 0.24$ ) and functioning ( $d = 0.45$ ) at 3-months, these increased to medium effects at 9 months, ( $d = 0.54$ ) and ( $d = 0.50$ )  Large effect size for pain acceptance at 3 months ( $d = 0.87$ ) this decreased significantly at 9 months ( $d = 0.05$ )

United Kingdom

QR = 31/36,  
86.1%  
 $\kappa = .832$



			Employment part time (other) $n=5$ Unpaid volunteer $n=1$ Homemaker $n=1$ Unemployed (because of pain) $n=13$ Unemployed (other reason) $n=3$ Student $n=1$ Retired $n=9$	Lower limbs $n=5$ Pelvic region $n=4$ Anal/genital $n=1$ Widespread pain $n=3$			
Scriven, H., Doherty, D. P., & Ward, E. C. (2019)	Aim: To evaluate a chronic pain management programme using a multisite telehealth group model.	Mixed methods Formative evaluation	$N=21$  Age: 57.95 years ( $M$ ) Range 29-83 years	Pain location: Single pain location 29% ( $n=6$ ) Multiple pain locations 71% ( $n=15$ )	Questionnaires and telephone interview  Primary outcome: CPAQ 20  Secondary outcomes: BPI DASS 21 PICS PSEQ	The Manage your Pain- South West program Video conferencing delivered multisite pain management group  Length: 4 weeks, one 2-hour session per week  ACT based content within session with additional manual for homework  Group facilitated by allied health professionals in separate hub via videoconferencing. Participants where in multiple rural sites. Discussion and reflection in group was encouraged  No control group	Attrition: Not stated  Significant improvement in total score of CPAQ ( $p=0.77$ ), though small effect size ( $d=0.28$ )  Small effect sizes for all secondary outcome measures  PICS: 50% reported improved pain, 57% improved physical activities and 61% improved mood. 65% indicated improvements in overall function.  Themes: Three main themes - Group experience, telehealth accessibility and limits and concerns  Value of group work and sharing with others, ease of accessibility when delivered by telehealth were strengths identified in interviews.
Australia  QR = 31/36, 86.1% $\kappa = .824$		Purposive sampling, clinical sample	Gender: Female 52% ( $n=11$ ) Male 48% ( $n=10$ )		PROMIS - (EQ-5D scores were predicted)  Interview: Six questions regarding experience of group and any changes or improvements  Matched pairs t-tests and 'generic qualitative approach'		
Trompetter, H. R., Bohlmeijer, E. T., Veehof, M. M., & Schreurs, K. M. G. (2015a)	Aim: Evaluate the efficacy of an internet-based, guided self-help, ACT-based intervention	Quantitative Randomised Controlled Trial	$N=238$ ACT: $N=82$ EW: $N=79$ WL: $N=77$	Duration >5 years ACT: 58.5% EW: 69.6% WL: 61.0%	Online questionnaires  Primary outcome: MPI-interference subscale  Secondary outcomes: HADS	Living with Pain: Internet delivered guided ACT intervention ( $n=82$ )  Length: 9-12 weeks. >3hours per week  Nine modules consisting of text, experiential exercises	Attrition: ACT: Discontinued intervention $n=23$ EW: Discontinued intervention $n=29$ Primary outcome: Significant improvement for ACT compared to EW ( $p=0.005$ ), small effect size ( $d=0.33$ ) at 3 months and 6 months ( $p<.001$ , $d=0.47$ )  Secondary outcomes:
The Netherlands		Purposive Sampling, self-referred sample from	Age: ACT: 52.9 years ( $M$ ) EW: 52.3 years ( $M$ ) WL: 53.2 years ( $M$ )	Diagnosis: ACT: None 14.6% Back 9.8%			

QR = 30/36, 83.3% $\kappa = .833$		general population	Gender: ACT: Female 76.8% EW: Female 75.9% WL: Female 75.3%	Fibromyalgia 15.9% Joint complaints 8.5% Rheumatic disease 9.8% Neuropathic complaints 11% Other 30.5%	PDI MHC-SF FFMQ-SF ELS PCS	and metaphors and additional mindfulness exercises Therapeutic guidance provided once a week via email	In comparison to EW, participants in the ACT group significantly improved in pain intensity ( $p = .040$ ), depression subscale, Pain disability index ( $p = .011$ ) and psychological inflexibility ( $p = <.001$ ) Moderate effect sizes ( $d = 0.23-0.49$ )
			Education: ACT: Low 19.5% Intermediate 35.4% High 45.1%	EW: None 17.7% Back 13.9% Fibromyalgia 29.1% Joint complaints 7.6% Rheumatic disease 7.6% Neuropathic complaints 6.3% Other 20.8%	Pain intensity- numeric scale (0 - no pain to 10 - pain as bad as you can imagine)	Control groups: Internet-based control condition Expressive Writing ( $n = 79$ ) Regular writing regarding experiences and emotions related to chronic pain at least 3 times a week	Significant improvement in ACT group compared to waiting list and 3 and 6 months.
			EW: Low 19.0% Intermediate 36.7% High 44.3%	WL: None 19.5% Back 14.3% Fibromyalgia 15.6% Joint complaints 9.1% Rheumatic disease 11.7% Neuropathic complaints 9.1% Other 20.7%	Intention-to-treat analyses using general linear mixed model Cohen's $d$ (Effect sizes)	Therapeutic guidance provided once a week via email	
			WL: Low 22.1% Intermediate 35.0% High 42.9%		Waiting list ( $n = 77$ )		
Trompetter, H. R., Bohlmeijer, E. T., Fox, J- P., & Schreurs, K. M. G. (2015b)  The Netherlands	Aim: To assess the unique and combined effects of psychological flexibility and pain catastrophizing on health and social outcomes from previous RCT data.	Quantitative Randomised Controlled Trial  Purposive Sampling Self-selected sample from general population	$N = 238$ Same data set as Trompetter et al., 2015	Same data set as Trompetter et al., 2015	Online questionnaires  Primary outcome: MPI-interference subscale  Secondary outcomes: HADS PDI MHC-SF	Living with Pain: Internet delivered guided ACT intervention ( $n = 82$ )  Same intervention as Trompetter et al. 2015a	PIPS and PCS outcomes showed similar associations with outcomes except for pain NRS which was significant with PIPS but not with PCS.  Improvements in pain-related psychological flexibility possibly mediated changes in pain interference, psychological distress, and pain intensity.  Pain catastrophizing demonstrates an indirect mechanism of change on pain-

QR = 27/36, 75.0% $\kappa = .889$					PIPS FFMQ-SF ELS PCS		related outcome via psychological flexibility with pain.
					Pain intensity- numeric scale (0 - no pain to 10 - pain as bad as you can imagine)		
					Mediation analysis		
Trompetter, H. R., Bohlmeijer, E. T., Lamers, S. M. A. & Schreurs, K. M. G. (2016)	Aim: To explore whether psychosocial domain factors function as moderators and predictors of pain interference change in daily life using data from a previous randomised controlled trial.	Quantitative Randomised Controlled Trial	$N = 238$  Same data set as Trompetter et al., 2015	Same data set as Trompetter et al., 2015	Online questionnaires  Primary outcome: MPI-interference subscale  Secondary outcomes: HADS PDI MHC-SF PIPS FFMQ-SF ELS PCS	Living with Pain: Internet delivered guided ACT intervention ( $n = 82$ )  Same intervention as Trompetter et al., 2015	Primary outcome: No significant interaction effects on pain interference were present for any of the demographic variables  Psychological wellbeing acted as a moderator to pain interference in ACT group in comparison to the two control groups
The Netherlands  QR = 27/36, 75% $\kappa = 1.000$		Purposive Sampling Self-selected sample from general population			Pain intensity- numeric scale (0 no pain to 10 pain as bad as you can imagine)		
					Exploratory Linear Regression analyses		
Yang, S., Moss-Morris, R., & McCracken, L. M. (2017)	Aim: To test the feasibility of an online ACT treatment for chronic pain in Singapore.	Quantitative Uncontrolled pre-post study?	$N = 33$  Age: 47.61 years ( $M$ )  Gender: Female 75.8% ( $n = 25$ )	Pain duration: 111.39 days ( $M$ )  Pain location: Low back pain 78.8%	Online questionnaires at baseline, after treatment and 3- month follow-up	iACT-CEL  Length: 5 weeks	Attrition: Discontinued intervention $n = 3$ Discontinued post follow-up $n = 3$  Significant improvements in depression ( $p = 0.002$ ) and pain intensity ( $p = 0.03$ )

<p>Singapore</p> <p>QR = 34/36, 94.4% <math>\kappa = 1.000</math></p>	<p>Purposive sampling Clinical sample</p>	<p>Male 24.2% (<math>n = 8</math>)</p> <p>Ethnicity: Chinese 66.7% (<math>n = 22</math>) Malay 12.1% (<math>n = 4</math>) Indian 6.1% (<math>n = 2</math>) Others 15.2% (<math>n = 5</math>)</p> <p>Education: 13.61 years (<math>M</math>)</p> <p>Employment status: Full time 54.5% (<math>n = 18</math>) Part time 15.2% (<math>n = 5</math>) Others 30.4% (<math>n = 10</math>)</p>	<p>Primary outcomes: BPI SWLS</p> <p>Secondary outcomes: Pain intensity – numeric scale (0 - no pain to 10 - worst possible pain)</p> <p>PHQ-9 CPAQ-8 AAQ-II CAQ</p> <p>Intention to treat, paired samples t- tests and Cohen's <math>d</math> (effect sizes)</p>	<p>Two face-to-face sessions (first and last) and six online sessions (45-minutes)</p> <p>Audio mindfulness exercises, experiential exercises, video, and text</p> <p>Therapist contact via email providing structured feedback</p> <p>No control group</p>	<p>All other outcomes were not significant.</p> <p>Small effect sizes were demonstrated for most outcomes (<math>d = 0.14</math>-<math>0.35</math>). Moderate effect size for depression (<math>d = 0.51</math>)</p>
---	---	---	---	---	--

**Key for acronyms:** AAQ-II - Acceptance and Action Questionnaire-II (Bond et al., 2011); BPI- Brief Pain Inventory -Short Form Interference Scale (Cleeland & Ryan, 1991); CAQ – Committed Action Questionnaire (McCracken, 2013); CPAQ - Chronic Pain Acceptance Questionnaire (McCracken et al., 2004); CSQ -The Coping Strategies Questionnaire (Rosentiel & Keefe, 1983); CSQ - Client Satisfaction Questionnaire (Attkisson & Zwick, 1982); DASS 21 - Depression Anxiety Stress Scale 21 (Lovibond & Lovibond, 1995); ELS - Engaged Living Scale (Trompetter et al., 2013); EQ-5D-3L -European Quality of Life Questionnaire (The EuroQol Group, 1990); FFMQ-SF - Five Facet Mindfulness Questionnaire-Short Form (Bohlmeijer et al., 2011); FIQ - Fibromyalgia Impact Questionnaire (Burckhardt et al., 1991); FSS - Fatigue Severity Scale (Krupp et al., 1989); GAD-7 - Generalized Anxiety Disorder Scale (Williams, 20114); HADS - Hospital and Anxiety Depression Scale (Snaith, 2003); ISI - Insomnia Severity Index (Bastien et al., 2001); MHC-SF - Mental Health Continuum-Short Form (Lamers et al., 2011); MPI - Multidimensional Pain Inventory (Kerns et al., 1985); QOLI - Quality of Life Inventory (Frisch et al., 1992); PAIRS - The Pain and Impairment Relationship Scale (Slater et al., 1991); PASS-20- Pain Anxiety Symptoms Scale- Short Form (McCracken et al., 1992); PCS - Pain Catastrophizing Scale (Sullivan et al., 1995); PDI -Pain Disability Index (Tait et al., 1987); PGIC - Patient Global Impression of Change Scale (Ferguson et al., 2009); PHQ-9 -Patient Health Questionnaire (Kroenke et al., 2001); PICS - Patient Impression of Change Scale; PII - Pain Interference Index (Martin et al., 2015); PIPS - Psychological Inflexibility in Pain Scale (Wicksell et al., 2007); PROMIS - Patient Reported Outcomes Measurement Information System (Hays et al., 2009); PSEQ - Pain Self Efficacy Questionnaire (Nicholas, 2007); PSQI - Pittsburgh Sleep Quality Index (Buysse et al., 1989); SF-12 - Medical Outcomes Study 12-item Short Form Health Survey (Ware et al., 1996); SWLS - Satisfaction with Life Scale (Diener et al., 1985); TIC-P - The Trimbos and Institute of Medical Technology Assessment Cost Questionnaire for Psychiatry (Bouwman et al., 2013); VQ - Valuing Questionnaire (Smout et al., 2014); WSAS - Work and Social Adjustment Scale (Mundt et al., 2002).

### Analytic Review Strategy

All of the selected papers are quantitative or mixed methods in nature, nevertheless the papers do not meet the requirements for a meta-analysis. In addition, the selection of a 'standardised metric' (Campbell et al., 2020) was considered. However, the diversity of approaches, populations, and outcomes was too varied to allow for this. A narrative synthesis approach was therefore adopted (Higgins et al., 2019). This method of analysis explores similarities and differences between the findings of different studies as well as studying possible patterns in the data and can be used to review quantitative and mixed methods studies (Dixon-Woods, et al., 2008).

In order to explore the intervention-specific, health, and social outcomes, all of the outcomes were grouped, according to five themes: *Intervention-Specific*, *Mental & Physical Health*, *Quality of Life & Daily Functioning*, *Relationship to Pain*, and *Self-Efficacy*. Thematic grouping of the outcomes was achieved by categorising outcomes in line with their primary focus. Outcomes that contained more than one subscale were grouped based on either the primary subscale or the subscale used or reported in the study. Table 4 presents the different thematic groups.

**Table 4.** *Development of Outcome Measure Groupings*

Paper	Intervention-Specific	Mental & Physical Health	Quality of Life & Daily Functioning	Relationship to Pain	Self-Efficacy
Buhrman et al. (2013)	✓	✓	✓	✓✓	✓
Gentili et al. (2021)	✓✓	✓✓✓	✓	✓✓✓	
Lin et al. (2017)	✓	✓✓		✓✓	✓
Ljótsson et al. (2014)	✓	✓✓	✓	✓✓	
Rickardsson et al. (2020)	✓✓✓	✓✓	✓	✓✓	
Rickardsson et al. (2021)	✓✓	✓✓✓	✓	✓✓	
Scott et al. (2018)	✓✓✓	✓	✓	✓✓	
Scriven et al. (2019)	✓	✓✓	✓	✓	✓
Trompetter et al. (2015a)	✓✓	✓✓		✓✓✓	
Trompetter et al. (2015b)	✓			✓	
Trompetter et al. (2016)		✓		✓	
Yang et al. (2017)	✓✓✓	✓	✓	✓✓	

In the table the spread of papers across the different groupings is displayed, studies which used more than one different outcome measure in each area have been illustrated with one or more '✓'s.

## Results

### Intervention-Specific

Acceptance was evaluated by five studies using the Chronic Pain Acceptance Questionnaire (CPAQ, McCracken et al., 2004 see also Buhrman et al., 2013; Lin et al., 2017; Scott et al., 2018, Scriven et al., 2019; Yang et al., 2017). Yang et al. (2017) were the only authors to report no significant increase in acceptance; they suggested that this may have been mediated by the reduction in pain and depression highlighted within the study. However, their small sample size and lack of further analyses regarding causality and mediation limits the generalizability of this finding. Studies that reported a significant increase in acceptance, demonstrated large variances in effect sizes,  $d = 0.09$ - $d = 1.19$ .

Psychological flexibility is a core component of ACT and was evaluated in five of the studies (Gentili et al., 2020; Ljótsson et al., 2015; Rickardsson et al., 2020; 2021; Trompetter et al., 2015a). For all of these studies increases in psychological flexibility were found to be significant with moderate to strong effect sizes,  $d = 0.60$ - $d = 1.56$ . Additionally, Trompetter et al. (2015b) demonstrated that increases in psychological flexibility potentially mediated changes in pain interference and psychological distress. Findings from these studies highlighted the possible importance of psychological flexibility in pain management, while the Trompetter et al. (2015b) results provide preliminary evidence to indicate that psychological flexibility may be a possible mechanism of change in online ACT.

Measures of values and committed action were administered in a small selection of the studies reviewed here; using the Valuing Questionnaire (VQ, Smout et al., 2014) which explores two subscales: Progress and Obstruction. For the three studies that used this measure, significant improvement was seen with moderate to strong effect sizes ( $d = 0.69$ - $d$

= 1.02) across both subscales (Gentili et al., 2013; Rickardsson et al., 2020; 2021).

Committed action was assessed in two studies, Scott et al. (2018) and Yang et al. (2017).

For Scott et al. (2018) significant improvement in committed action was seen, though the effect size was small,  $d = 0.26$ . However, for Yang et al. (2017) there was no significant improvement, and the effect size was minimal,  $p = 0.73$ ,  $d = 0.06$ .

### **Relationship to Pain**

As recommended by IMMPACT (Dworkin et al., 2008), the majority of the studies focussed on outcomes which explored the participant's relationship to their pain, such as pain interference, pain intensity, and pain disability. Pain interference was the primary outcome for six of the studies (Gentili et al., 2021; Lin et al., 2017; Rickardsson et al., 2020; 2021; Trompetter et al., 2015a; Yang et al., 2017) and for most highlighted significant post-intervention reductions which were maintained at follow-up. Gentili et al. (2021) demonstrated a significant reduction in pain interference with a large effect size,  $p = 0.000$ ,  $d = -1.01$ , as did Rickardsson et al. (2021),  $p = <0.001$ ,  $d = 0.99$ . However, although Lin et al. (2017) reported a significant decrease for the guided ACT group intervention compared to the control group, ( $p = 0.001$ ), significant decreases were not seen when the guided and unguided ACT groups were compared, or when the unguided ACT group was compared to the control group. This suggests that therapist presence (as in the guided ACT group) may augment intervention efficacy.

Conversely, Scriven et al. (2019) and Yang et al. (2017) found that their interventions did not result in significant decreases in pain interference,  $p = 0.17$ ,  $d = 0.20$  and  $p = 0.24$ ,  $d = 0.22$  respectively. Scriven et al. (2019) reported that this lack of significant findings did not reflect individual participant experiences, with almost a fifth of participants reporting meaningful change in their ability to function and engage in life. However, this perceived meaningful change was only reported by one fifth of participants with the remaining participants not describing a meaningful change in function and engagement with life. This

suggests that the lack of significant decrease in pain interference did reflect the majority of participants' experience.

Pain intensity was a favoured outcome across the studies included. However, significant reduction in pain intensity was only found in three studies with moderate to large effect size; Gentili et al. (2021)  $p = 0.000$ ,  $d = -0.44$ , Rickardsson et al. (2020)  $p = 0.001$ ,  $d = 0.73$  and Rickardsson et al. (2021),  $p = 0.004$ ,  $d = 1.0$ . Interestingly Gentili et al. (2021), were the only study to use therapists who were experienced in both chronic pain and ACT and were not students or recently qualified. This may have been one of the factors which impacted the large effects demonstrated.

Finally, pain disability was explored by Trompetter et al. (2015a) and Ljótsson, et al. (2014). Trompetter et al. (2015a) demonstrated a significant decrease in pain disability between the ACT and expressive writing groups,  $p = -0.05$ ,  $d = .40$ . However, there was no significant decrease in pain disability in comparison to the waiting list,  $p = .202$ . Ljótsson, et al. (2014) mirrored this lack of significant decrease within their sample. In both studies pain disability was explored using the Pain Disability Index (PDI, Tait et al., 1987), an older measure, the PDI has been criticised for conflicting evidence regarding test-retest reliability and factor structure (Soer et al., 2013).

### **Mental and Physical Health**

Mental health outcomes were typically assessed through use of depression and anxiety measures. Depression and anxiety symptoms were measured using the Hospital and Anxiety Depression Scale (HADS, Snaith, 2003 see also Buhrman et al., 2013; Ljótsson et al., 2014; Rickardsson et al., 2020; 2021; Trompetter et al., 2015a), the Public Health Questionnaire-9 (PHQ-9, Kroenke et al., 2001 see also Gentili et al., 2021; Lin et al., 2017; Scott et al., 2018; Yang et al., 2017), Generalized Anxiety Disorder- 7 scale (GAD-7, Williams, 2014 see also Gentili, et al., 2021; Lin et al., 2017) and the Depression Anxiety and Stress Scale- short form (DASS-21, Lovibond & Lovibond, 1995; Scriven et al., 2019). Significant effects in terms of post-intervention reduction in depression symptoms with



moderate to large effect sizes were found in five of the studies (Gentili et al., 2021; Ljótsson et al., 2014; Rickardsson et al., 2020; 2021; Yang et al., 2017). However, Ljótsson et al. (2014) excluded participants with significant experiences of depression or suicidal ideation, which raises questions about the ecological validity and clinical relevance of their findings. Additionally, though Buhrman et al. (2013) reported a significant decrease in depression symptoms, the effect size was small, and the change was not sustained when re-evaluated at the follow-up time point. Conversely, Scriven et al. (2019) and Trompetter et al. (2015a) demonstrated no significant decrease in depression symptoms, with small effect sizes evident.

In regard to anxiety symptoms, five of the studies demonstrated significant reductions, however effect sizes were varied from very small to large,  $d = 0.19-0.90$  (Buhrman et al., 2013; Gentili et al., 2021; Ljótsson et al., 2014; Rickardsson et al., 2020; 2021), while three of the studies found no significant decrease in anxiety (Lin et al., 2017; Scriven et al., 2019; Trompetter et al., 2015a). Additionally, Scriven et al. (2019) used the DASS-21 (Lovibond & Lovibond, 1995), it has been suggested that in the DASS-21, the subscale of anxiety is not appropriate to use at an individual level due to its low internal reliability (Parkitny et al., 2012).

Discrepancies across studies in findings for anxiety and depression could be impacted by differences in participant characteristics. Clinical samples may be more likely to report higher baseline depression or anxiety score than participants recruited from the community. Therefore, change may be less likely or alternatively, effect sizes may be greater depending on the impact of the intervention. For example, Trompetter et al. (2016) reported that higher baseline levels were indicators of higher pain interference at six months post-intervention compared to the expressive writing comparator group. This suggests that individuals with higher baseline depression and anxiety scores are more likely to experience smaller reductions in pain interference, which may possibly also influence other health and social gains. In addition, Scriven et al. (2019) who found no significant reduction in either

anxiety or depression, evaluated a short four-week intervention. ACT can be used flexibly, and brief ACT interventions have been shown to be effective (Dindo et al., 2017). However, Scriven et al. (2019) do not describe using a specific, brief ACT approach and therefore the length of intervention may have influenced outcome.

Additional physical health outcomes included measures focussing on fatigue or insomnia. Three studies used the Insomnia Severity Index (ISI, Bastien et al., 2001) to measure various aspects of sleep and sleep problems (Gentili et al., 2021; Rickardsson et al., 2020; 2021). Two studies found significant reductions in insomnia with moderate effect sizes,  $p = 0.004$ ,  $d = 0.47$ ;  $p = <0.001$ ,  $d = -0.42$  (Gentili et al., 2021; Rickardsson et al., 2020). However, Rickardsson et al. (2021) did not find a significant reduction  $p = 0.025$ ,  $d = 0.40$ . Although they reported that positive between-group effects for insomnia were found, these were not significant. Alternatively, Ljótsson et al. (2014) used the Fatigue Severity Scale (FSS, Krupp et al., 1989) to explore the impact of fatigue on participant's lives, finding a significant reduction in fatigue with strong effect sizes.

### **Quality of Life and Daily Functioning**

Three different outcome measures were used across studies to measure quality of life. The Short Form-12 (SF-12, Ware et al., 1996) assesses health related quality of life through two constructs: the mental component summary and physical component summary. This measure has been found to be both valid and reliable for individuals living with chronic pain (Hayes et al., 2017). Three studies utilised this measure, two finding significant post-intervention improvements across both of the component summaries (Ljótsson et al., 2014; Rickardsson et al., 2020) with Lin et al. (2017) finding no significant improvement. The Quality of Life Inventory (QoLI, Frisch et al., 1992) and European Quality of Life (EQ-5D-3L, The EuroQol Group, 1990) were the alternative measures evident in the remaining studies (Buhrman et al., 2013; Gentili et al., 2021; Rickardsson et al., 2021; Scriven et al., 2019), all of these measures demonstrated significant improvement in quality of life except Buhrman et al. (2013), who found no significant difference.

Scott et al. (2018) used the Work and Social Adjustment Scale (WSAS, Mundt et al., 2002) to measure the impact of chronic pain in daily functioning. Significant improvements in functioning were reported with moderate effect sizes,  $d = 0.45$ . However, a breakdown of the WSAS was not explored and thus inferences regarding functioning across different factors cannot be drawn.

Finally, Yang et al. (2017) considered global life satisfaction with the Satisfaction with Life Scale (SWLS, Diener et al., 1985) and found there were no significant improvements from baseline to follow-up. Though the SWLS has some normative data across cultures (Pavot & Diener, 2009) it is unclear whether this includes Singapore where the Yang et al. (2017) study was conducted.

### **Self-Efficacy**

Self-efficacy or an individual's belief in their ability to perform a task (Heslin & Klehe, 2006) was examined in four studies. Two of these studies used a patient global impression of change scale to assess how participants rated their perception of change during the treatment (Lin et al., 2017; Scott et al., 2018). Both of these studies found a significant post-intervention improvement. In the Scott et al. (2018) study, 56.5% of participants reported perceptions of *improved* to *very improved* in comparison to only 20.0% of the control group. However, this reduced to 27.3% at nine months post-intervention, raising questions about maintenance of gains.

Additionally, Scriven et al. (2019) employed the Pain Self Efficacy Questionnaire (PSEQ, Nicholas, 2007), however they noted no significant improvement which may have been potentially mediated by the lack of a significant reduction in pain interference and distress levels.

### **Critique of Included Studies**

Ten of the included studies were quantitative in design with two employing a mixed methods design. Five of the studies were randomised controlled trials (RCTs, Buhrman et

al., 2013; Lin et al., 2017; Rickardsson et al., 2021; Scriven et al., 2019; Trompetter et al., 2015a), though they are often considered the gold standard of research, there were a number of weaknesses in the studies included in this review. Firstly, attrition rates were high at 20-25% for most of the studies and as high as 60% for Buhrman et al. (2013). However, Gentili et al. (2021) reported only a small attrition percentage of 6%. This may be related to the method of delivery as Gentili et al. (2021) were the only study to deliver the intervention via smartphone, it has been suggested that attrition rates may be lower in acceptance-based interventions delivered by smartphone in part because of accessibility (Linardon & Fuller-Tyzkiewicz, 2020). However, the quality of engagement in smartphone-based interventions has not been explored. Furthermore, measures of adherence differed between studies with some reporting adherence when all online modules had been completed and others when only a percentage of modules had been completed, generating inconsistency between adherence rates.

In addition, several of the studies were pilot or feasibility studies, which did not include a control group (Gentili et al., 2021; Ljótsson et al., 2014; Rickardsson et al., 2020), even though pilot studies should be small scale replicas of the intended RCT (O’Cathain, et al., 2015). Furthermore, in order to maximise the impact of a pilot study, researchers should consider the collection of qualitative data to thoroughly explore the impact of the intervention and any necessary adjustments to consider when preparing for a larger trial (O’Cathain et al., 2015). Of the studies reviewed here, only Rickardsson et al. (2020) included qualitative interviewing as part of their study design.

The combination of pilot studies and RCTs meant that sample sizes varied greatly from 21 (Scriven et al., 2019) to 303 (Lin et al., 2017). Whilst the sample sizes were appropriate to the design and methodology and pilot studies are expected to include smaller samples, the weighting given to findings from studies with smaller sample sizes should be considered.

Diversity across samples was limited, with the majority of participants being female with an average age of 48.58 years. Additionally, only two studies reported participant ethnicity (Scott et al., 2018; Yang et al., 2017), indicating that the health, social, and intervention-specific outcomes for participants from minority ethnic backgrounds were not adequately explored. In the UK and USA individuals from Black, Asian, or mixed ethnic backgrounds may be more likely to report chronic pain (Mills et al., 2019) therefore including people from diverse backgrounds is essential when evaluating online interventions for chronic pain.

Furthermore, several studies excluded participants with significant mental health difficulties comorbid to their chronic pain, evidence of suicidal thoughts or previous suicide attempts (Gentili et al., 2021; Ljótsson et al., 2014; Lin et al., 2017; Rickardsson et al., 2020; 2021). It is well documented that mental health difficulties and chronic pain are highly correlated, with roughly 60% of people living with chronic pain meeting the criteria for depression and 33% meeting the criteria for severe depression (Rayner et al., 2016). Excluding people with significant mental health difficulties may have meant that a large proportion of people living with chronic pain were not considered, raising questions about the ecological validity of those studies. Additionally, it has been suggested that chronic pain and a history of trauma are highly correlated (Nicol et al., 2016), excluding individuals who may have this experience is a further limitation that may limit generalisability of findings to real-world clinical contexts.

Finally, a significant critique of the studies in this review is the dominance of a select group of authors, papers Buhrman et al. (2013), Gentili et al. (2021), Lin et al. (2017), Ljótsson et al. (2014), Rickardsson et al. (2020; 2021), Scott et al. (2019) and Yang et al. (2017) share various authors. This researcher dominance increases the likelihood of bias within this body of evidence.

## Discussion

Synthesising the data from twelve included studies, this review describes outcomes grouped as: *Intervention-Specific*, *Mental and Physical Health*, *Relationship to Pain*, *Quality of Life and Daily Functioning*, and *Self-Efficacy*. These groupings are similar to those demonstrated in a review exploring face-to-face ACT for chronic pain (Hann & McCracken, 2014) and are equally in-line with those recommended by IMMPACT (Dworkin et al., 2008). However, unlike the Hann & McCracken (2014) review, five of the studies reviewed here included a patient global impression of change scale or alternative methods of assessing participant's satisfaction with the intervention as recommended by IMMPACT.

Findings from this review illustrate the wide range of different outcomes measures used across studies. The positive impact of the online ACT interventions on depression, anxiety, and quality of life in the majority of studies reviewed here, points to a breadth of benefits of ACT for people who experience chronic pain. However, the non-significant findings in relation to certain outcomes are also noteworthy and may point to some limitations in terms of the benefits of online ACT interventions. For example, Buhrman et al. (2013) and Lin et al. (2017) in this review found no post-intervention improvement in quality of life, a finding that is echoed in previous research exploring the efficacy of face-to-face ACT (Wetherell et al., 2011).

In addition, the inclusion of the Work and Social Adjustment Scale (Mundt et al., 2002) in Scott et al. (2018) provided the only evidence of an outcome focussed specifically on social factors. Though other research papers collected participant demographics regarding work status or sick leave they did not comment on any change in these social factors within their results.

Findings from this review highlight the biological, psychological, and social nature of chronic primary pain, with significant post-intervention changes evidenced across a range of different outcomes encompassing all three of these domains. Additionally, the importance of psychological flexibility as a core component of ACT interventions for chronic primary pain, is

suggested by findings from several of the reviewed studies. As well as preliminary indications that psychological flexibility may be a possible mediating factor regarding psychological wellbeing and pain interference is important to note.

Furthermore, though online ACT intervention may imply less therapist involvement it was evident that outcomes were improved when this was present. Lin et al. (2017) found greater improvement in health and social outcomes in the guided iACT intervention in comparison to the unguided intervention. However, Rickardsson et al. (2020) noted that although therapist involvement was helpful, the psychologists spent less than 15 minutes a week with their participants. This suggests that even a small amount of therapist involvement may augment positive outcomes for participants without significantly reducing the cost-effectiveness of these online interventions (Rickardsson et al., 2020).

## **Limitations**

Although this review sought to explore chronic primary pain, it was evident that most of the studies contained a combination of participants with chronic primary pain and chronic secondary pain. This could impact the validity of the review with regard to chronic primary pain. However, as the term chronic primary pain has newly been introduced within diagnostic systems, it may be that future studies can distinguish between the two terms more clearly. Furthermore, the review did exclude studies that obviously explored conditions under the chronic secondary pain category such as Rheumatoid Arthritis.

Additionally, all of the studies included within this review were considered to have a majority of participants with chronic primary pain. However, the method of establishing whether participants could meet chronic primary pain criteria had limitations. Assumptions that high levels of chronic primary pain may exist within Nociceptive and Neuropathic pain populations are supported by the literature but may not have accurately reflected participants' experiences.

Another limitation of the current review is the lack of homogeneity across the studies. The range of different outcome measures used as well as the different interventions between studies made drawing comparisons between studies more problematic.

Finally, although the use of narrative synthesis allowed for the nuanced exploration of health and social outcomes, it has been criticised for lacking methodological transparency and therefore having a potential for bias (Campbell et al., 2020). The inclusion of the groupings table provided additional transparency regarding the outcome groupings; however, the findings were still subject to interpretation.

### **Clinical Implications**

The findings of this review have several clinical implications for practice. Many of the studies in this review have focussed on values or acceptance when evaluating their interventions (Buhrman et al., 2013; Lin et al., 2017; McCracken et al., 2013). However, an increased focus on psychological flexibility may have benefits for secondary outcomes such as mental health and quality of life. This is supported by findings from the present review showing significant, post-intervention improvements in psychological flexibility with large effect sizes across five studies. This is further indicated by findings from Trompetter et al. (2015b) that increased psychological flexibility can potentially mediate reductions in both pain interference and distress. Introducing elements such as defusion exercises and present moment skills into future online ACT interventions may further promote the development of psychological flexibility (Wetherell et al., 2011).

In addition, although online interventions may ideally reduce clinician involvement and associated cost, the findings of this review indicated that some degree of therapist involvement should be incorporated into online ACT interventions where possible. Within online ACT interventions a combination of face-to-face and online therapist contact may support increased completion of treatment. Individuals should also continue to receive regular contact with a therapist to support their learning and development or check progress. Ideally, an interdisciplinary approach should be used alongside online interventions to



support and maintain improvements in psychological wellbeing, pain interference, and daily functioning (Wetherell et al., 2011).

Finally, consideration should be made regarding the use of online ACT with individuals with significant mental health experiences or suicidal ideation. Many of the studies in this review did not include participants with significant psychiatric diagnoses or a history of suicidal ideation (Gentili et al., 2021; Lin et al., 2017; Ljótsson et al., 2014; Rickardsson et al., 2020; 2021). Therefore, we cannot assume that an online ACT intervention will be appropriate for people experiencing both chronic primary pain and significant mental health issues.

### **Future Research Recommendations**

Future research should further explore individual experiences of completing an online ACT intervention and their perceived impact on health and social outcomes. Understanding individual experiences will result in a richer understanding of interventions and their wider impact. Qualitative methods such as interviews or focus groups might facilitate this richer understanding (Alshenqeeti, 2014).

Additionally, future research should seek to include participants across socioeconomic groups, gender, and ethnicity. Current research does not consider the potential influence of demographic characteristics, such as ethnicity and socio-economic status on chronic pain. In the current review, only two papers collected information regarding ethnicity (Scott et al., 2018; Yang et al., 2017) despite individuals from minority ethnic backgrounds reporting higher levels of chronic pain (Mills et al., 2019).

Individuals from socio-economically deprived backgrounds and with low levels of education are also more likely to report chronic pain, and experience more severe pain and greater levels of pain-related disability (Mills et al., 2019). The majority of the participants in the studies included in this review were highly educated (Buhrman et al., 2013; Lin et al., 2017; Scott et al., 2018). Future research should consider engaging participants across

socioeconomic groups. This may also contribute to further understanding the variety of health and social outcomes that may be impacted by online ACT interventions.

In the present review, Scott et al. (2018) were the only study to include a social outcome, the Work and Social Adjustment Scale. Additional outcome measures exploring the social impact of online ACT intervention should be explored. Outcomes considering the impact of work, social relationships, and engagement in the community may provide a broader understanding of the impact of online ACT across a person's life.

Additionally, future research should consider the involvement of individuals experiencing significant mental health difficulties or a history of trauma, as these show high comorbidity rates within the chronic pain population (Nicol et al., 2016; Rayner et al., 2016). In order to fully understand the health and social outcomes of online ACT, a representative sample of participants should be drawn upon including those with significant mental health difficulties.

Finally, future studies should define the parameters of chronic primary pain and modify inclusion criteria for participant characteristics to reflect this. Most of the studies in the current review included a combination of both chronic primary and chronic secondary pain. Future research should focus specifically on chronic primary pain rather than a mixture of diagnoses in order to more clearly understand the impact of online ACT interventions on health and social outcomes.

## **Conclusion**

Acceptance and Commitment Therapy has been recommended as an appropriate intervention for chronic primary pain. Online ACT interventions provide an accessible and cost-effective alternative to face-to-face interventions for this debilitating condition. The findings from this review indicate that online ACT interventions for individuals with chronic pain may improve health and social outcomes such as depression, anxiety, and quality of life. Additionally, increased psychological flexibility was found to improve both psychological

wellbeing and pain interference and should form a specific focus of ACT interventions and research moving forward, as a potential mechanism of change.

## References

- Alshenqeeti, H. (2014). Interviewing as a Data Collection Method: A Critical Review. *English Linguistics Research*, 3(1). <https://doi.org/10.5430/elr.v3n1p39>
- Attkisson., C. C. & Zwick, R. (1982). The Client Satisfaction Questionnaire: Psychometric Properties and Correlations with Service Utilization and Psychotherapy Outcome. *Evaluation and Program Planning*, 5(3), 233-237. [https://doi.org/10.1016/0149-7189\(82\)90074-X](https://doi.org/10.1016/0149-7189(82)90074-X)
- Amichai-Hamburger, Y., Klomek, A. B., Friedman, D., Zuckerman, O., Shani-Sherman, T. (2014). The Future of Online Therapy. *Computers in Human Behavior*, 41, 288-294. <http://dx.doi.org/10.1016/j.chb.2014.09.016>
- Bailey, R. W., Vowles, K. E., Witkiewitz, K., Sowden, G., & Ashworth, J. (2016). Examining Committed Action in Chronic Pain: Further Validation and Clinical Utility of the Committed Action Questionnaire. *The Journal of Pain*, 17(10), 1095-1104. <https://doi.org/10.1016/j.jpain.2016.06.011>
- Bastien, C. H., Vallières, A., & Morin, C. M. (2001). Validation of Insomnia Severity Index as an Outcome Measure for Insomnia Research. *Sleep Medicine*, 2(4), 297-307. [https://doi.org/10.1016/S1389-9457\(00\)00065-4](https://doi.org/10.1016/S1389-9457(00)00065-4)
- Bender, J.L., Radhakrishnan, A., Diorio, C., Englesakis, M., & Jadad, A. R. (2011). Can Pain be Managed through the Internet? A Systematic Review of Randomized Controlled Trials. *Pain*, 152, 1740-1750. <https://doi.org/10.1016/j.pain.2011.02.012>
- Bohlmeijer, E., ten Klooster, P. M., Fledderus, M., Veehof, M., & Baer, R. (2011). Five Facet Mindfulness Questionnaire- Short Form.
- Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., Zettle, R. D. (2011). Preliminary Psychometric Properties of the Acceptance and

Action Questionnaire-II: A Revised Measure of Psychological Inflexibility and Experiential Avoidance. *Behavior Therapy*, 42(4), 676-688.

<https://doi.org/10.1016/j.beth.2011.03.007>

Bouwman, C., De Jong, K., Timman, R., Zijlstra-Vlasveld, M., Van der Feltz-Cornelis, C., Tan, S., & Hakkaart van Roijen. (2013). Feasibility, Reliability and Validity of a Questionnaire on Healthcare Consumption and Productivity Loss in Patients with a Psychiatric Disorder (TiC-P). *BMC Health Services Research*, 13, 217.

<https://doi.org/10.1186/1472-6963-13-217>

Breivik, H., Collett, B., Ventafridda, V., Cohen, R., & Gallacher, D. (2006). Survey of Chronic Pain in Europe: Prevalence, Impact on Daily Life and Treatment. *European Journal of Pain* 10, 287-333. <https://doi.org/10.1016/j.ejpain.2005.06.009>

\*Buhrman, M., Skoglund, A., Husell, J., Bergström, K., Gordh, T., Hursti, T., Bendelin, N., Furmark, T., & Andersson, G. (2013). Guided Internet-delivered Acceptance and Commitment Therapy for Chronic Pain Patients: A Randomized Controlled Trial. *Behaviour Research and Therapy*, 51, 307-315.

<http://dx.doi.org/10.1016/j.brat.2013.02.010>

Burckhardt, C. S., Clark, S. R., & Bennett, R. M. (1991). The Fibromyalgia Impact Questionnaire: Development and Validation. *Journal of Rheumatology*, 18(5), 728-733.

Buyse, D. J., Reynolds, C. F., Monk, T. H., Berman, S. R., & Kupfer, D. J. (1989). The Pittsburgh Sleep Quality Index: A New Instrument for Psychiatric Practice and Research. *Psychiatry Research*, 28(2), 193-213. [https://doi.org/10.1016/0165-1781\(89\)90047-4](https://doi.org/10.1016/0165-1781(89)90047-4)

Caldwell, K., Henshaw, L., & Taylor, G. (2011). Developing a framework for critiquing

health research: An early evaluation. *Nurse Education Today*, 31(8), 1-7.

<https://doi.org/10.1016/j.nedt.2010.11.025>

Campbell, M., McKenzie, J. E., Sowden, A., Katikireddi, S. V., Brennan, S. E., Ellis, S., Hartmann-Boyce, J., Ryan, R., Shepperd, S., Thomas, J., Welch, V., & Thomson, H. (2020). Synthesis without Meta-analysis (SWiM) in Systematic Reviews: Reporting Guideline. *BMJ*. <https://doi.org/10.1136/bmj.l6890>

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, 49(1), 71-75.

[https://doi.org/10.1207/s15327752jpa4901\\_13](https://doi.org/10.1207/s15327752jpa4901_13)

Dindo, L., Van Liew, J. R., & Arch, J. J. (2017). Acceptance and Commitment Therapy: A Transdiagnostic Behavioural Intervention for Mental Health and Medical Conditions. *Neurotherapeutics*, 14, 546-553.

<https://link.springer.com/content/pdf/10.1007/s13311-017-0521-3.pdf>

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., Bonas, S., Booth, A., & Jones, D. (2007). Appraising Qualitative Research for Inclusion in Systematic Reviews: A Quantitative and Qualitative Comparison of Three Methods. *Journal of Health Services Research & Policy*, 12(1), 42-47.

<https://doi.org/10.1258/135581907779497486>

Dixon-Woods, M., Agarwal, S., Jones, D. R., Young, B., Sutton, A. J., & Noyes, J. (2008). Synthesising Qualitative and Quantitative Evidence within a Systematic Review. In R. Watson, H. McKenna, S. Cowman, & J. Keady (Ed.), *Nursing Research Designs and Methods* (89-100). Churchill Livingstone.

Dworkin, R. H., Turk, D. C., Wyrwich, K. W., Beaton, D., Cleeland, C. S., Farrar, J. T., Haythornthwaite, J. A., Jensen, M. P., Kerns, R. D., Ader, D. N., Brandenburg, N., Burke, L. B., Cella, D., Chandler, J., Cowan, P., Dimitrova, R., Dionne, R., Hertz, S.,

- Jadad, A. R.... Zavisic, S. (2008). Interpreting the Clinical Importance of Treatment Outcomes in Chronic Pain Clinical Trials: IMMPACT Recommendations. *The Journal of Pain*, 9(2), 105-121. <https://doi.org/10.1016/j.jpain.2007.09.005>
- Eccleston, C., Williams, A., & Morley, S. (2009). Psychological Therapies for the Management of Chronic Pain (excluding headache) in Adults. *Cochrane Database for Systematic reviews*, 2. <https://doi.org/10.1002/14651858.CD007407.pub2>
- EuroQol. (1990). EuroQol – A New Facility for the Measurement of Health-Related Quality of Life. *Health Policy*, 16(3), 199-208. [https://doi.org/10.1016/0168-8510\(90\)90421-9](https://doi.org/10.1016/0168-8510(90)90421-9)
- Feliu-Soler, A., Montesinos, F., Gutierrez-Martinez, O., Scott, W., McCracken, L. M., & Luciano, J. V. (2018). Current Status of Acceptance and Commitment Therapy for Chronic Pain: A Narrative Review. *Journal of Pain Research*, 11, 2145-2159. <https://doi.org/10.2147/JPR.S144631>
- Ferguson, L., & Scheman, J. (2009). Patient Global Impression of Change Scores within the Context of a Chronic Pain Rehabilitation Program. *Journal of Pain*, 10(4), S73. <https://doi.org/10.1016/j.jpain.2009.01.258>
- Fine, P. G. (2011). Long-term Consequences of Chronic Pain: Mounting Evidence for Pain as a Neurological Disease and Parallels with Other Chronic Disease States. *Pain Medicine*, 12(7), 996-1004. <https://doi.org/10.1111/j.1526-4637.2011.01187.x>
- Frisch, M. B., Cornell, J., Villanueva, M., & Retzlaff, P. J. (1992). Clinical Validation of the Quality of Life Inventory. A Measure of Life Satisfaction for Use in Treatment Planning and Outcome Assessment. *Psychological Assessment*, 4(1), 92–101. <https://doi.org/10.1037/1040-3590.4.1.92>
- \*Gentili, C., Zetterqvist, V., Rickardsson, J., Holmström, L., Simons, L. E., Wicksell, R. K. (2021). ACTsmart: Guided Smartphone-Delivered Acceptance and Commitment

Therapy for Chronic Pain – A Pilot Trial. *Pain Medicine* 22(2), 315-328.

<https://doi.org/10.1093/pm/pnaa360>

Hadi, M. A., McHugh, G. A., & Closs, S. J. (2019). Impact of Chronic Pain on Patients' Quality of Life: A Comparative Mixed-Methods Study. *Journal of Patient Experience*, 6(2), 133-141. <https://doi.org/10.1177/2374373518786013>

Haliloglu, S., Carlioglu, A., Akdeniz, D., Karaaslan, Y., & Kosar, A. (2014). Fibromyalgia in Patients with Other Rheumatic Diseases: Prevalence and Relationship with Disease Activity. *Rheumatology International*, 34(9), 1275-1280.

<https://doi.org/10.1007/s00296-014-2972-8>

Hann, K. E. J., & McCracken, L. M. (2014). A Systematic Review of Randomized Controlled Trials of Acceptance and Commitment Therapy for Adults with Chronic Pain: Outcome Domains, Design Quality and Efficacy. *Journal of Contextual Behavioural Science*, 3, 217-227. <http://dx.doi.org/10.1016/j.jcbs.2014.10.001>

Hays, R. D., Bjorner, J. B., Revicki, D. A., Spritzer, K. L., & Cella, D. (2009). Development of Physical and Mental Health Summary Scores from Patient-reported Outcomes Measurement Information System (PROMIS) Global Items. *Quality of Life Research*, 18, 873-880. <https://doi.org/10.1007/s11136-009-9496-9>

Hayes, C. J., Bhandari N. R., Kathe, N. & Payakachat, N. (2017). Reliability and Validity of the Medical Outcomes Short Form-12 Version 2 in Adults with Non-Cancer Pain. *Healthcare* 5(22). <https://doi.org/10.3390/healthcare5020022>

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and Commitment Therapy: Model, Processes and Outcomes. *Behaviour Research and therapy*, 44, 1-25. <https://doi.org/10.1016/j.brat.2005.06.006>



- Heslin, P. A., & Klehe, U. C. (2006). "Self-efficacy." In *Encyclopaedia of Industrial/Organizational Psychology*, Edited by S. G. Rogelberg, 705-708. Sage.
- Higgins, J. P. T., López-López, J. A., Becker, B. J., Davies, S. R., Dawson, S., Grimshaw, J. M., McGuinness, L. A., Moore, T. H. M., Rehfuss, E. A., Thomas, J., & Caldwell, D. M. (2019). Synthesising Quantitative Evidence in Systematic Reviews of Complex Health Interventions. *BMJ Global Health*, 4(Suppl 1). <https://doi.org/10.1136/bmjgh-2018-000858>
- Hobbs, K. (2015). Which Factors Influence the Development of Post-traumatic Stress Disorder in Patients with Burn Injuries? A Systematic Review of the Literature. *Burns*, 41(3), 421-430. <https://doi.org/10.1016/j.burns.2014.10.018>
- Kelson, J., Rollin, A., Ridout, B., & Campbell, A. (2019). Internet-Delivered Acceptance and Commitment Therapy for Anxiety Treatment: Systematic Review. *Journal of Medical Internet Research*, 21(1). <https://doi.org/10.2196/12530>
- Kerns, R. D., Turk, D. C., & Rudy, T. E. (1985). The West Haven-Yale Multidimensional Pain Inventory (WHYMPI). *Pain*, 23(4), 345-356. [https://doi.org/10.1016/0304-3959\(85\)90004-1](https://doi.org/10.1016/0304-3959(85)90004-1)
- Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9. Validity of a Brief Depression Severity Measure. *Journal of General Medicine*, 16(9), 606-613. <https://doi.org/10.1046/j.1525-1497.2001.016009606.x>
- Krupp, L. B., LaRocca, N. G., Muir-Nash, J., & Steinberg, A. D. (1989). The Fatigue Severity Scale. Application to Patients with Multiple Sclerosis and Systemic Lupus Erythematosus. *Archives of Neurology*, 46(10), 1121-1123. <https://doi.org/10.1001/archneur.1989.00520460115022>

- Lamers, S. M. Westerhof, G. J., Bohlmeijer, E. T., ten Klooster, P. M., & Keyes, C. L. (2011). Evaluating the Psychometric Properties of the Mental Health Continuum-Short Form (MHC-SF). *Journal of Clinical Psychology*, 67(1), 99-110.  
<https://doi.org/10.1002/jclp.20741>
- Lappalainen, P., Granlund, A., Siltanen, S., Ahonen, S., Vitikainen, M., Tolvanen, A., & Lappalainen, R. (2014). ACT Internet-based vs Face-to-Face? A Randomized Controlled Trial of Two Ways to Deliver Acceptance and Commitment Therapy for Depressive Symptoms: An 18- month Follow-up. *Behaviour Research and Therapy*, 61, 43-54. <https://doi.org/10.1016/j.brat.2014.07.006>
- \*Lin, J., Paganini, S., Sander, L., Lüking, M., Ebert, D. D., Buhrman, M., Andersson, G., & Baumeister, H. (2017). An Internet-Based Intervention for Chronic Pain: A Three-Arm Randomized Controlled Study of the Effectiveness of Guided and Unguided Acceptance and Commitment Therapy. *Deutsches Ärzteblatt International*, 141(41), 681-688. <https://doi.org/10.3238/arztebl.2017.0681>
- Linardon, J., & Fuller-Tyzkiewicz, M. (2020). Attrition and Adherence in Smartphone-delivered Interventions for Mental Health Problems: A Systematic and Meta-analytic Review. *Journal of Consulting and Clinical Psychology*, 88(1), 1-13.  
<https://doi.org/10.1037/ccp0000459>
- \*Ljótsson, B., Atterlöv, E., Lagerlöf, M., Andersson, E., Jernelöv, S., Hedman, E., Kemani, M. & Wicksell, R. K. (2014). Internet-Delivered Acceptance and Values-Based Exposure Treatment for Fibromyalgia: A Pilot Study. *Cognitive Behaviour Therapy*, 43(2), 93-104. <https://doi.org/10.1080/16506073.2013.846401>
- Lovibond, S. H., & Lovibond, P. F. (1995). Manual for the Depression Anxiety Stress Scales (2nd ed.). Psychology Foundation.

- Mariano, T. Y., Wan, L., Edwards, R. R., & Jamison, R. N. (2019). Online Teletherapy for Chronic Pain: A Systematic Review. *Journal of Telemedicine and Telecare* 0(0), 1-14. <https://doi.org/10.1177/1357633X19871746>
- Martin, S., Nelson Schmitt, S., Wolters, P. L., Abel, B., Toledo-Tamula, M. A., Baldwin, A., Wicksell, R. K., Merchant, M., & Widemann, B. (2015). Pain Interference Index and Pain Interference Index-Parent Report. *Pain Medicine*, 16(2), 367-373. <https://doi.org/10.1111/pme.12620>
- McCracken, L. M. (2013). Committed Action: An Application of the Psychological Flexibility Model to Activity Patterns in Chronic Pain. *Journal of Pain*, 14(8), 828-835. <https://doi.org/10.1016/j.jpain.2013.02.009>
- McCracken, L. M. & Gutierrez-Martinez, O. (2001). Process of Change in Psychological Flexibility in an Interdisciplinary Group-based Treatment for Chronic Pain Based on Acceptance and Commitment Therapy. *Behaviour Research and Therapy*, 49(4), 267-274. <https://doi.org/10.1016/j.brat.2011.02.004>
- McCracken, L. M., Sato, A., & Taylor, G. J. (2013). A Trial of a Brief Group-Based Form of Acceptance and Commitment Therapy (ACT) for Chronic Pain in General Practice: Pilot Outcome and Process Results. *The Journal of Pain*, 14(11), 1398-1406. <http://dx.doi.org/10.1016/j.jpain.2013.06.011>
- McCracken, L. M., Zayfert, C., Gross, R. T. (1992). The Pain Anxiety Symptoms Scale: Development and Validation of a Scale of Measure Fear of Pain. *Pain*, 50(1), 67-73. [https://doi.org/10.1016/0304-3959\(92\)90113-P](https://doi.org/10.1016/0304-3959(92)90113-P)
- McHugh, M. L. (2012). Interrater Reliability: The Kappa Statistic. *Biochemia medica*, 22(3), 276-282. <https://hrcak.srce.hr/89395>

- Mills, S. E., Nicolson, K. P. & Smith, B. H. (2019). Chronic Pain: A Review of its Epidemiology and Associated Factors in Population-based Studies. *British Journal of Anaesthesia*, 123(2), 273-283. <https://doi.org/10.1016/j.bja.2019.03.023>
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Prisma Group. (2009). Preferred Reporting Items for Systematic Reviews and Meta-analyses: The PRISMA Statement. *PLoS Medicine*, 6 (7), e1000097. <https://doi.org/10.1371/journal.pmed.1000097>
- Mundt, J. C., Marks, I. M., Shear, M. K., & Greist, J. M. (2002). The Work and Social Adjustment Scale: A Simple Measure of Impairment in Functioning. *The British Journal of Psychiatry*, 180(5), 461-464. <https://doi.org/10.1192/bjp.180.5.461>
- National Health Service England. (2020). IAPT Guide for Delivering Treatment Remotely During the Coronavirus Pandemic. <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Final-C0042-MHLDA-Covid-19-Guidance-IAPT-.pdf>
- National Institute for Health and Care Excellence. (2021). Chronic Pain in Over 16s: Assessment of All Chronic Pain and Management of Chronic Primary Pain, NICE guideline [NG193]. <https://www.nice.org.uk/guidance/ng193/resources/chronic-pain-primary-and-secondary-in-over-16s-assessment-of-all-chronic-pain-and-management-of-chronic-primary-pain-pdf-66142080468421>
- Nicholas, M. K. (2007). The Pain Self-Efficacy Questionnaire: Taking Pain in Account. *European Journal of Pain*, 11(2), 153-163. <https://doi.org/10.1016/j.ejpain.2005.12.008>
- Nicol, A. L., Sieberg, C. B., Clauw, D. J., Hassett, A. L., Moser, S. E., & Brummett, C. M. (2016). The Association Between a History of Lifetime Traumatic Events and Pain Severity, Physical Function and Affective Distress in Patients with Chronic Pain. *Journal of Pain*, 17(12), 1334-1348. <https://doi.org/10.1016/j.jpain.2016.09.003>

- O'Cathain, A., Hoddinott, P., Lewin, S., Thomas, K. J., Young, B., Adamson, J., Jansen, Y., Mills, N., Moore, G., & Donovan, J. L. (2015). Maximising the Impact of Qualitative Research in Feasibility Studies for Randomised Controlled Trials: Guidance for Researchers. *Pilot and Feasibility Studies*, 1. <https://doi.org/10.1186/s40814-015-0026-y>
- Parkitny, L., McAuley, J. H., Walton, D., Pena Costa, L. O., Refshauge, K. M., Wand, B. M., Di Pietro, F., & Moseley, G. L. (2012). Rasch Analysis Supports the Use of the Depression, Anxiety and Stress Scales to Measure Mood in Groups but Not in Individuals with Chronic Low Back Pain. *Journal of Clinical Epidemiology*, 65, 189-198. <https://doi.org/10.1016/j.jclinepi.2011.05.010>
- Pavot, W., & Diener, E. (2009). "Review of the Satisfaction with Life Scale." In *Assessing Well-Being. Social Indicators Research Series*. Edited by E. Diener, 101-117. Springer.
- Pots, W. T. M., Trompetter, H. R., Schreuers, K. M.G., & Bohlmeijer, E. T. (2016). How and for Whom Does Web-based Acceptance and Commitment Therapy Work? Mediation and Moderation Analyses of Web-based ACT for Depressive Symptoms. *BMC Psychiatry*, 16(158). <https://doi.org/10.1186/s12888-016-0841-6>
- Rayner, L., Hotopf, M., Petkova, H., Matcham, F., Simpson, A., & McCracken, L. M. (2016). Depression in Patients with Chronic Pain Attending a Specialised Pain Treatment Centre: Prevalence and Impact on Health Care Costs. *Journal of Pain*, 15(7), 1472-1479. <https://dx.doi.org/10.1097%2Fj.pain.0000000000000542>
- \*Rickardsson, J., Zetterqvist, V., Gentili, C., Andersson, E., Holmström, L., Lekander, M., Persson, M., Persson, J., Ljótsson, B., & Wicksell, R. K. (2020). Internet-delivered Acceptance and Commitment Therapy (iACT) for Chronic Pain-Feasibility and

Preliminary Effects in Clinical and Self-referred Patients. *mHealth*, 6(27).

<http://dx.doi.org/10.21037/mhealth.2020.02.02>

\*Rickardsson, J., Gentili, C., Holmström, L., Zetterqvist, V., Andersson, E., Persson, J., Lekander, M., Ljótsson, B., & Wicksell, R. K. (2021). Internet-delivered Acceptance and Commitment Therapy as Microlearning for Chronic Pain: A Randomized Controlled Trial with 1-year Follow-up. *European Journal of Pain*, 1-19.

<https://doi.org/10.1002/ejp.1723>

Ridley, D. (2008). *The Literature Review: A Step-by-Step Guide for Students*. Sage Publications Ltd.

Rosentiel, A. K., & Keefe, F. J. (1983). The Use of Coping Strategies in Chronic Low Back Pain Patients: Relationship to Patient Characteristics and Current Adjustment. *Pain*, 17(1), 33-44. [https://doi.org/10.1016/0304-3959\(83\)90125-2](https://doi.org/10.1016/0304-3959(83)90125-2)

Schardt, C., Adams, M. B., Owens, T., Keitz, S., & Fontelo, P. (2007). Utilization of the PICO Framework to Improve Searching PubMed for Clinical Questions. *BMC Medical Informatics and Decision Making* 7, (16). <https://doi.org/10.1186/1472-6947-7-16>

Scott, W., Hann, K. E., & McCracken, L. M. (2016). A Comprehensive Examination of Changes in Psychological Flexibility Following Acceptance and Commitment Therapy for Chronic Pain. *Journal of Contemporary Psychotherapy*, 46, 139-148. <https://doi.org/10.1007/s10879-016-9328-5>

\*Scott, W., Chilcot, J., Guildford, B., Daly-Eichenhardt, A., & McCracken, L. M. (2018). Feasibility Randomized-controlled Trial of Online Acceptance and Commitment Therapy for Patients with Complex Chronic Pain in the United Kingdom. *European Journal of Pain*, 22, 1473-1484. <https://doi.org/10.1002/ejp.1236>

- \*Scriven, H., Doherty, D. P., & Ward, E. C. (2019). Evaluation of a Multisite Telehealth Group Model for Persistent Pain Management for Rural/ Remote Participants. *Rural and Remote Health*, 19. <https://doi.org/10.22605/RRH4710>
- Slater, M. A., Hall, H. F., Hampton Atkinson, J., Garfin, S. R. (1991). Pain and Impairment Beliefs in Chronic Low Back Pain: Validation of the Pain and Impairment Relationship Scale (PAIRS). *Pain*, 44(1), 51-56. [https://doi.org/10.1016/0304-3959\(91\)90146-O](https://doi.org/10.1016/0304-3959(91)90146-O)
- Smith, B.H., Fors, E. A., Korwisi, B., Barke, A., Camerson, P., Colvin, L., Richardson, C., Rief, W., Treede, R-D., The IASP Taskforce for Classification of Chronic Pain. (2019). The IASP Classification of Chronic Pain for ICD-11: Applicability in Primary Care. *The Journal of the International Association for the Study of Pain*, 160(1), 83-87. [https://journals.lww.com/pain/Abstract/2019/01000/The\\_IASP\\_classification\\_of\\_chronic\\_pain\\_for.11.aspx](https://journals.lww.com/pain/Abstract/2019/01000/The_IASP_classification_of_chronic_pain_for.11.aspx)
- Snaith, R. P. (2003). The Hospital Anxiety and Depression Scale. *Health and Quality of Life Outcomes*, 1(29). <https://doi.org/10.1186/1477-7525-1-29>
- Soer, R., Koke, A. J., Vroomen, P. C., Stegeman, P., Smeets, R. J. E. M., Coppes, M. H., & Reneman, M. (2013). Extensive Validation of the Pain Disability Index in 3 Groups of Patients with Musculoskeletal Pain. *Spine*, 38(9), 562-568. <http://doi.org/10.1097/brs.0b013e31828af21f>
- Sullivan, M. J. L., Bishop, S. R., & Pivik, J. (1995). The Pain Catastrophizing Scale: Development and Validation. *Psychological Assessment*, 7(4), 524-532. <https://doi.org/10.1037/1040-3590.7.4.524>
- Tait, R. C., Pollard, A. C., Margolis, R. B., Duckro, P. N., & Krause, S. J. (1987). The Pain Disability Index: Psychometric and Validity Data. *Archives of Physical Medicine and Rehabilitation*, 68(7), 438-441. <https://www.researchgate.net/profile/Raymond->

[Tait/publication/19556299 The Pain Disability Index Psychometric and validity data/links/543c0c150cf2d6698be3640d/The-Pain-Disability-Index-Psychometric-and-validity-data.pdf](https://www.tait/publication/19556299/The-Pain-Disability-Index-Psychometric-and-validity-data/links/543c0c150cf2d6698be3640d/The-Pain-Disability-Index-Psychometric-and-validity-data.pdf)

Treede, R-D., Rief, W., Barke, A., Aziz, Q., Bennett, M. I., Benoliel, R., Cohen, M., Evers, S., Finnerup, N. B., First, M. B., Giamberardino, M. A., Kaasa, S., Kosek, E., Lavand'homme, P., Nicholas, M., Perrot, S., Scholz, J., Schug, S., Smith, B. H.,...Wang, S-J. (2015). A Classification of Chronic Pain for ICD-11. *International Association for the Study of Pain*, 156(6), 1003-1007.  
<http://dx.doi.org/10.1097/j.pain.0000000000000160>

Trompetter, H. R., ten Klooster, P. M., Schreurs, K. M., Fledderus, M., Westerhof, G. J., & Bohlmeijer, E. T. (2013). Measuring Values and Committed Action with the Engaged Living Scale (ELS): Psychometric Evaluation in a Nonclinical Sample and a Chronic Pain Sample. *Psychological Assessment*, 25(4), 1235-1246.  
<https://doi.org/10.1037/a0033813>

\*Trompetter, H. R., Bohlmeijer, E. T., Veehof, M. M., & Schreurs, K. M. G. (2015a). Internet-based Guided Self-help Intervention for Chronic Pain Based on Acceptance and Commitment Therapy: A Randomized Controlled Trial. *Journal of Behavioural Medicine*, 38(1), 66-80.  
<https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1007%2Fs10865-014-9579-0>

\*Trompetter, H. R., Bohlmeijer, E. T., Fox, J., & Schreurs, K. M. G. (2015b). Psychological Flexibility and Catastrophizing as Associated Change Mechanisms During Online Acceptance and Commitment Therapy for Chronic Pain. *Behaviour Research and Therapy*, 74, 50-59. <http://dx.doi.org/10.1016/j.brat.2015.09.001>



- \*Trompetter, H. R., Bohlmeijer, E. T., Lamers, S. M. A., & Schreurs, K. M. G. (2016). Positive Psychological Wellbeing is Required for Online Self-Help Acceptance and Commitment Therapy for Chronic Pain to be Effective. *Frontiers in Psychology*, 7. <https://doi.org/10.3389/fpsyg.2016.00353>
- Turk, D. C., & Dworkin, R. H. (2004). What Should be the Core Outcomes in Chronic Pain Clinical Trials? *Arthritis Research & Therapy*, 6, 151. <https://doi.org/10.1186/ar1196>
- Veehof, M. M., Oskam, M.-J., Schreurs, K. M. G., Bohlmeijer, E. T. (2011). Acceptance-based Interventions for the Treatment of Chronic Pain: A Systematic Review and Meta-analysis. *Pain*, 152(3), 533-542. <https://doi.org/10.1016/j.pain.2010.11.002>
- Ware, J. E., Kosinski, M., & Keller, S. D. (1996). A 12-Item Short-Form Health Survey: Construction of Scales and Preliminary Tests of Reliability and Validity. *Medical Care*, 34(3), 220-233. <https://www.jstor.org/stable/3766749>
- Wetherell, J. L., Afari, N., Rutledge, T., Sorrell, J. T., Stoddard, J. A., Petkus, A. J., Solomon, B. C., Lehman, D. H., Liu, L., Lang, A. J., & Atkinson, J. H. (2011). A Randomised Controlled Trial of Acceptance and Commitment Therapy and Cognitive-behavioural Therapy for Chronic Pain. *Pain*, 152(9), 2098-2107. <https://doi.org/10.1016/j.pain.2011.05.016>
- Wicksell, R. K., Ahlqvist, J., Bring, A., Melin, L., & Olsson, G. L. (2008). Can Exposure and Acceptance Strategies Improve Functioning and Life Satisfaction in People with Chronic Pain and Whiplash-Associated Disorders (WAD)? A Randomised Controlled Trial. *Cognitive Behaviour Therapy*, 37(3). <https://doi.org/10.1080/16506070802078970>
- Wicksell, R. K., Renöfält, J., Olsson, G. L., Bond, F. W., & Melin, L. (2007). Avoidance and Cognitive Fusion – Central Components in Pain Related Disability? Development and

Preliminary Validation of Psychological Inflexibility in Pain Scale (PIPS). *European Journal of Pain*, 12(4), 491-500. <https://doi.org/10.1016/j.ejpain.2007.08.003>

Williams, A. C. D. C., Fisher, E., Hearn, L., & Eccleston, C. (2020) Psychological Therapies for the Management of Chronic Pain (excluding headaches) in Adults (Review). Cochrane Database of Systematic Reviews. <https://doi.org/10.1002/14651858.CD007407.pub4>

Williams, N. (2014). The GAD-7 Questionnaire. *Occupational Medicine*, 64(3), 224. <https://doi.org/10.1093/occmed/kqt161>

World Health Organization. (2019). International Statistical Classification of Diseases and Related Health Problems (11<sup>th</sup> ed.). <https://icd.who.int/>

\*Yang, S-Y., Moss-Morris, R., & McCracken, L. M. (2017). iACT-CEL: A Feasibility Trial of a Face-to-Face and Internet-based Acceptance and Commitment Therapy Intervention for Chronic Pain in Singapore. *Pain Research and Treatment*. <https://doi.org/10.1155/2017/6916915>

## **Chapter Two**

### **Online Supervision during the Covid-19 Pandemic: Perspectives of Trainee Clinical Psychologists and Clinical Supervisors.**

This paper will be adapted for submission to the journal, The Clinical Supervisor (see Appendix H for Author Guidelines)

This empirical paper was registered with the Open Science Framework

(<https://doi.org/10.17605/OSF.IO/S64FC>)

Overall Chapter Word Count at Submission (excluding abstract, tables, figures, and references): 8,403 words

### **Abstract**

The Covid-19 pandemic has resulted in an increase in online working for Clinical Psychologists in the UK, including a move to online, clinical supervision. To explore and understand the impact of online supervision within this context, eleven Trainee Clinical Psychologists and eleven Clinical Supervisors were interviewed to gain insight. Using reflexive thematic analysis, four themes were generated from the data highlighting the impact of online supervision on the practical aspects and supervision processes. A continuity in structure and consistency was evident in online supervision. However, both supervisors and supervisees described a perceived reduction in nonverbal communication, endings, and emotional connection compared with previous experiences of face-to-face supervision. These factors affected the development of supervisory relationships and the space for both reflection and vulnerability. The results indicated that online supervision is perceived to have both strengths and limitations in comparison to perceptions of face-to-face supervision. Findings from this study have implications in relation to online supervision training and practice. Future studies should aim to recruit a more diverse sample and should also consider exploring supervisors' experiences in more depth.

## Context

### Research Purpose and Significance

The introduction of the Covid-19 pandemic in 2020 significantly impacted the lives of millions across the globe. The UK was particularly affected with high mortality rates and reported cases, in order to manage the impact on the National Health Service (NHS) the government mandated that all citizens stay at home and a national 'lockdown' was enforced in March until mid-May 2020 (Dawson & Golijani-Moghaddam, 2020). Any employees not classified as 'critical workers' were asked to work from home and many others were temporarily furloughed or made redundant (Dawson & Golijani-Moghaddam, 2020). Physical distancing rules which continued throughout 2020 and 2021, also meant that people were asked to restrict in-person social contact and during lockdown, isolate in their own homes. This physical distancing has been linked to increased rates of loneliness and co-morbid mental health difficulties (Groarke et al., 2020).

Throughout the national lockdown, physical and mental health services continued to provide services for individuals with critical needs. In some mental health settings referrals decreased (Chen et al., 2020; Tromans et al., 2020). However, despite reduced referrals, healthcare workers were under increasing pressure to provide services online rather than face to face and many employees were redeployed to other services to support with the management of Covid-19 (Johnson et al., 2020). With these additional pressures and unexpected circumstances, it is unsurprising that during the pandemic nearly a third of healthcare workers reported moderate to severe levels of anxiety and depression (Gilleen et al., 2021). Risk factors such as age, gender, and pre-existing mental or physical health conditions increased the likelihood of individuals struggling with their mental health (Kwong et al., 2021). Additionally, mental health staff reported increased concerns for service users with reduced access to services and difficulties managing significant service adaptations in response to national lockdowns (Johnson et al., 2020).

The pandemic has undoubtedly changed the way that mental health professionals are required to work and deliver care to service users (British Psychological Society [BPS], 2020a; Johnson et al., 2020). Increasingly, digital or telephone platforms are used to provide both therapy (BPS, 2020b) and clinical supervision online (BPS & Division of Clinical Psychology [DCP], 2020; Tarlow, et al., 2020).

Clinical supervision has been defined as “the formal provision by senior (or) qualified health practitioners of an intensive relationship-based education and training that is case-focused, and which supports, directs, and guides the work of colleagues (supervisees)” (Milne, 2007; 440). Clinical Psychologists consider supervision an essential part of their continuing professional development and it can provide a safe space for reflection and increased understanding (BPS, 2017). For Trainee Clinical Psychologists, supervision is a core part of their training programme (BPS, 2010; O’Donovan et al., 2011; Wilson et al., 2016). Supervisors are required to provide at least one hour of formal supervision a week and an additional three hours of informal supervision for Trainee Clinical Psychologists whilst they are on a clinical placement (BPS, 2010).

A review of research revealed that Trainee Clinical Psychologists rate supervision as one of the five most stressful parts of training, however it is also rated as one of the top five coping strategies (Cushway & Knibbs, 2004). For Trainee Clinical Psychologists, supervision should provide a safe base, reflective education, and formative feedback (BPS, 2010; UKCP; 2018). Indeed, these benefits are also some of the main functions of clinical supervision (Palomo et al., 2010). Additional components include the need for commitment, structure, boundaries, and trust within supervision (BPS, 2010; Palomo et al., 2010). The supervisory relationship is considered the core aspect of supervision and parallels between therapeutic relationships and supervision relationships are often drawn (O’Donovan et al., 2011; Perry, 2012).

Clinical Supervisors are expected to provide both formal and informal supervision as well as to consider clinical caseload and suitability, recommending relevant reading, and

monitoring the Trainee Clinical Psychologist's experience of their placement (BPS, 2010). Clinical Supervisors reported that the supervisory relationship is the most important aspect of supervision (Rothwell et al., 2019). However, difficulties with providing appropriate feedback, managing supervision boundaries and time can be significant barriers for supervisors (Bang & Park, 2009; Rothwell et al., 2019). Supervision research has previously focussed on the supervisee's experience of supervision (Bang & Park, 2009). Little qualitative research in the UK has considered supervisors' experience of supervision alongside supervisees' experience. Conducting empirical research that considers supervisors' and supervisees' experiences of supervision is essential to develop the evidence-based, theoretical foundation for clinical supervision including supervision models (Milne et al., 2008).

### **Supervision Models**

There are many models for supervision that have been developed, including those aligned to particular therapeutic approaches such as psychodynamic, systemic, and cognitive behavioural (Milne et al., 2008). Three widely used supervision models are the Discrimination Model, the Integrated Developmental Model of supervision and the Seven-Eyed model of supervision (Stoltenberg et al., 2014). The Discrimination Model is considered to be an accessible and empirically validated model for supervisors to use (Crunk & Barden, 2017). This conceptualisation of clinical supervision suggests that it is both an educational and relational process. The model addresses these processes by presenting a dual function of assessing the supervisee's skill and also highlighting the appropriate role for the supervisor to address the supervisee's needs (Crunk & Barden, 2017). However, this model can be limited as it is designed to be used at a fixed time point and then adapted when reapplied at different time points.

The Integrated Developmental Model (IDM) provides a conceptualisation of supervision that can be used across a students' development as they progress and improve their clinical skills (McNeill et al., 1992). Presented as three levels of development, the model

provides suggestions for supervisors regarding the adjustments and considerations that they may need to make within supervision for their supervisee, in line with the stage of development that they are practising at (Stoltenberg et al., 2014). However, the model focusses mostly on the supervisee and their experience of supervision rather than also considering the role of supervisor.

Developed from coaching supervision, the Seven-Eyed Model focusses on the processes of supervision and has been used in clinical settings across the world (Hawkins, 2010). The purpose of the model is to provide different areas of focus for supervision that consider the systemic context and multiple relationships that exist within and alongside supervision. The model can be used by both supervisor and supervisee to explore and evaluate the supervision process (Hawkins, 2010; Hawkins & Shohet, 2012). All of the models described have different strengths and limitations, however there is little consideration of the relevance of these models to online supervision.

### **Online Supervision**

Developments in providing supervision and training through digital technology have included the use of videoconferencing, tracking clinical outcomes through online applications, and providing training through online sharing software (Rousmaniere et al., 2014). Using videoconferencing to facilitate supervision can enable the provision of supervision in remote and rural areas and across international settings (Rousmaniere et al., 2014). Many mental health professionals and therapists already advocate the use of online supervision (Rothwell et al., 2019).

Multiple terms are used within the literature to describe supervision conducted remotely or online. Terms such as tele supervision, videoconferencing supervision, and remote supervision have been used in previous research (Abbass et al., 2011; Gammon et al., 1998; Tarlow et al., 2020). Within the present study, the term online supervision has been used; this term was indicated by a group of Trainee Clinical Psychologists and Clinical Supervisors practising in the UK who were consulted during the development of the project.



## Previous Literature

Previous literature has focussed on student or trainee psychologists' experiences and not on the supervisors' (Amanvermez et al., 2020; Tarlow et al., 2020). In Turkey, Amanvermez and colleagues used thematic analysis to explore student counsellors' experiences of supervision online. Six participants completed individual interviews and a focus group to explore their experiences. Themes focussing on the strengths and drawbacks of the online environment were generated. The authors suggested that there were many shared characteristics between online and face-to-face supervision, including the supervisor's role. Additionally, they suggested that the accessibility of online supervision could be advantageous when finding time for supervision sessions. However, they concluded that technical difficulties and restricted perception of communication cues could provide limitations to online supervision (Amanvermez et al., 2020). The study focussed particularly on student counsellors based in Turkey, where the training differs from the UK training in Clinical Psychology. In addition, the participants received online supervision as part of the project and were not receiving online supervision in clinical practice. A thematic analysis was completed; however, themes appear to be descriptive in nature and do not provide an analytic response to the data (Amanvermez et al., 2020).

Additional research suggests that online or tele supervision may be equivalent in nature and content to face-to-face supervision (Jordan & Shearer, 2019). Jordan & Shearer (2019) explored the experience of twelve supervisees regarding online supervision. A mixed methods approach was used and questionnaires including the Supervisory Working Alliance Inventory (Trainee Version) were completed. Results found that similar components indicated for beneficial face-to-face supervision were also important in online supervision. However, they suggested that online supervision may not be suitable for all supervisees as more initiative is needed to engage supervisors online, and individuals who have great difficulty in this area may not benefit from online supervision as much (Jordan & Shearer, 2019).

Tarlow and colleagues (2020) investigated online supervision experiences of two Trainee Clinical Psychologists and one Trainee Counselling Psychologist within the USA. Questionnaires such as the Supervision Satisfaction Questionnaire were used to generate data alongside interviews with the participants. In order to control for differences in supervision, the same supervisor was used for all participants. The results highlighted the importance of a supervisor being familiar with technology in order to manage any difficulties (Tarlow et al., 2020). All three participants reflected that the supervisor was the most important factor in effective supervision and not the modality. As with previous research, this paper concluded that online supervision can be equivalent to face-to-face supervision (Tarlow et al., 2020). However, all three participants had experienced face-to-face supervision with their supervisor prior to engaging online. Additionally, supervision satisfaction and the supervisory working alliance were rated as high, prior to engaging in online supervision (Tarlow et al., 2020). It is unknown whether the already developed alliance and satisfaction influenced perceptions of the online supervision experience. As with previous research, this study did not consider the experience of the supervisor.

Research considering supervisors' experiences of and perspectives on supervision is limited and currently, there are few published studies in this area. One study which explored supervisors' reflections and experiences of supervision, focussing solely on face-to-face supervision, was conducted by Bang and Park, (2009) in Korea. Using a grounded theory approach, eleven supervisors were interviewed, and 28 themes grouped into six categories, were developed. The results highlighted the role of the supervisor as a teacher and counsellor; however, the role of consultant was not as thoroughly explored (Bang & Park, 2009). The authors reflected that this could be because of the cultural and hierarchical social relationships emphasised in Korean culture. Additionally, recommendations for training for supervisors included, relationship building with the supervisee, attention to the triadic relationship between the supervisor, supervisee and client, and an understanding of wider contextual factors that can affect the supervision relationship (Bang & Park, 2009). Though

this study did not consider online supervision, the focus on supervisors' perspectives provided findings that have relevance for supervisory guidelines and could usefully inform training considerations. However, there are likely to be cultural differences with supervisors' experiences in Korea in comparison to the UK context.

### **Rationale and Research Question**

Understanding the experience of online supervision from both supervisees' and supervisors' perspectives is crucial to developing evidence-based policies and guidelines and informing supervision training considerations. Previous research has highlighted the importance of the supervisory relationship and the increased accessibility of online supervision (Amanvermez et al., 2020; Bang & Park, 2009) but has not considered the experiences and perceptions of both supervisees and supervisors. There is also a lack of research relating specifically to Clinical Psychology in the UK. Given the centrality of clinical supervision to Clinical Psychology training, understanding supervision from both perspectives could usefully inform training, competency development, and supervision delivery. With the impact of the Covid-19 pandemic and a possible ongoing need for online supervision during clinical psychology training, a better understanding of online supervision and any necessary adaptations will be important moving forward.

The rationale for the current study is threefold. Firstly, there is a paucity of research exploring the perspectives of both supervisees and supervisors in regard to online supervision. Secondly, developing a more nuanced understanding of how online supervision is experienced by both supervisors and supervisees can serve to identify some of the perceived strengths and difficulties, which in turn may inform training needs in this area moving forward. Thirdly, carrying out this study would also serve to increase our understanding of the impact, if any, of the wider context of the Covid-19 pandemic on the experience of clinical supervision for both Trainee Clinical Psychologists and Clinical Supervisors.

The research question for the present study is, therefore: What are Trainee Clinical Psychologists' and Clinical Supervisors' perspectives and experiences of online supervision in the context of the Covid-19 pandemic?

This research question was developed and refined throughout the data collection and analysis process to reflect the themes generated from the data (Hammersley, 2015).

## **Method**

### **Research Design**

This study employed a qualitative design with reflexive thematic analysis. Reflexive thematic analysis emphasises an organic, flexible approach where the researcher's role and subjectivity are considered to encourage a reflective and thoughtful engagement with the data and analytic process (Braun & Clarke, 2019). A critical realist or contextualist ontological position was taken, where the reality of the participants was interpreted within the socio-cultural context of the Covid-19 pandemic (Terry et al., 2017). For the purposes of this study, online interviews were used to generate the data.

### **Procedure**

#### ***Ethical Considerations***

The project was granted ethical approval from Coventry University Ethics Committee (Appendix I). The British Psychological Society (BPS, 2018) Code of Ethics and Conduct was adhered to throughout all stages of the research. Prior to completing the interview, each participant completed an informed consent form (Appendix J) and were given a participant information sheet to read (Appendices K and L). At the end of each interview the researcher highlighted the participant's right to withdraw. Further information regarding withdrawal and signposting for additional support was provided in the debrief sheet (Appendices M and N).

## Participants

### *Recruitment*

A non-probability, purposive sampling technique was used to recruit participants who met the inclusion and exclusion criteria. Participants were recruited primarily through three online groups on Facebook where the study posters (Appendices O and P) were shared. Additionally, Trainee Clinical Psychologists were emailed via their doctoral training programme director to inform them about the study.

In total, 32 participants (14 Trainee Clinical Psychologists and 18 Clinical Supervisors) expressed interest in the study and were emailed the consent form and participant information sheet. However, 10 participants were not eligible or did not contact the researcher following the initial email.

### *Eligibility Criteria*

Specific inclusion criteria (Table 5) were developed to focus on exploring the experience of the target population.

**Table 5. Inclusion Criteria**

<b>Criteria</b>	<b>Inclusion</b>
<b>Job Role</b>	Trainee Clinical Psychologists in years 1, 2 & 3 of a UK Doctorate in Clinical Psychology training programme
	Clinical Psychologists who have been engaged in provision of clinical supervision for Trainee Clinical Psychologists during the Covid-19 pandemic
<b>Setting</b>	Engaged in receiving or providing clinical supervision in the UK during the Covid-19 pandemic
<b>Supervision Method</b>	Participants must be providing or receiving supervision online

Participants had to be Trainee Clinical Psychologists enrolled in a Clinical Psychology doctoral programme, at a UK based university, or qualified Clinical Psychologists who were currently supervising or had supervised a Trainee Clinical

Psychologist during the Covid-19 pandemic. Participants needed to be providing or receiving supervision online, with limited face-to-face contact with their supervisor or supervisee. This was in line with the public health guidelines at the time and hence this study of online supervision is framed within the wider context of the Covid-19 global pandemic.

### ***Participant Characteristics***

Twenty-two participants aged between 22 and 41 ( $M = 31$ ,  $SD = 4.56$ ) participated in this study. Of the eleven Trainee Clinical Psychologists, six (55%) were in their third year of training, three (27%) in their second year and two (18%) in their first year, at the time of interview. Clinical Supervisors had experience of providing supervision ranging from less than one year to twelve years ( $M = 4$ ,  $SD = 3.62$ ). All Trainee Clinical Psychologists had experienced 81-100% of their supervision online, during their current or most recent placement. The most popular online platform used for supervision was Microsoft Teams, with use of Zoom, Cisco WebEx and WhatsApp Video platforms also reported. Further details regarding participant demographics can be seen in Table 6.

**Table 6.** *Participant Demographics*

<b>Characteristics Category</b>	<b>Characteristic Specifics</b>	<b>Number of Participants</b>	<b>Percentage of Participants</b>
Ethnicity	White British	18	81%
	Other White	2	9%
	White Irish	1	5%
	Black Caribbean	1	5%
Gender	Female	21	95%
	Gender Variant/Non-conforming	1	5%
University Delivering Programme	Coventry University	2	18.5%
	Plymouth University	1	9%
	Queens University Belfast	1	9%
	Staffordshire University	1	9%
	University College London	1	9%
	University of Edinburgh	2	18.5%
	University of Hull	1	9%
	University of Manchester	1	9%
	University of Sheffield	1	9%

## ***Materials***

A semi-structured, interview guide was developed by the research team providing key questions as well as allowing the researcher and participants to explore ideas and themes (Gill et al., 2008; Appendices Q and R). The interview guide sought to explore the experience and impact of online supervision guided by the integral features of supervision as detailed in supervision guidelines and policies (British Association for Behavioural and Cognitive Psychotherapies [BABCP], 2020; BPS 2010; BPS 2020a, BPS 2020b; BPS & DCP, 2020). Themes from previous research exploring online supervision were also used to support the development of the interview guide (Jordan & Shearer, 2019; Tarlow et al., 2020). Additionally, three Trainee Clinical Psychologists reviewed the guide, provided feedback, and indicated that the questions and content all seemed appropriate.

## ***Interview Procedure***

All interviews were conducted online via Microsoft teams due to Covid-19 restrictions. The interviews were conducted between July 2020 and November 2020 and were audio-recorded and transcribed verbatim. The interviews ranged between 19 and 59 ( $M = 35$ ) minutes for Clinical Supervisors and for Trainee Clinical Psychologists the range was 24 to 48 ( $M = 31$ ) minutes. Identifiable information (e.g. references to NHS trusts, names of supervisors or locations) was removed during transcription and each participant was allocated a participant number. All recordings of interviews were destroyed once transcription was completed.

## ***Data Analysis***

A reflexive thematic analysis approach was used to engage with the data. The six-phase approach was used during the process (Braun and Clarke, 2006; Braun et al., 2019; Terry et al., 2017; Table 7).

**Table 7.** *Six Phases of Reflective Thematic Analysis*

<b>Stage of Analysis</b>	<b>Details</b>
Stage 1: Data Familiarisation and Writing Familiarisation Notes	Transcripts were read and reviewed multiple times, notes and reflections were made about the transcripts
Stage 2: Systematic Data Coding	Each transcript was coded by the primary researcher. Codes were revisited and refined to capture concepts clearly.
Stage 3: Generating Initial Themes from Coded and Collated Data	Similar codes were grouped together and collated. Patterns within codes were drawn together to develop central concepts and initial themes were generated
Stage 4: Developing and Reviewing Themes	Themes were reviewed against codes and the transcripts. Additional themes were added, and thematic map created
Stage 5: Refining, Defining, And Naming Themes	Themes were reviewed and theme names were defined, thematic map was adjusted.
Stage 6: Writing the Report	Report was written, research question was reviewed to reflect the themes. Quotes were used both illustratively & analytically to support themes.

The first stages were revisited multiple times to review coding and reanalyse the data additionally, continual questioning and considering assumptions was carried out whilst interpreting and coding the data (Braun et al., 2016). An inductive approach was employed, therefore, both semantic and latent codes were developed to inform themes generated from the data, coding was open and organic and did not use a coding framework (Braun & Clarke, 2020).

Additionally, the quality checklist for thematic analysis (Appendix S) was used to evaluate the completed analysis and generation of themes to ensure clarity in the analytic process and demonstrate a thorough, reflexive, and analytic approach (Braun & Clarke, 2006; Terry, et al., 2017).

### ***Reflexivity***

Reflexive thematic analysis requires the researcher to engage reflectively and thoughtfully during the analytic process. Whilst engaging with the analysis, the primary researcher remained mindful of any preconceptions they carried and their own experience of



the Covid-19 pandemic context, as well as online supervision. Research supervision, a bracketing interview, and reflective journal were used to gain insight regarding the primary researcher's role and subjectivity. A second researcher independently coded two full transcripts (one from a supervisor and one from a supervisee). This contributed to a richer, more nuanced reading of the data and additional reflections on the codes generated (Braun & Clarke, 2019). There was strong convergence between the codes and the two researchers discussed any areas of divergence for clarification. The primary researcher then held in mind any minor areas of divergence when reviewing the initial codes and developing themes.

### **Results**

Four themes with additional subthemes were developed from the data; *Effects on the Mechanics of Supervision*, *Process Differences- Us*, *Process Differences- Me* and *Context Influences the Content*. The themes are represented in the first thematic map (Figure 2) alongside relationships between the themes and both Trainee Clinical Psychologists and Clinical Supervisors.

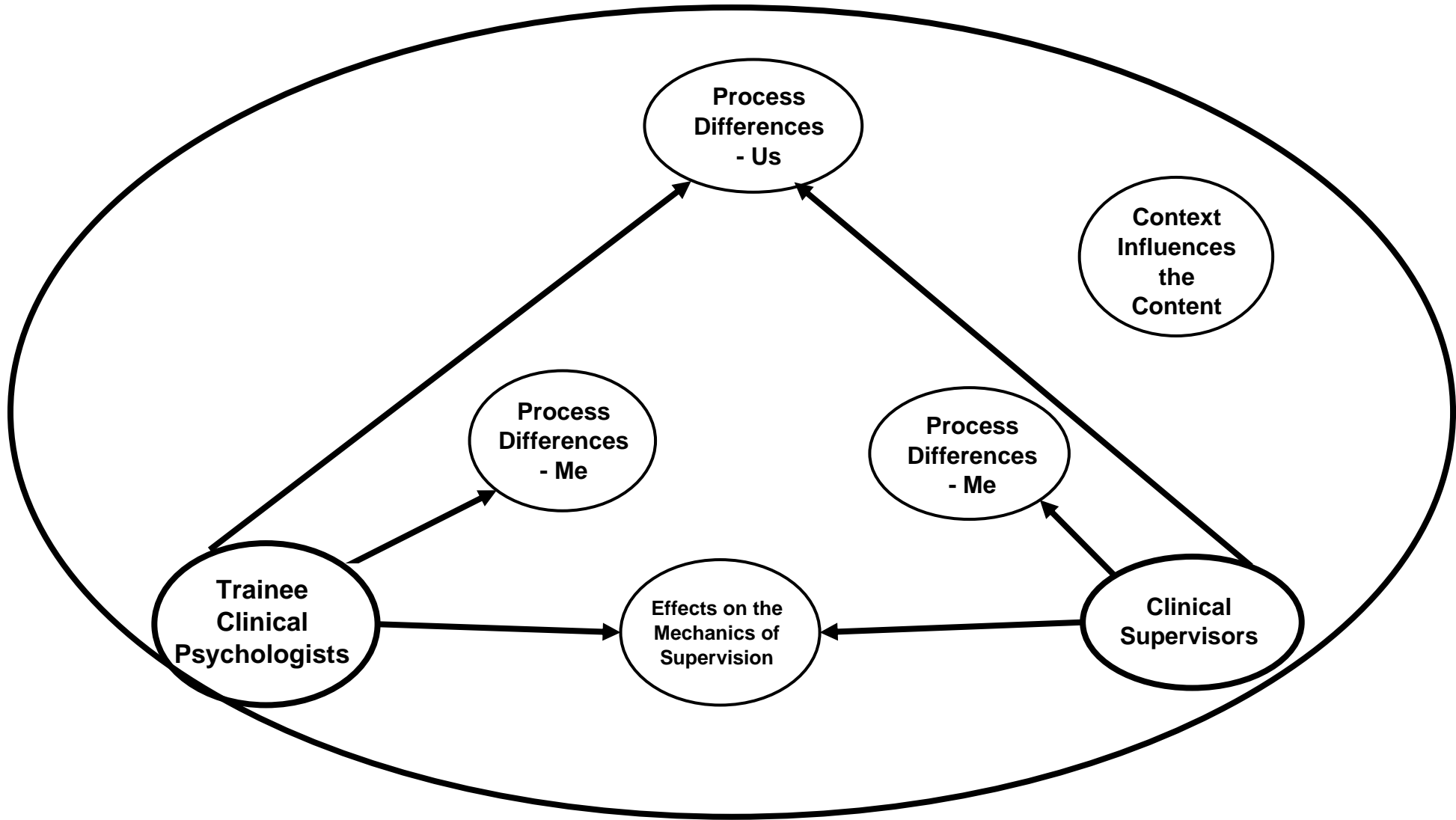


Figure 2. *Thematic Map*

A second thematic map (Figure 3) details the subthemes and additional relationships and links between themes and subthemes. Both maps indicate the complexity of the online supervision experience and highlight areas of overlap between the experiences of Clinical Supervisors and Trainee Clinical Psychologists. The shared themes, sub-themes, and links emphasise the complexity of online supervision with experiences reflecting losses and gains, and other negative and positive aspects.

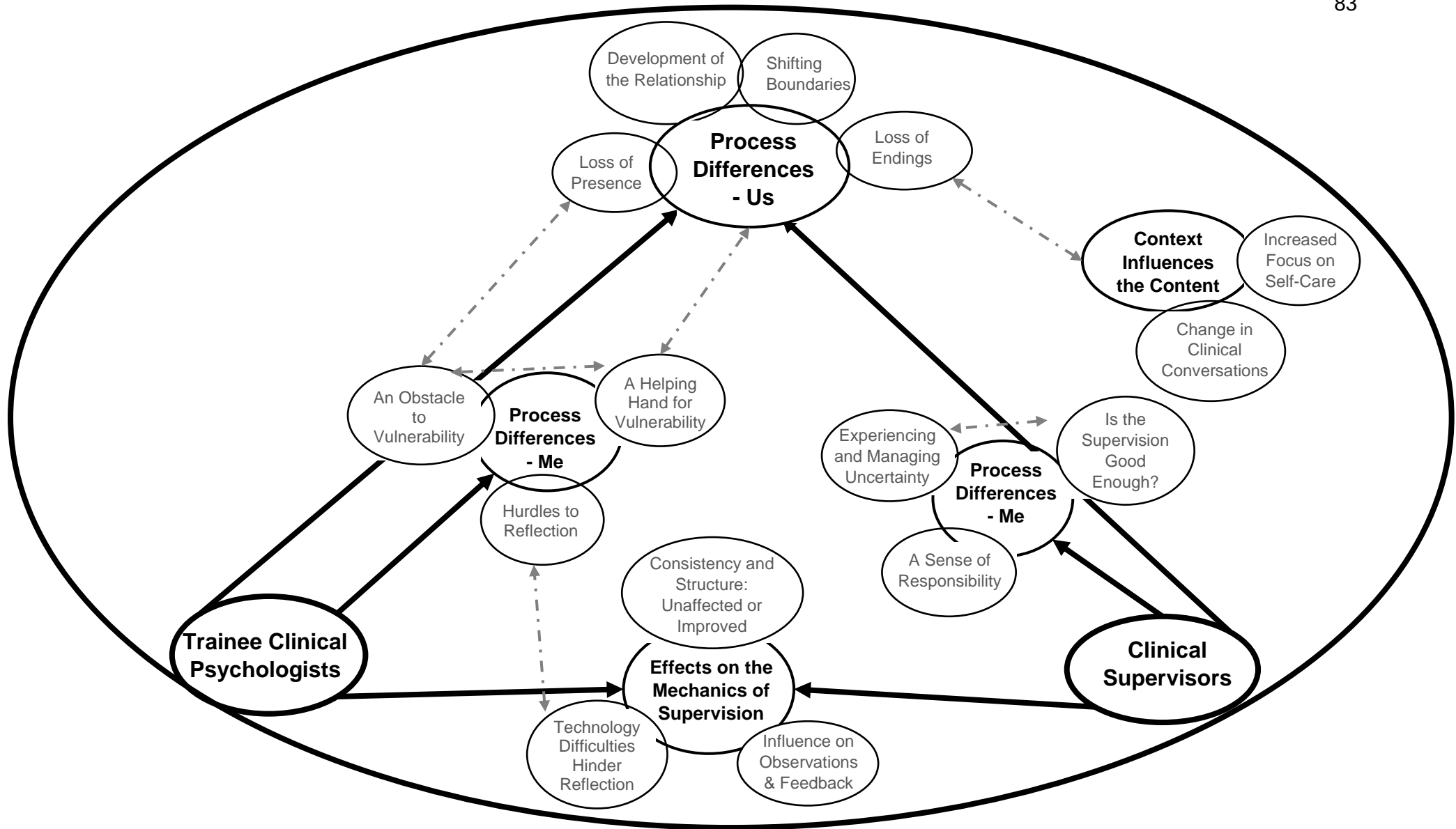


Figure 3. Thematic Map with Subthemes and Links

## **Context Influences the Content**

For both Trainee Clinical Psychologists and Clinical Supervisors, the context of the pandemic affected the content and their experience of online supervision. However, this was more evident amongst the Clinical Supervisors.

### ***Change in Clinical Conversations***

The Covid-19 pandemic context impacted the clinical conversations and content of supervision sessions.

*“Yeah, it does feel hard, it does feel like supervision feels different and this feels like, it does feel like it’s affecting what’s being brought to supervision.”*

*Clinical Supervisor 1028, Lines 66-68*

This supervisor reflected that the items that supervisees were bringing to supervision changed because of the pandemic and new experiences.

In addition, different supervisory conversations regarding clients and their experiences within the pandemic were noted.

*“So, we’ve had a lot more conversations about readiness for therapy and where people are at in terms of the external stressors that they’ve got going on.”*

*Clinical Supervisor 1019, Lines 29-31*

Considering the pandemic within therapeutic conversations and client focussed work, changed the content within supervision discussions, reflecting the different clinical experiences that supervisees were facing.

### ***Increased Focus on Self-Care***

Supervisors commented that the context renewed the focus on self-care within supervision.

*“Erm, and I’d say that other thing is we’ve had a lot more conversations about self-care then we’d have on a typical placement.”*

*Clinical Supervisor 1019, Lines 160-161*

The conversations around self-care increased in relation to face-to-face supervision prior to the Covid-19 pandemic. The context and additional pressures on supervisees reflected a necessity to focus on self-care whilst on placement and made it a priority for supervisors.

### **Effects on the Mechanics of Supervision**

*Effects on the Mechanics of Supervision* was divided into three subthemes; *Consistency and Structure: Unaffected or Improved*, *Influence on Observations and Feedback*, and *Technology Difficulties Hinder Reflection*. This theme highlighted the impact that online supervision had on the practical aspects as experienced by the supervisees and supervisors.

#### ***Consistency and Structure: Unaffected or Improved***

Consistency was highlighted as remaining the same online as experienced face-to-face or increasing because supervision was online.

*“Erm, I think it’s been just as consistent if not a little bit more consistent.”*

*Trainee Clinical Psychologist 1023, Line 131*

*“If anything, it made it slightly more consistent because often we are working from home and you haven’t got the added pressures of room bookings and things like that.”*

*Clinical Supervisor 1028, Lines 218-220*

Consistency was potentially aided by the accessibility of online platforms and less demands to manage travel, room bookings, and other members of staff.

Similarly, the structure of online supervision was experienced as unchanged or improved.

*“I think it’s remained quite structured because generally I’ll bring quite a solid agenda to any supervision, so I’ve still been doing that, erm so, yeah, the structure’s been the same, I think.”*

*Trainee Clinical Psychologist 1008, Lines 84-86*

*“Maybe, it makes you more structured and that, you just get through what you want to get through.”*

*Clinical Supervisor 1020, Lines 52-53*

For some, the structure was similar to face-to-face supervision and agendas were bought to guide the structure. For others, the experience of being online resulted in a feeling of completing what was necessary, reflecting a need for efficiency.

### ***Influence on Observations and Feedback***

Observations of clinical work and feedback were hindered and enhanced by online supervision.

*“Erm, and yeah, it’s harder to get opportunities to observe and give feedback.”*

*Clinical Supervisor 1009, Lines 203*

*“Yeah, definitely I think not being able to do observations and discuss observations in the same way.”*

*Trainee Clinical Psychologist 1031, Lines 254-255*

The limited possibility for observations subsequently impacted the feedback that was available for supervisees.

However, there was also evidence that the flexibility within online platforms could increase opportunities for observation and therefore the feedback that was provided.

*“Erm, facilitation of observation so I guess the practical side of it has been really, really helpful.”*

*Clinical Supervisor 1028, Lines 240-241*

*“Erm, well, actually I suppose, it has definitely provided more opportunities for observation, erm, so thus then it has provided far more opportunities for feedback.”*

*Trainee Clinical Psychologist 1010, Lines 78-79*

### ***Technology Difficulties Hinder Reflection***

Trainee Clinical Psychologists particularly focussed on the impact that technology difficulties and disruptions had on reflection and moments of authentic sharing within a supervision session.

*“I’ve had some issues with kind of my sound and, my camera and just all those things just kind of getting in the way of really getting deeper into the topics.”*

*Trainee Clinical Psychologist 1008, Lines 161-162*

*“Conversations can get disrupted in a way that they really don’t in real life and, then you’ll like lose your train of thought or get cut off, like a really useful bit of thinking and then the essence of that is lost once you manage to reconnect.”*

*Trainee Clinical Psychologist 1007, Lines 222-225*

The moments of connection and deeper conversations were disrupted and halted by technology difficulties such as loss of internet, sound, or camera difficulties. The flow of conversation was impacted and could not always be re-established.

### **Process Differences – Us**

*Process Differences – Us* was divided into four subthemes: *Development of the Relationship*, *Shifting Boundaries*, *Loss of Presence*, and *Loss of Endings*. The theme captured the impact of online supervision on supervision processes shared within the supervision relationship and wider supervision experience.

#### ***Development of the Relationship***

Clinical Supervisors commented on the impact of online supervision on the development of the supervisory relationship.



*“So, I think it can impact on the supervisory relationship in that way, it can make things slower, I think.”*

*Clinical Supervisor 1028, Lines 129-130*

This supervisor reflected that the supervisory relationship developed more slowly online, impacted by the time taken to develop trust and feel able to share with each other.

*“Erm, I don’t necessarily think that it is a barrier really, but it could possibly be because I already knew my trainee and we’d already had that relationship.”*

*Clinical Supervisor 1020, Lines 16-18*

Alternatively, this quote suggests that the online format was not a hindrance to the development of the relationship as it had already been built. This suggests that if a relationship existed before online supervision began this may have supported the continuity of the relationship online; perhaps there was a memory or internalised representation of the physical presence that was experienced face-to-face and could have been transferred to the online space.

### ***Shifting Boundaries***

For Clinical Supervisors one reflection on boundaries was that they became more blurred within online supervision. The distinction between professional and personal life was unclear as supervisors were entering their supervisees’ personal space alongside sharing aspects of their own home lives.

*“So that’s been one challenge, and I think that the boundaries have become a bit blurred with that because I’ve had like my kids coming in.”*

*Clinical Supervisor 1005, Lines 28-30*

*“Erm, I think there was some elements where boundaries got a lot more blurred. I was really mindful that I was dropping into my trainee’s living room”*

*Clinical Supervisor 1029, Lines 56-57*

Evidently, this shift in boundaries was something that supervisors were acutely aware of and had to hold in mind during online supervision sessions.

Similarly, supervisees highlighted the informality of seeing into a supervisor's home.

*"Erm, again that more informality, you can see into people's houses, so it feels a lot more informal that way. Err, and I've found it's impacted, it's a lot harder to share things."*

*Trainee Clinical Psychologist 1002, Lines 51-53*

The potential informality of online supervision influenced not only the boundaries between supervisor and supervisee but also the supervisee's perception of sharing in this informal space.

However, for several supervisors and supervisees, some boundaries were experienced as strengthened and increased.

*"Erm, I think in other ways maybe it sort of lends itself to strengthening boundaries in some way just in terms of sort of keeping to time. I don't know you've kind of got your little clock at the top and that kind of thing so maybe in some senses that's quite helpful."*

*Clinical Supervisor 1028, Lines 101-104*

Time keeping boundaries were perceived as improved; perhaps the presence of the clock made the temporal boundary of the session more explicit or present for the supervisor, permitting them to feel less concerned about monitoring time during supervision sessions.

Additionally, a supervisee reported:

*"I'm not sure it's changed a huge amount, I feel like the boundaries in terms of having a space, like a private space and a ring-fenced space erm and that it won't be interrupted by other people, that's been better."*

*Trainee Clinical Psychologist 1011, Lines 82-84*

It appears that online supervision could be experienced as more containing, with a private space solely for supervisor and supervisee, uninterrupted by other professionals. This contrasted with the experience of those supervisees who experienced the blurred boundaries as less formal and potentially not containing.

Furthermore, one supervisee commented:

*“It feels strange talking about them seeing my background as a positive thing, but I think it creates that sense that you’re like more personable. Being able to see them as real people rather than psychologists.”*

*Trainee Clinical Psychologist 1016, Lines 44-46.*

The change in boundaries online and sharing more of their own personal space increased a sense of shared humanity between supervisor and supervisee. This shared humanity was perceived as enabling the supervisor and supervisee to engage with one another on a more human level, potentially impacting the power dynamic in the supervisory relationship.

### ***Loss of Presence***

This subtheme reflected the loss that both Trainee Clinical Psychologists and Clinical Supervisors felt regarding their emotional connection, felt physical presence, and the informality of their relationship.

*“What you can’t quantify there is, what gets lost in translation, all the sort of interpersonal cues that make a good supervisory relationship.”*

*Clinical Supervisor 1019, Lines 267-268*

Being unable to read micro expressions and nonverbal cues, impacted the communication and depth of what was shared between supervisor and supervisee. There was an element of unknown when not all of the nonverbal cues could be picked up within the relationship.

*“The main barrier is, you can’t pick up on nonverbal communication, erm, so it’s a lot harder to judge what they’re thinking or feeling about what you’re sharing.”*

*Trainee Clinical Psychologist 1002, Lines 223-224*

The perceived loss of nonverbal communication also impacted supervisees’ sense of safety when sharing with their supervisors. They reported that they were unable to perceive their supervisor’s thoughts and feelings in regard to reflections and conversations.

In addition to the nonverbal cues, having a physical separation within online supervision reduced the process of transference and countertransference.

*“The reduced ability to erm, feel things within the room, the sort of transference, to pick up on body language at the same level.”*

*Clinical Supervisor 1004, Lines 35-37*

This supervisor reflected on the loss of embodied physical and emotional sensations in the virtual space in comparison to face-to-face. Perhaps the limited visual field through a computer screen may have inhibited the perception of some elements of non-verbal communication or subtle physical reactions and therefore interfered with aspects of transference or countertransference that could have been present.

The physical separation could have also resulted in a loss of informality described by one supervisor:

*“Erm, I think the difference is usually if we shared an office, I’d expect them to be pretty much checking in with me throughout the day, erm and I’m, I think having supervision online made that feel more formal.”*

*Clinical Supervisor 1019, Lines 87-89*

This decrease in informal ‘checking in’ may have impacted the connection between supervisor and supervisee and increased the formal or professional nature of the relationship.

### ***Loss of Endings***

Endings were highlighted as significant, participants reflected on the loss of this experience in the conclusion of their supervisory relationship and clinical placement as well as the impact on how endings were experienced online.

*“Yeah, it’s just felt a bit, erm, it’s not felt as personal, so it feels more like just ending a business meeting rather than a relationship that’s actually been really significant.”*

*Clinical Supervisor 1019, Lines 313-315*

The quote above implied that their online ending lacked congruence with the meaning that was felt in the relationship. The online ending missed the personal experience that was had when endings were completed face-to-face.

*“I think it, erm, it didn’t feel like the ending that I would have wanted it to have it didn’t feel like as personal an ending. Because we had, if you have a lot of supervision you can develop quite a close relationship erm and maybe the ending didn’t feel as personal.”*

*Trainee Clinical Psychologist 1016, Lines 213-216*

*“Definitely feels like quite an odd, unsatisfactory ending in some ways.”*

*Trainee Clinical Psychologist 1007, Line 326*

For the Trainee Clinical Psychologists, they reported that there was a disappointment in the online ending. For the supervisees the ending did not reflect the significance of the relationship and personal connection. This highlights the combined losses of the supervisory relationship and placement ending and dissatisfaction that the supervisees’ expectations had not been met.

## Process Differences – Me

Though the Trainee Clinical Psychologists and Clinical Supervisors shared this main theme, the subthemes differed between the two groups, reflecting differences in roles and experiences. For the Clinical Supervisors the subthemes were: *Is the Supervision Good Enough?*, *Experiencing and Managing Uncertainty* and *A Sense of Responsibility*. For the Trainee Clinical Psychologists, the subthemes were: *A Helping Hand or an Obstacle to Vulnerability?* and *Hurdles to Reflection*.

### ***Is the Supervision Good Enough?***

Supervisors reflected the uncertainty and doubt regarding whether supervision was good enough for supervisees and met necessary requirements.

*“There will be reasons that I can’t quite put my fingers on but there’s something about doing it online that even though I know it’s not my choice and I know it’s not my fault makes me think I’m not doing it good enough.”*

*Clinical Supervisor 1006, Lines 105-107*

Within this quote the supervisor reflected on being unable to gauge whether supervision was adequate and demonstrated a responsibility to provide supervision of suitable quality despite their lack of control around the wider context and move to online supervision.

Supervisors continued to hold the question of good enough in mind whilst preparing for new supervisees.

*“I think that was the question that was always in the back of my mind and continues to be as I’m preparing to welcome a new trainee, will this be enough, is it good enough.”*

*Clinical Supervisor 1015, Lines 13-14*

This quote suggested that supervisors perceived that the supervision they were providing might not be adequate; evidently, the desire to provide acceptable supervision was an important consideration for supervisors preparing for new supervisees.

### ***Experiencing and Managing Uncertainty***

Clinical Supervisors cited having to manage uncertainty whilst providing online supervision and not knowing whether that would be successful.

*“It was almost like a process of kind of, searching around in the dark a little bit, not quite knowing how it would work, how we would make it work, what the relationship would be like, the logistics of it, the trainee’s viewpoints.”*

*Clinical Supervisor 1021, Lines 14-16*

This quote indicates that the supervisor experienced uncertainty regarding multiple aspects of online supervision and not knowing how it would work. In addition, this relates to the previous subtheme; supervisors were managing uncertainty and the unknown whilst also trying to provide good enough supervision for their supervisees.

*“I do worry about next time I I’m not, I feel really unsure of how to create that safe base with my next trainee.”*

*Clinical Supervisor 1009, Lines 207-209*

Mirrored in this second quote, the uncertainty was being contributed to anxiety about the provision of supervision in the future and the opportunity to provide containment and safety for supervisees.

### ***A Sense of Responsibility***

Additionally, Clinical Supervisors, reflected on the sense of responsibility to look after their supervisees and ensure that they were coping, whilst also managing their own workload and wellbeing.

*“As a supervisor trying to hold her needs in mind, trying to manage my own needs, park them as best that I can but in a time when I have, I’m feeling totally, totally just overwhelmed.”*

*Clinical Supervisor 1009, Lines 669-671*

The impact of this sense of responsibility for the supervisee resulted in the supervisor feeling overwhelmed and struggling to manage their own needs.

### ***A Helping Hand or an Obstacle to Vulnerability***

Trainee Clinical Psychologists reflected that their experience of vulnerability was most evident in the changes to supervisory processes. For some online supervision enabled them to be vulnerable and share with their supervisor.

*“I’ve noticed for me; I do find it easier to be a bit more open online... I think, erm, there’s something about the distance, like you can feel quite connected with somebody...like for me, it removes a bit of embarrassment or anxiety, or maybe like the shame feelings.”*

*Trainee Clinical Psychologist 1011, Lines 154-165*

The online context facilitated a perception of distance and supervisee buffering against unhelpful self-conscious emotions. Consequently, this facilitated a sense of feeling safe and confident to be more open in supervision.

Additionally, one supervisee reflected that the increased sense of physical distance created by the lack of nonverbal cues enabled their openness.

*“Yeah, I think it’s, again, easier to talk about personal stuff remotely, than it would be in real life; whereas remotely, you can’t read all of those cues so much, so again it’s slightly distanced, so it feels a little bit more comfortable. Erm, cos you’re not necessarily able to pick up, erm, those really, really subtle shifts in body language and stuff that you notice in real life and which makes me a bit more open.”*

*Trainee Clinical Psychologist 1007, Lines 184-185 & 188-192*



The physical distance and separation of supervisor and supervisee created by engaging with online supervision produced a new space where emotion and vulnerability could be contained. The supervisee did not have to worry about nonverbal cues and reading their supervisor's body language, they could instead feel safe to share and be open. Additionally, they may have felt less inhibited due to not being in position of sharing a physical space with their supervisor.

Alternatively, for other Trainee Clinical Psychologists, the experience of online supervision acted as a hindrance to openness and vulnerability.

*“Just because I think there’s a bit of disconnect somehow with this kind of format and maybe I didn’t go into as much depth as I could have done.”*

*Trainee Clinical Psychologist, Lines 112-114*

For this supervisee, online supervision resulted in a sense of disconnection with their supervisor. This could have meant there was a decreased sense of safety and containment and therefore supervisees did not feel able to explore their experiences to the same degree that they would face-to-face.

This was echoed again:

*“But I also feel like there are some things that I feel like I wouldn’t want to share online versus in person. It just feels a lot more impersonal.”*

*Trainee Clinical Psychologist 1018, Lines 83-84.*

A feeling of online supervision being more ‘impersonal’ inhibited this supervisee’s desire to share. This highlighted the impact of the physical distance between supervisor and supervisee that may have resulted in a perceived loss of safety and a possible barrier to communicating their vulnerability.

### ***Hurdles to Reflection***

Trainee Clinical Psychologists reflected that online supervision provided hurdles to reflection.

*“Erm, so I guess there’s less depth to it, there’s less opportunity to, there is reflection of course but there’s less opportunity to reflect on so much of that.”*

*Trainee Clinical Psychologist 1012, Lines 256-258.*

This Trainee Clinical Psychologist considered that though reflection was possible in online supervision, the depth was limited and there was reduced space and opportunity to reflect.

This was mirrored in the second quote below:

*“Erm, it would sometimes be that we just talked through what we needed to talk through and then we’d kind of get on. Whereas maybe face-to-face it might have had a bit more maybe depth to it or maybe time to talk about things.”*

*Trainee Clinical Psychologist 1022, Lines 63-66.*

Evidently, for the supervisees the space for reflection was perceived as limited and the focus of online supervision was to complete the necessary work rather than explore their experiences or reflect on other topics. There was a comparison drawn with face-to-face supervision where there may have been more opportunities for reflection and space to explore.

### **Discussion**

This study explored perceptions of online supervision during the Covid-19 pandemic of eleven Trainee Clinical Psychologists and eleven Clinical Supervisors. Four themes were developed: *Context Influences the Content*, *Effects on the Mechanics of Supervision*, *Process Differences – Us* and *Process Differences – Me*, which sought to answer the research question: what are Trainee Clinical Psychologists’ and Clinical Supervisors’

perspectives and experiences of online supervision in the context of the Covid-19 pandemic?

The wider context of the Covid-19 pandemic and lockdown restrictions across the UK, framed the online supervision experiences of all of the participants. The legal mandate to stay at home, expecting supervisors and supervisees to work from home created a physical distance and separation in the supervisory relationship. The use of videoconferencing software to deliver supervision had some strengths regarding structure, consistency, observations and feedback, and boundaries. However, the remote nature of supervision also impacted the processes that typically occur within the relationship building, connection, and rapport. Additionally, some supervisees felt unable to be open or vulnerable in an online context, describing feeling disconnected and perceiving online supervision as more impersonal. Conversely, others experienced online supervision as facilitating openness and diminishing the shame and anxiety surrounding vulnerability. This study highlights the complexity of online supervision and the differences in experiences across Trainee Clinical Psychologists.

In contrast to previous studies, this study considers the impact of the wider context of a pandemic when exploring the perspectives of supervisors and supervisees. Primarily identified as impacting the content of supervision, the context of the Covid-19 pandemic affected what supervisees brought to supervision and the conversations held. Additionally, the background of the pandemic meant that all the participants were attending online supervision as a matter of necessity rather than choice or for research purposes as seen in previous studies (Amanvermez, et al., 2020; Jordan & Shearer, 2019). This may have influenced the experience of online supervision as it may not have been a preferred option; both supervisors and supervisees may have also been impacted personally by the pandemic which may have affected their perception of online supervision.

Participants explained that online supervision did affect fundamental aspects of supervision such as consistency and structure. In line with previous research (Amanvermez,

et al., 2020), the accessibility of online supervision meant that observations and feedback could be facilitated more easily for some participants, and it was possible to maintain the consistency and structure of supervision as it would be face-to-face. However, the maintenance of these important factors was not a shared experience across the whole participant group and some participants described difficulties with facilitating observations online and a negative impact of technical difficulties on reflective conversations.

The shift in supervision boundaries is a theme that has not emerged in previous research on this subject. Within this study, participants predominantly described a blurring of boundaries whilst working online. The contextual impact of working from home meant that supervisors and supervisees were sharing aspects of their lives that would have previously been private. Clinical Supervisors highlighted the negative effects of this change in boundaries including potentially providing distraction and blurring the professional boundaries between supervisee and supervisor.

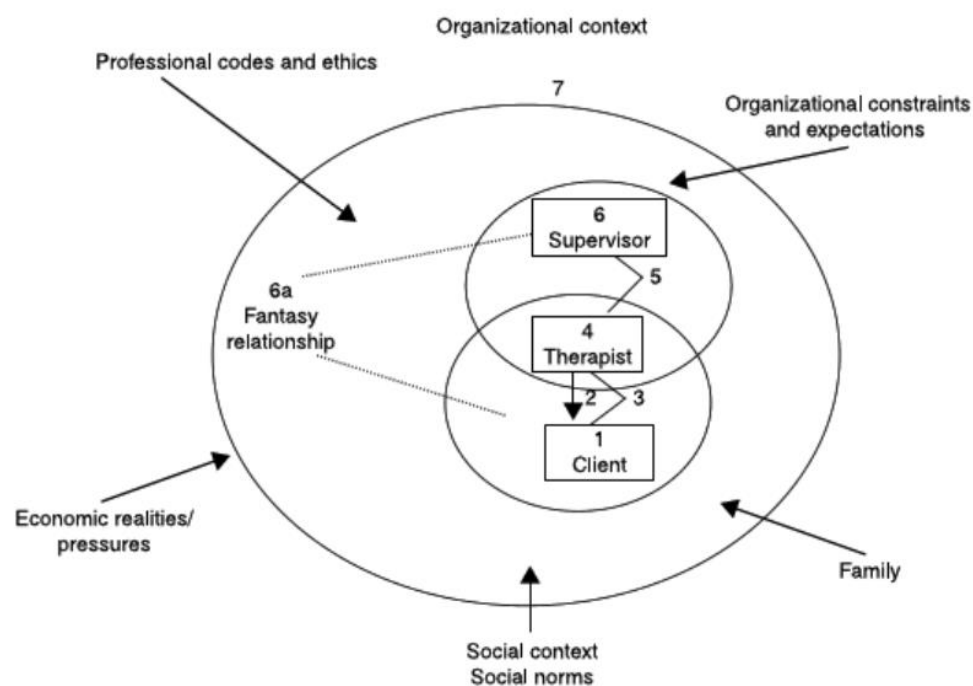
Conversely, some of the Trainee Clinical Psychologists emphasised benefits of the blurred boundaries. The insight into their supervisor's home accentuated the shared experiences and increased the sense of shared humanity. For these Trainee Clinical Psychologists, the shift in boundaries was perceived to reduce the hierarchy and formality that can exist within the supervisory relationship (Egan et al., 2017), instead facilitating an open, authentic, and collaborative experience.

Within this study, some participants did not perceive the supervisory relationship to be impacted and this is consistent with previous research (Tarlow et al., 2020). The majority of supervisors and supervisees in both the Tarlow et al. (2020) study and in the current one had built a relationship prior to beginning online supervision. For those supervisors and supervisees who had not had the opportunity to meet face-to-face, the relationship was perceived as lacking elements of openness and connection, suggesting, that the supervisory relationship can be adversely impacted by online supervision, when a face-to-face

supervisory relationship between the supervisor and supervisee has not previously been established.

Furthermore, the loss of nonverbal communication because of the visual restrictions when engaging via computer screens may have negatively impacted the development of the relationship. Although Amanvermez, et al. (2020) highlighted the loss of nonverbal communication, they did not consider the impact that this may have on the relationship. In the present study, it was evident that the reduced level of nonverbal communication or nonverbal information resulted in limited openness and less opportunities for reflection, and for some supervisees a decrease in safety and containment. Perceived safety is an integral part of the supervisory relationship and enables deeper reflection and exploration within supervision (Palomo et al., 2010).

The impact of online supervision on the inter- and intra-personal aspects of supervision from this study, can be mapped onto the Seven-Eyed model of supervision developed by Hawkins and Shohet (2012; Figure 4).



**Figure 4.** *Seven-Eyed Model (Hawkins & Shohet, 2012)*

The Seven-Eyed model emphasises the importance of reflection within supervision, in particular reflections on the relationships that exist between supervisee and client, the supervisory relationship and the relationship between supervisor and client. They highlight the value of transference when exploring these relationships and suggest that supervisors should be aware of this and the countertransference that is evident between themselves and their supervisee (Hawkins & Shohet, 2012). In this study, supervisors reported that transference was lost because of the difficulties reading nonverbal communication in online supervision. Potential difficulties in determining whether aspects of transference or countertransference were present and perceptions of difficulty developing a safe supervisory relationship may have resulted in a diminution in the salience of multiple processes within supervision. This may also have contributed to a perception of loss among supervisors in relation to more nuanced aspects of the supervisory relationship.

In addition, Hawkins & Shohet (2012) suggest that there should be significant focus on the wider context in which clinical work and supervision are completed. In the present study, participants reflected on the impact that the pandemic had on the content of their supervision and discussions regarding self-care. Furthermore, some participants described having supervisory discussions about the restrictions that online supervision and the pandemic had on endings. However, it is unclear whether wider discussion regarding the impact of the pandemic on the supervision experience took place.

### **Limitations**

The main limitations of this study relate to the participant demographics. All of the participants were female, and the majority (95%) were White. Black, Asian, and Minority Ethnic (BAME) individuals are underrepresented in Clinical Psychology within the UK; roughly 12% of Trainee Clinical Psychologists are from BAME backgrounds (Clearing House for Postgraduate Courses in Clinical Psychology [CHPCCP], 2018) and in 2014, 9.6% of qualified Clinical Psychologists were from a BAME background (Department of Health,

2014). The limited representativeness in terms of both gender and ethnic diversity in the present study will have informed the experiences that were and were not captured.

In addition, a further potential source of bias is that supervisors and supervisees who volunteered to be interviewed may have wanted to share their experiences or may possibly have been more likely to have had significantly negative or positive experiences.

Some of the supervisees and supervisors reported in their interviews that they had developed a supervisory relationship prior to moving online. However, this information was not gathered in the participant demographics and so it is not known what impact this may have had. Furthermore, this means that there was an additional element of heterogeneity in the sample, which may have influenced the findings.

Finally, the impact of the Covid-19 pandemic was acknowledged by all participants, particularly in relation to connection, shared experience, and content. This precise context is unlikely to be experienced again, though similar, or equivalent contexts could arise in the future.

### **Clinical Implications**

Online supervision is likely to continue to be used within clinical environments. In order to establish secure and containing supervisory relationships, supervisors should consider initial face-to-face supervision sessions to establish trust and openness. If this is not possible, supervision contracts and agendas should reflect the importance of discussing the restrictions that online supervision places. Adopting strategies such as extending the length of supervision sessions to include an informal 'chat time' may help to address perceptions of increased professional boundaries and supervisees' perceived sense of 'distance' from the supervisor. Ideally, a combination of both face-to-face and online supervision would enable the supervisory relationship to develop more naturally.

In addition, to facilitate reflective space and openness, building in supplementary supervision sessions to reflect and discuss supervision processes such as the supervisory

relationship and transference and countertransference are recommended in line with the BPS guidelines for digital adaptations for supervision (BPS & DCP, 2020). Holding an extra space for reflection can ensure that it is prioritised and supported.

Trainee Clinical Psychologists and Clinical Supervisors should seek to develop informal spaces where they can 'chat' and reflect. In addition, these informal spaces may provide time to discuss administration queries or reflect on client conversations. Regular informal contact alongside formal supervision sessions may support the development of a secure supervisory relationship.

Recommendations for Clinical Supervisors within their own supervision, include making space to consider those aspects of the supervision processes that may be restricted when engaging in online supervision. Using models such as Hawkins and Shohet's Seven-Eyed model (Hawkins & Shohet, 2012) to explore the processes that supervisors should be aware of in online supervision may help to enhance the supervisory experience for supervisees and should be considered. The provision of online supervision training for supervisors could helpfully incorporate a focus on the restrictions that online supervision faces and suggestions on how to address, mitigate, or overcome those challenges.

Finally, findings of the present study should also inform any future guidelines on supervisory practice that may be developed by the British Psychological Society or the Division of Clinical Psychology.

### **Future Research Recommendations**

Future research could expand on the findings of this study by recruiting a more diverse sample of Trainee Clinical Psychologists and Clinical Supervisors, particularly in terms of gender and ethnicity. Within this study the focus was solely on online supervision; other research could consider a comparison of experience of supervision face-to-face and online to explore differences and similarities. Alternatively, an evaluation of supervisees who have experienced face-to-face supervision and then moved to online compared to those who



have experienced only online supervision could reveal more information regarding the impact of transitioning to online supervision.

Finally, within this study, the Clinical Supervisors had a wide range of supervision experience. Comparing the experiences of supervisors at different points in their supervising experience may provide additional useful information.

### **Conclusion**

This study has reported the diverse experiences of online supervision for twenty-two Trainee Clinical Psychologists and Clinical Supervisors within the context on the Covid-19 pandemic. Results demonstrated that, although online supervision can provide consistency, structure, and observations similar to face-to-face supervision, the impact on the supervisory relationship and supervision processes is significant. The wider impact of the pandemic meant that the content of supervision had changed and there was less space for reflection both for supervisors and for supervisees. It is clear that online supervision has certain strengths as well as providing an alternative modality for the delivery of supervision. However, the adverse impact on the various aspects of clinical supervision evidenced in this study, highlights that it is not necessarily a completely satisfactory alternative. The findings of this study suggest that online supervision should rather be considered as a potentially viable alternative option that may be enhanced if some degree of face-to-face supervision is retained. Considering the processes that can be diminished or enhanced in online supervision would appear vital to the development of appropriate training and clinical guidance. Future research should focus on capturing experiences of more diverse and representative samples and exploring supervisors' experiences in more depth.

## References

- Abbass, A., Arthey, S., Elliott, J., Fedak, T., Nowoweiski, D., Markovski, J., & Nowoweiski, S. (2011). Web-conference Supervision for Advanced Psychotherapy Training: A Practical Guide. *Psychotherapy*, 48(2), 109-118. <https://doi.org/10.1037/a0022427>
- Amanvermez, Y., Zeren, S. G., Erus, S. M., & Buyruk Genc, A. (2020). Supervision and Peer Supervision in Online Setting: Experiences of Psychological Counsellors. *Eurasian Journal of Educational Research*, 86, 249-268. <https://dergipark.org.tr/en/pub/ejer/issue/54088/729899>
- Bang, K., & Park, J. (2009). Korean Supervisors' Experiences in Clinical Supervision. *The Counselling Psychologist*, 37(8), 1042-1075. <https://doi.org/10.1177/0011000009339341>
- Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3, 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V. & Clarke, V. (2019). Reflecting on Reflexive Thematic Analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589-597. <https://doi.org/10.1080/2159676X.2019.1628806>
- Braun, V. & Clarke, V. (2020). One Size Fits All? What Counts as Quality Practice in (reflexive) Thematic Analysis. *Qualitative Research in Psychology*. <https://doi.org/10.1080/14780887.2020.1769238>
- Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). "Thematic Analysis" In *Handbook of Research Methods in Health Social Sciences*, edited by P. Liamputton, 843-860. Springer Nature. [https://doi.org/10.1007/978-981-10-5251-4\\_103](https://doi.org/10.1007/978-981-10-5251-4_103)
- Braun, V., Clarke, V., & Weate, P. (2016). "Using Thematic Analysis in Sport and Exercise Research." In *International Handbook on Qualitative Research in Sport and Exercise*, edited by B. Smith and A. Sparkes, 191–205. Routledge.

British Association for Behavioural & Cognitive Psychotherapies (BABCP). (2020). *Guidance for the Delivery of Remote Supervision*. <https://www.babcp.com/Therapists/COVID-19/Guidance-for-the-Delivery-of-Remote-Supervision.aspx>

British Psychological Society (BPS). (2010). *Additional Guidance for Clinical Psychology Training Programmes: Guidelines on Clinical Supervision*.  
<https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Guidelines%20on%20clinical%20supervision.pdf>

British Psychological Society (BPS). (2017). *Practice Guidelines; Third Edition*.  
<https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Practice%20Guidelines%20%28Third%20Edition%29.pdf>

British Psychological Society. (2018). *Code of Ethics and Conduct*.  
<https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct>

British Psychological Society (BPS). (2020a). *Guidance for Psychological Professionals during the Covid-19 Pandemic*. <https://www.bps.org.uk/news-andpolicy/new-guidance-psychological-professionals-during-covid-19-pandemic>

British Psychological Society (BPS). (2020b). *Adaptations to Psychological Practice: Interim Guidance during Covid-19 Pandemic*.  
<https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Adaptations%20to%20psychological%20practice%20-%20interim%20guidance%20during%20Covid-19.pdf>

British Psychological Society (BPS) & Division of Clinical Psychology (DCP). (2020). *Digital Adaptations to Supervision and Observations*.  
<https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Digital%20adaptations%20to%20supervision%20and%20observations.pdf>

- Chen, S., Jones, P. B., Underwood, B. R., Moore, A., Bullmore, E. T., Banerjee, S., Osimo, E. F., Deakin, J. B., Hatfield, C. F., Thompson, F. J., Artingstall, J. D., Slann, M. P., Lewis, J. R., & Cardinal, R. N. (2020). The Early Impact of Covid-19 on Mental Health and Community Physical Health Services and their Patients' Mortality in Cambridgeshire and Peterborough, UK. *Journal of Psychiatric Research*, 131, 244-254. <https://doi.org/10.1016/j.jpsychires.2020.09.020>
- Clearing House. (2018). Equal Opportunities. Retrieved from: <http://www.leeds.ac.uk/chpccp/equalopps.html>
- Crunk, A. E. & Barden, S. M. (2017). The Common Factors Discrimination Model: An Integrated Approach to Counsellor Supervision. *The Professional Counsellor*, 7(1), 62-75. <http://dx.doi.org/10.15241/aec.7.1.62>
- Cushway, D., & Knibbs, J. (2004). Trainees' and Supervisors' Perceptions of Supervision. In *Supervision and Clinical Psychology*, edited by I. Fleming and L. Steen, 163-187. Brunner-Routledge.
- Dawson, D. L., & Golijani-Moghaddam, N. (2020). COVID-19: Psychological Flexibility, Coping, Mental Health and Wellbeing in the UK During the Pandemic. *Journal of Contextual Behavioural Science*, 17, 126-134. <https://doi.org/10.1016/j.jcbs.2020.07.010>
- Department of Health (2014). NHS Hospital and Community Health Service Non-Medical Workforce Census England: 30 September 2013. Department of Health. <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-hospital-and-community-health-services-medical-and-dental-staff/nhs-hospital-and-community-health-service-hchs-workforce-statistics-in-england-non-medical-staff-2003-2013-as-at-30-september>

- Egan, R., Maidment, J., & Connolly, M. (2017). Trust, Power and Safety in the Social Work Supervisory Relationship: Results from Australian Research. *Journal of Social Work Practice*, 31(3), 307-321. <https://doi.org/10.1080/02650533.2016.1261279>
- Gammon, D., Solie, T., Bergvik, S., & Hoifodt, T. S. (1998). Psychotherapy Supervision Conducted by Videoconferencing: A Qualitative Study of Users' Experiences. *Journal of Telemedicine and Telecare*, 4(1), 33-35. <https://doi.org/10.1258/1357633981931353>
- Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of Data Collection in Qualitative Research: Interviews and Focus Groups. *British Dental Journal*, 204(6), 291-295. <https://doi.org/10.1038/bdj.2008.192>
- Gilleen, J., Santaolalla, A., Valdearenas, L., Salice, C., Fusté, M. (2021). Impact of the Covid-19 Pandemic on the Mental Health and Well-being of UK Healthcare Workers. *British Journal of Psychiatry Open*, 7(3), e88. <https://doi.org/10.1192/bjo.2021.42>
- Groarke, J. M., Berry, E., Graham-Wisener, L., McKenna-Plumley, P. E., McGlinchey, E., & Armour, C. (2020). Loneliness in UK During the Covid-19 Pandemic: Cross-sectional Results from the Covid-19 Psychological Wellbeing Study. *PLoS ONE*, 15(9): e0239698. <https://doi.org/10.1371/journal.pone.0239698>
- Hammersley, M. (2015). Sampling and Thematic Analysis: A Response to Fugard and Potts. *International Journal of Social Research Methodology*, 18(6), 687–688. <https://doi.org/10.1080/13645579.2015.1005456>
- Hawkins, P. (2010). "Coaching Supervision." In *The Complete Handbook of Coaching*, edited by E. Cox, T. Bachkirova, & D. Clutterbuck, 381-393. Sage Publications.
- Hawkins, P., & Shohet, R. (2012). *Supervision in the Helping Professions* (4th ed.). McGraw-Hill Education.

- Johnson, S., Dalton-Locke, C., San Juan, N. V., Foye, U., Oram, S., Papamichail, A., Landau, S., Olive, R. R., Jeynes, T., Shah, P., Rains, L. S., Lloyd-Evans, B., Carr, S., Killaspy, H., Gillard, S., Simpson, A., & The Covid-19 Mental Health Policy Research Unit Group. (2021). *Social Psychiatry and Psychiatric Epidemiology*, 56, 25-37.  
<https://doi.org/10.1007/s00127-020-01927-4>
- Jordan, S. E., & Shearer, E. M. (2019). An Exploration of Supervision Delivered via Clinical Video Telehealth (CVT). *Training and Education in Professional Psychology*, 13(4).  
<http://dx.doi.org/10.1037/tep0000245>
- Kwong, A. S. F., Pearson, R. M., Adams, M.J., Northstone, K., Tilling, K., Smith, D., Fawns-Ritchie, C., Bould, H., Warne, N., Zammit, S., Gunnell, D. J., Moran, P. A., Micali, N., Reichenberg, A., Hickman, M., Rai, D.,... & Timpson, N. J. (2021). Mental Health Before and During the Covid-19 Pandemic in Two Longitudinal UK Population Cohorts. *The British Journal of Psychiatry*, 218(6), 334-343.  
<https://doi.org/10.1192/bjp.2020.242>
- Martin, P., Lizarondo, L., & Kumar, S. (2017). A Systematic Review of the Factors that Influence the Quality and Effectiveness of Tele-supervision for Health Professionals. *Journal of Telemedicine and Telecare*, 24(4), 271-281.  
<https://doi.org/10.1177/1357633X17698868>
- McNeill, B. W., Stoltenberg, C. D., & Romans, J. C. (1992). The Integrated Developmental Model of Supervision: Scale Development and Validation Procedures. *Professional Psychology: Research and Practice*, 23(6), 504-508.  
[https://www.researchgate.net/profile/Brian-Mcneill/publication/232530247\\_The\\_Integrated\\_Developmental\\_Model\\_of\\_Supervision\\_on\\_Scale\\_Development\\_and\\_Validation\\_Procedures/links/56b2953f08ae795dd5c7d292/The-Integrated-Developmental-Model-of-Supervision-Scale-Development-and-Validation-Procedures.pdf](https://www.researchgate.net/profile/Brian-Mcneill/publication/232530247_The_Integrated_Developmental_Model_of_Supervision_on_Scale_Development_and_Validation_Procedures/links/56b2953f08ae795dd5c7d292/The-Integrated-Developmental-Model-of-Supervision-Scale-Development-and-Validation-Procedures.pdf)

- Milne, D. (2007). An Empirical Definition of Clinical Supervision. *British Journal of Clinical Psychology*, 46, 437-447. <https://doi.org/10.1348/014466507X197415>
- Milne, D., Aylott, H., Fitzpatrick, H., & Ellis, M. V. (2008). How Does Clinical Supervision Work? Using a “Best Evidence Synthesis” Approach to Construct a Basic Model of Supervision. *The Clinical Supervisor*, 27(2), 170-190.  
<https://doi.org/10.1080/07325220802487915>
- O'Donovan, A., Halford, W. K., & Walters, B. (2011). Towards Best Practice Supervision of Clinical Psychology Trainees. *Australian Psychologist*, 46(2), 101-112.  
<https://doi.org/10.1111/j.1742-9544.2011.00033.x>
- Palomo, M., Beinart, H., & Cooper, M. J. (2010). Development and Validation of the Supervisory Relationship Questionnaire (SRQ) in UK Trainee Clinical Psychologists. *British Journal of Clinical Psychology*, 49, 131-149.  
<https://doi.org/10.1348/014466509X441033>
- Perry, C. W. (2012). Constructing Professional Identity in an Online Graduate Clinical Training Program: Possibilities for Online Supervision. *Journal of Systemic Therapies*, 31(3), 53-67.  
<https://guilfordjournals.com/doi/pdfplus/10.1521/jsyt.2012.31.3.53>
- Rothwell, C., Kehoe, A., Farook, S., & Illing, J. (2019). The Characteristics of Effective Clinical and Peer Supervision in the Workplace: A Rapid Evidence Review.  
<https://www.hcpc-uk.org/globalassets/resources/reports/research/effective-clinical-and-peer-supervision-report.pdf>
- Rousmaniere, T., Abbass, A., & Frederickson, J. (2014). New Developments in Technology-Assisted Supervision and Training: A Practical Overview. *Journal of Clinical Psychology: In Session*, 70(11), 1082 – 1093. <https://doi.org/10.1002/jclp.22129>

- Simpson, S. (2008). Psychotherapy via Videoconferencing: A Review. *British Journal of Guidance & Counselling*. 37(3), 271-286.  
<https://doi.org/10.1080/03069880902957007>
- Stoltenberg, C. D., Bailey, K. C., Cruzan, C. B., Hart, J. T. & Ukuku, U. (2014). "The Integrative Developmental Model of Supervision" In *The Wiley International Handbook of Clinical Supervision*, edited by C. E. Watkins Jr & D. L. Milne, 576-597. Wiley.
- Tarlow, K. R., McCord, C. E., Nelon, J. L., & Bernhard, P. A. (2020). Comparing in-person Supervision and Tele supervision: A Multiple Baseline Single-case Study. *Journal of Psychotherapy Integration*, 30(2), 383-393. <http://dx.doi.org/10.1037/int0000210>
- Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). "Thematic Analysis" In *The Sage Handbook of Qualitative Research in Psychology*, edited by C. Willig, & S. Rogers, W, 17-36. Sage Publications.
- Tromans, S., Chester, V., Harrison, H., Pankhania, P., Booth, H. & Chakraborty, N. (2020). Patterns of Use of Secondary Mental Health Services Before and During Covid-19 Lockdown: Observational Study. *British Journal of Psychiatry Open*, 6(6), 1-6.  
<https://doi.org/10.1192/bjo.2020.104>
- UK Council for Psychotherapy (UKCP). (2018). *UKCP Practice Guidelines for Supervisors*.  
<https://www.psychotherapy.org.uk/wp-content/uploads/2019/01/UKCP-Practice-Guidelines-for-Supervisors-2018.pdf>
- Wilson, H. M. N., Davies, J. S., & Weatherhead, S. (2016). Trainee Therapists' Experiences of Supervision during Training: A Meta-synthesis. *Clinical Psychology and Psychotherapy*, 23, 340-351. <https://doi.org/10.1002/cpp.1957>



## **Chapter Three**

### **A Reflection on the Research Journey: Working Towards a Position of Safe Uncertainty**

Overall Chapter Word Count at Submission (excluding abstract, tables, figures, and references): 2,861 words

Paper not intended for publication.

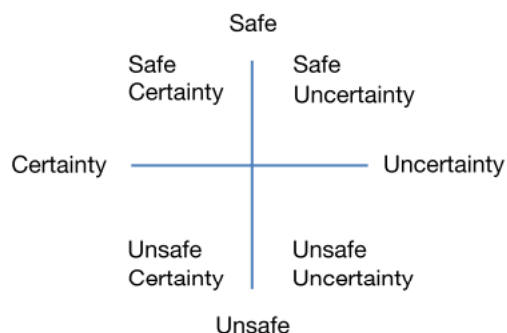
## **Introduction**

The following paper provides an opportunity for personal reflection and exploration on the process of completing this thesis. The paper will focus on the experience of developing a position of safe uncertainty as a researcher by using the safe uncertainty model. The impact of the Covid-19 pandemic and additional challenges of the research process are also explored.

## **Reflective Practice**

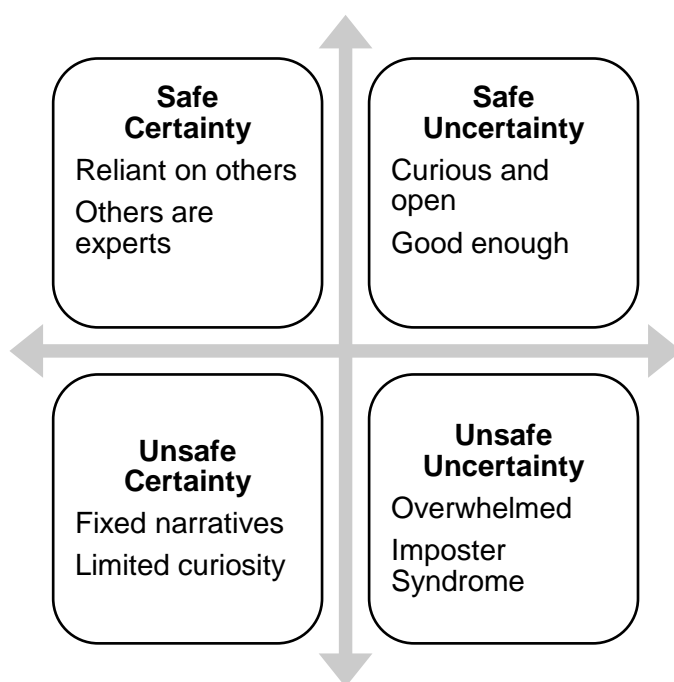
Reflective practice is a key aspect of Trainee Clinical Psychologists' clinical and professional skills (Division of Clinical Psychology; DCP, 2010). Throughout my training, reflective practice has provided opportunities to be open and curious in my clinical work; considering my own privilege and when I am remaining in my 'comfort zone'. Reflection is equally important within research and reflexivity is an integral component of reflexive thematic analysis (Braun & Clarke, 2019). Braun et al. (2019) recommend that researchers should be thoughtful and aware of their assumptions when conducting and analysing qualitative data.

To aid this reflective process and facilitate curiosity, openness and awareness in this paper, the safe uncertainty model (Mason, 1993) will be used. The model has been significant to me throughout my clinical development and has helped me to consider the assumptions and roles that I adopt within therapeutic relationships. Developed by Barry Mason (1993) and used within Family Therapy practice, safe uncertainty is a position that the therapist seeks to support the client and themselves to reach. This position is not fixed and reclaims curiosity encouraging therapists to take time to understand rather than jumping to assumptions about the client and their relationships (Mason, 1993; 2019). In order to thoroughly explore safe uncertainty three alternative positions will also be considered: unsafe uncertainty, unsafe certainty, and safe certainty (Figure 5; Mason, 2019).



**Figure 5.** *Safe Uncertainty Positions (Mason, 1993)*

Each of these positions were experienced in the research process as well as in the experiences described by the participants. Details of the different positions of safe uncertainty that I experienced during the research process are illustrated in Figure 6 and will be referred to throughout the paper.



**Figure 6.** *My Experience of the Four Safe Uncertainty Positions*

### **Unsafe Uncertainty**

Unsafe uncertainty is characterised by a loss of believing in oneself, fear of the future and experience of powerlessness (Mason, 2019). Like many people across the UK, my

experience of unsafe uncertainty was engendered by the onset of the Covid-19 pandemic. The national restrictions and limitations meant that I had to abandon my original thesis research project, leaving me feeling overwhelmed and disappointed. I found myself feeling burdened with the task of developing a new research project that resonated with me and would be possible within the new limitations. The weight of this uncertainty resulted in me questioning my abilities as a researcher and skills as a clinician. I struggled to find meaning and reason in the sudden change of circumstances which was confounded by the loss of support from my cohort. The physical distance enforced by the lockdown meant that I was unable to meet or speak to my course mates face-to-face. I noticed that this distance resulted in me feeling less able to share my feelings and unsafe uncertainty difficulties with them through online platforms. Interestingly, this experience of feeling less able to share was echoed in some of the research interviews with Trainee Clinical Psychologists for my empirical paper, who reflected that online supervision was at times, an obstacle to vulnerability and sharing with their supervisors.

This experience of unsafe uncertainty resurfaced whilst I was finding a topic for the systematic literature review (SLR). I felt overwhelmed by the task and choosing an appropriate idea. I experienced feelings of being stuck with the SLR and my view of myself as a researcher. I found myself believing that I did not have the skills to complete the SLR and realised I was forming a narrative of 'I can't do this'. This narrative of 'I can't do this' has been a story that I have experienced repeatedly throughout the doctoral course, reflecting my experience of feelings of inadequacy or imposter syndrome. Feelings of inadequacy are common amongst therapists, particularly Trainee Clinical Psychologists (Thériault & Gazzola, 2006; Woodward et al., 2015). Imposter syndrome has equally been demonstrated as widespread amongst academic researchers at the early stages of their research careers (Gill, 2020). Discussions within clinical supervision during clinical placements and in my own personal therapy had highlighted my experience of imposter syndrome in my clinical work, however I was surprised to find this narrative had crept into my role as a researcher. The

position of unsafe uncertainty had also exacerbated my experience of imposter syndrome and narratives, which I became increasingly aware of throughout the research process.

Alongside that internal narrative and experience of imposter syndrome, I noticed the impact of power whilst in the unsafe uncertainty position. Initially when I was interviewing supervisors, I found the process challenging. As the interviewer I was supposedly in a position of power, directing the questions and reflections. However, interviewing supervisors with many years of clinical experience and knowledge felt daunting and left me feeling powerless. Power dynamics within clinical supervision can be inherent because of the hierarchical structure of supervision (Cook et al. 2018). Power imbalance can also exist within qualitative interviews between interviewer and interviewee (Anyan, 2013). My experience of power dynamics in clinical supervision was mirrored in the interviews, I placed the supervisor in a position of greater power as the more experienced clinician. I noticed a pull to impress them during the interview and demonstrate my knowledge and experience rather than remaining focussed on the interview and gaining their perspective of online supervision. McNair et al. (2008), recommend using reflexivity and reciprocity within qualitative interviews to manage power dynamics, encourage open dialogue, and enhance rapport. During interviews where I disclosed small elements of my own experience of online supervision, I found my perception of the power dynamics changed. Acknowledging the shared experience emphasised the collaborative nature of the interview and importance of understanding between myself and the supervisors.

### **Unsafe Certainty**

The domain of unsafe certainty is characterised by a reduction in curiosity of other's perspectives and a fixed position in one's own opinions and points of views (Mason, 2019). On reflection, I have noticed that the positions of unsafe uncertainty and unsafe certainty were closely related and held similar experiences for me. The start of the project and experience of insecurity in my new choice of research topic served to maintain the narrative of 'I can't do this' and my sense of imposter syndrome as a researcher. As I began to collect

qualitative data through interviews, I noticed that I became increasingly anxious during each exchange. The bracketing interview completed prior to data collection highlighted that I was open to different experiences and did not appear to hold any bias towards a particular outcome or theme. However, my reflective diary revealed a different story, whilst conducting my first interviews with supervisors and supervisees my curiosity was limited and I was intent on following one narrative. The narrative that I appeared to be focussed on mirrored my own experience of online supervision; distant, limited and less reflective. I had entered the interview stage of my research with this narrative fixed at the forefront of my mind and convinced that all of the participants would share this experience. This fixed narrative limited my curiosity and openness during interviews, and I held back from asking further questions or reflecting on comments that participants made.

This position of comfort in that dominant narrative was shaken when I interviewed a supervisee who had a positive and affirming experience of online supervision. I was surprised and caught off guard; until this point the other interviews had fitted with my narrative and I was certain that I had captured the experiences of my participants. I then noticed that my first interviews had been shorter and at points, were perhaps lacking in depth. I had been drawn into the trap of the 'insider-outsider controversy' where clinician-researchers are seen by themselves or participants as an insider because of their shared experience with their participants (McNair et al., 2008). This can result in the blurring of boundaries between research and participant as well as 'shared conceptual blindness', where typically the participant may become less cautious and guarded during the interview because of the common language and shared understanding with the researcher who is also a peer (Probst, 2015). However, in my case the shared conceptual blindness resulted in my becoming less cautious and curious during the interviews. The shared experience of online supervision and my own bias had impacted my sense of the boundaries between myself as a researcher and the participants, and to some degree, this may have been narrowing the focus of the data.

At this point in the research process, my chosen narrative was disproven, which meant that I was now able to accept (tentatively) different perspectives and a new diversity in the data. I observed that I began to ask more follow-up questions during interviews, to draw out more information and seek a full understanding of their experience. I was able to be curious without feeling scared of the outcome. This increased curiosity resulted in longer interviews with candid and authentic experiences reported by participants which described both positive and negative aspects of online supervision.

### **Safe Certainty**

The third domain in the safe uncertainty model, the position of safe certainty is described as the place everyone wishes to be, which provides unquestionable safety and security (Mason, 2019). This safety and security can often come from other people or processes. In the context of the pandemic, Sim (2020) compared safe certainty to the experience of wearing a mask and adhering to lockdown restrictions in an effort to combat the Covid-19 virus. People became reliant on masks and restrictions enforced and created by others to protect them from the virus.

I noticed that my own experience of safe certainty was marked by my reliance on others, positioning others as experts, and finding safety in familiar processes. After developing a new research project, submitting a proposal to the ethics board, and completing my interviews I felt exhausted and in search of safe foundations to build my research on. I had chosen reflexive thematic analysis as the method of data analysis as it provided a flexible approach to analytic process (Braun & Clarke, 2019) and because I was familiar with the process from my master's degree. This familiarity with the analysis brought a sense of comfort and security, perhaps I now knew what I was doing and the continuing story of 'I can't do' this would no longer apply.

However, whilst generating themes from the data, the familiar shadow of imposter syndrome crept in. My passion for the data and desire to share my participants stories fully and authentically left me doubting my ability to develop themes that adequately illustrated

the richness of their experiences. In desperation to reclaim safe certainty I reached out to my research supervisors to help navigate the theme development. I hoped that my supervisors with their many years of experience and knowledge would be able to generate expert and perfect themes that illustrated my participants experience in a way that I believed I was unable to achieve. However, my supervisors met me with curiosity, encouragement, and reflexivity. They had suggestions for theme names and grouping of codes and yet they reflected that I was the expert. The hours that I had spent immersed in the data and the passion I felt for the stories I had heard, meant that I was best placed to generate the themes and illustrate the stories authentically. This position of myself as the expert was in contradiction with my experience of imposter syndrome and the well told story of 'I can't do this'. I was unsure how to hold this position tentatively in a way that would provide safety and curiosity. It was at this point in the research process that I reflected on the position of safe uncertainty and the curiosity, openness, and evolving characteristics that underpin this domain.

### **Safe Uncertainty**

Mason describes safe uncertainty as an evolving position where doubts, uncertainty, and discomfort can be safely explored and developed (Mason 1993; 2019). Integral to safe uncertainty are curiosity and openness; two central aspects of systemic family therapy (Brown, 2010; Cecchin, 1987). Within the research process working towards safe uncertainty allowed me to acknowledge my imposter syndrome and self-doubt and accept that it was part of my journey. This acceptance was particularly important whilst developing and writing the systematic literature review. The SLR was a new challenge for me and felt difficult and daunting. At the beginning of the research process, when confronted with this new challenge I had listened to the narrative of 'I can't do this' and allowed the imposter syndrome to become my identity. From a position of safe uncertainty, I was able to recognise and embrace these old stories and approach them with curiosity and openness. This process of



curiosity reminded me that these stories were based in my values of doing my best and working hard.

In Acceptance and Commitment Therapy (ACT), values are defined as guiding principles that are reflections of what an individual finds meaningful (Reilly et al., 2019). My experience of imposter syndrome and the importance I placed in completing the SLR reflected my value of industry or to work hard and be dedicated. Refocussing on my values and the drive behind completing the SLR enabled me to hold the 'I can't do this' story lightly, accepting that it was present and continuing to move forward towards my values.

Whilst working towards a position of safe uncertainty, I was also reminded of the phrase good enough. Though my value of industry drove my desire to complete the SLR and whole research project well, at times this value could be compromised by my chosen behaviours (Wersebe et al., 2017). In order to manage my imposter syndrome, I placed high expectations on myself, forcing my work to be perfect and without flaws. Focussing on safe uncertainty encouraged me to be open to my work not being perfect. The concept of good enough was introduced by Winnicott and Buttellheim specifically regarding good enough parenting (Ramaekers & Suissa, 2011). Accepting things as good enough can humble us and help us be kinder and more accepting of our mistakes (Rabin, 2014). For me, accepting my work could be good enough and not perfect felt daunting. However, from a position of safe uncertainty, I did not need to avoid these difficult feelings and could embrace a place of good enough that was both safe and at times uncertain.

### **My Personal Learning**

Using the safe uncertainty model to explore the research process and my reflections has been enlightening. I was aware of my internal battles with imposter syndrome and stories of 'I can't do this' from my clinical work and supervision. However, I had not considered that these narratives could also affect my role as a researcher.

I had always assumed that my roles as clinician and researcher were very separate requiring different skills and responsibilities. The British Psychological Society (BPS; 2019) recommends that Trainee Clinical Psychologists should develop skills which reflect both scientist-practitioners and reflective practitioners. The scientist-practitioner model is based on the idea that Clinical Psychologists should have skills in research and clinical practice (Jones & Mehr, 2007). There is some debate that the scientist-practitioner model is less valid for Clinical Psychologists as the roles of clinician and researcher are in conflict (Blair, 2010; Long & Hollin, 1997). However, this model enables psychologists to evaluate their own clinical work and effectiveness as practitioners (Blair, 2010).

Alternatively, the reflective practitioner role requires clinicians to take a metacognitive approach and reflect on the wider picture of their therapeutic and clinical work (Youngsson, 2009). The combination of these roles, the reflective scientist-practitioner enables Clinical Psychologists to place equal priority on a scientific, research role, and self-reflection (Blair, 2010). This reflective scientist-practitioner role fits with my experience of the research process. My roles as clinician and researcher are not in conflict but combined by the importance of reflection and self-awareness. Reflecting on my own biases and assumptions within my clinical work helps me to identify possible transference and countertransference during therapeutic sessions and within my research projects, this self-awareness allows me to identify any subjectivity and remain curious and open during data collection and analysis.

### **Future Directions**

As the final stages of this thesis project approach, I am looking towards my role as a qualified psychologist. Previously, I had not associated this role with research and thought I would focus on the therapeutic aspects of the job. However, this reflective process has encouraged me to continue to develop my research skills and embrace the role of reflective scientist-practitioner. Considering research opportunities such as audits, evaluations of therapeutic interventions and using outcome measures with clients are different ways that I can continue to engage with research within a clinical setting.

Additionally, I will endeavour to continue my journey towards the position of safe uncertainty. Increasing my awareness of the narratives that influence me throughout my clinical and research roles will support this journey, as well as continuing to develop my skills in curiosity and openness moving forward.

## References

- Anyan, F. (2013). The Influence of Power Shifts in Data Collection and Analysis Stages: A Focus on Qualitative Research Interview. *The Qualitative Report*, 18(36), 1-9.  
<https://doi.org/10.46743/2160-3715/2013.1525>
- Blair, L. (2010). A Critical Review of the Scientist-practitioner Model for Counselling Psychology. *Counselling Psychology Review*, 25(4), 19-30.  
[https://www.researchgate.net/profile/Lewis\\_Blair/publication/272021892\\_A\\_critical\\_review\\_of\\_the\\_scientist\\_practitioner\\_model\\_for\\_counselling\\_psychology/links/54ff0f9e0cf2741b69f2122b.pdf](https://www.researchgate.net/profile/Lewis_Blair/publication/272021892_A_critical_review_of_the_scientist_practitioner_model_for_counselling_psychology/links/54ff0f9e0cf2741b69f2122b.pdf)
- Braun, V. & Clarke, V. (2019). Reflecting on Reflexive Thematic Analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589-597.  
<https://doi.org/10.1080/2159676X.2019.1628806>
- Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). "Thematic Analysis" In *Handbook of Research Methods in Health Social Sciences*, edited by Liamputton, P., 843-860. Springer Nature. [https://doi.org/10.1007/978-981-10-5251-4\\_103](https://doi.org/10.1007/978-981-10-5251-4_103)
- British Psychological Society. (2019). *Standards for the Accreditation of Doctoral Programmes in Clinical Psychology*.  
<https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%202019.pdf>
- Brown, J. (2010). The Milan Principles of Hypothesising, Circularity and Neutrality in Dialogical Family Therapy: Extinction, Evolution, Eviction... or Emergence? *The Australian and New Zealand Journal of Family Therapy*, 31(3), 248-265.  
<https://doi.org/10.1375/anft.31.3.248>
- Cecchin, G., (1987). Hypothesizing, Circularity, and Neutrality Revisited: An Invitation to Curiosity. *Family Process*, 26(4), 405-413. <https://doi.org/10.1111/j.1545-5300.1987.00405.x>

- Cook, R. M., McKibben, W. B., & Wind, S. A. (2018). Supervisee Perception of Power in Clinical Supervision: The Power Dynamics in Supervision Scale. *Training and Education in Professional Psychology, 12*(3), 188-195.  
<https://doi.org/10.1037/tep0000201>
- Division of Clinical Psychology (2010). *Clinical Psychology Leadership Development Framework*. Leicester.  
<https://www.bps.org.uk/sites/bps.org.uk/files/Member%20Networks/Faculties/>
- Gill, P. (2020). Imposter Syndrome: Why is it So Common Amongst Nurse Researchers and is it Really a Problem? *Nurse Researcher, 28*(3).  
<http://dx.doi.org/10.7748/nr.2020.e1750>
- Jones J. L. & Mehr, S. L. (2007). Foundations and Assumptions of the Scientist-Practitioner Model. *American Behavioural Scientist, 50*(6), 766-771.  
<https://doi.org/10.1177/0002764206296454>
- Long, C. G., & Hollin, C. R. (1997). The Scientist-Practitioner Model in Clinical Psychology: A Critique. *Clinical Psychology and Psychotherapy, 4*(2), 75-83.  
[https://doi.org/10.1002/\(SICI\)1099-0879\(199706\)4:2<75::AID-CPP116>3.0.CO;2-E](https://doi.org/10.1002/(SICI)1099-0879(199706)4:2<75::AID-CPP116>3.0.CO;2-E)
- Mason, B. (1993). Towards Positions of Safe Uncertainty. *Human Systems, 4*(3-4), 189-200.  
<https://sfwork.com/resources/interaction/04Mason.pdf>
- Mason, B. (2019). Re-visiting Safe Uncertainty: Six Perspectives for Clinical Practice and the Assessment of Risk. *Journal of Family Therapy, 41*(3), 343-356.  
<https://doi.org/10.1111/1467-6427.12258>
- McNair, R., Taft, A., & Hegarty, K. (2008). Using Reflexivity to Enhance In-depth Interviewing Skills for the Clinician Research. *BMC Medical Research Methodology, 8*(73).  
<https://doi.org/10.1186/1471-2288-8-73>

- Probst, B. (2015). The Eye Regards Itself: Benefits and Challenges of Reflexivity in Qualitative Social Work Research. *Social Work Research*, 39(1), 37-48.  
<https://doi.org/10.1093/swr/svu028>
- Rabin, C. (2014). Winnicott and 'Good Enough' Couple Therapy. Reflections of a Couple Therapist. Routledge.
- Ramaekers, S., & Suissa, J. (2011). Good Enough Parenting? In: *The Claims of Parenting. Contemporary Philosophies and Theories in Education*, vol 4. Springer.  
[https://doi.org/10.1007/978-94-007-2251-4\\_4](https://doi.org/10.1007/978-94-007-2251-4_4)
- Reilly, E. D., Ritzert, T. R., Scoglio, A. A. J., Mote, J., Fukusa, S. D., Ahern, M. E., & Kelly, M. M. (2019). A Systematic Review of Values Measures in Acceptance and Commitment Therapy Research. *Journal of Contextual Behavioural Science*, 12, 290-304. <https://doi.org/10.1016/j.jcbs.2018.10.004>
- Sim, T. (2020). Safe Uncertainty: Reflecting on the Pandemic Responses of Two Asian Cities. *Qualitative Social Work*, 20(1-2), 305-311.  
<https://doi.org/10.1177/1473325020973331>
- Thériault, A. & Gazzola, N. (2006). What are the Sources of Feelings of Incompetence in Experienced Therapists? *Counselling Psychology Quarterly*, 19(4), 313-330.  
<https://doi.org/10.1080/09515070601090113>
- Wersebe, H., Lieb, R., Meyer, A. H., Hoyer, J., Wittchen, H-U., & Gloster, A. T. (2017). Changes of Valued Behaviours and Functioning during an Acceptance and Commitment Therapy Intervention. *Journal of Contextual Behavioural Science*, 6(1), 63-70. <https://doi.org/10.1016/j.jcbs.2016.11.005>
- Woodward, N. S., Keville, S., & Conlan, L-M. (2015). The Buds and Shoots of What I've Grown to Become: The Development of Reflective Practice in Trainee Clinical

Psychologists. *Reflective Practice* 16(6), 777-789.

<https://doi.org/10.1080/14623943.2015.1095728>

Youngson, S. (2009). "Personal Development in Clinical Psychology: The Context." In *Personal Development and Clinical Psychology*, edited by J. Hughes & S. Youngson, 8-23. Blackwell.

## Appendices

### Appendix A. Author Guidelines for the Journal of Pain and Symptom Management

#### Types of Articles

The *Journal of Pain and Symptom Management* publishes the following types of articles:

**Note: JPSM publishes descriptions of original research findings in multiple sections. Please submit new work of this type to the appropriate section based on the description below.**

*Original Articles* may describe research studies of any type or design. The section is appropriate for articles describing methodologically rigorous studies and studies that generate complex results. Articles that describe clinical trials should generally comport with the Consolidated Standards of Reporting Trials (CONSORT) Statement and guidelines (see <http://www.consort-statement.org> and its links). Clinical trials also must be registered at an accepted online repository before enrollment. Most Phase II and Phase III trials should be registered at either the National Institute of Health site, <http://www.clinicaltrials.gov>, or the International Standard Randomized Controlled Trials site, <http://www.controlled-trials.com> (see <http://www.clinicaltrials.gov> for guidance concerning the types of trials that must be registered). The maximum length for Original Articles is 3500 words (not including Abstract or references) and the text should be divided into sections with the headings Abstract (see below), Introduction, Methods, Results, Discussion, Disclosures and Acknowledgments, and References. In the Methods section of an article describing a clinical trial, please include a statement about where the registration information is available.

*Brief Reports* may describe research studies of any type or design. The section is appropriate for work that can be described succinctly, often because it is preliminary, largely confirmatory, or limited by its design or methodology. Articles that describe clinical trials should generally comport with the Consolidated Standards of Reporting Trials (CONSORT) Statement and guidelines (see <http://www.consort-statement.org> and its links). Clinical trials also must be registered at an accepted online repository before enrollment. The maximum length of a Brief Report is 2500 words (not including Abstract or references) and the text should be divided into sections with the headings Abstract (see below), Introduction, Methods, Results, Discussion, Disclosures and Acknowledgments, and References.

*Brief Methodological Reports* present research studies that are intended to expand the measurement capabilities of existing instruments. Although translation may be part of the reported work, appropriate submissions typically describe validation or statistical innovation. The maximum length is 2500 words (not including Abstract or references) and the text should be divided into sections with the headings Abstract (see below), Introduction, Methods, Results, Discussion, Disclosures and Acknowledgments, and References.

*Brief Quality Improvement Reports* present quality improvement research. Appropriate submissions describe the problem that has been addressed, the quality framework used to implement change, and the specific methods and outcomes. Details sufficient to encourage replication are encouraged. The maximum length is 2500 words (not including Abstract or references) and an Abstract is required (see below). Suggested headings include Background, Measures, Intervention, Outcomes, Conclusions/Lessons Learned.

*Clinical Notes* are case series or small observational studies describing new or interesting clinical observations. The maximum length is 2500 words (not including Abstract or references) and an Abstract is required (is required). Suggested headings include Introduction, Methods, Results, Discussion, Disclosures and Acknowledgments, and References.

*Palliative Care Rounds* use a case to describe an important clinical condition or syndrome, and then provide a brief narrative review of the evidence supporting best practices of assessing and/or managing that condition. The narrative review should include a description of the condition or syndrome, prevalence and pathophysiology, and a concise summary of treatment options with the evidence supporting each. The maximum length is 2500 words (not including references), and an Abstract is not required. Suggested headings include Introduction, Case Description, Discussion, and References.

*Letters* may be used to report case descriptions or preliminary observations acquired through studies. They are also a forum for opinion, including specific comments related to a previously published article. Letters may undergo external review, and those that comment on a prior JPSM publication are typically forwarded to the authors of this publication for a response. Letters are published online only; the title and a link to



the *JPSM* website appears in the contents of the printed Journal. The maximum length for all types of Letters is 1250 words (not including references); no more than 10 references and one table or figure is suggested. Letters should begin with "To the Editor." Those that describe research findings may use additional headings, include Methods, Results, Comment, and References; those that present a case description may include the headings Case Description, Comment, and References.

**Note: *JPSM* publishes clinical observations, experiences and reviews of existing work in multiple sections. Please submit new work of this type to the appropriate section based on the description below.**

*Reviews* describe and evaluate previously published material. The emphasis is on systematic reviews, but high-quality narrative reviews will be considered. Systematic reviews should comport with the minimum standards described in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (<http://www.prisma-statement.org>) or comparable guideline. The maximum length of a Review is 7000 words and an Abstract is required (see below).

*Special Articles and Special Series Articles* *JPSM* may consider an article that does not fit into other sections as a Special Article. In some cases, a thematically-linked group of these articles is developed as a Special Series on behalf of an organization or through the efforts of an individual. Topics have included program descriptions, meeting proceedings, calls for research, new hypotheses, and descriptions of understudied or poorly recognized areas of clinical interest. The maximum length of a Special Article is 7000 words and an Abstract is required (see below).

**Note: *JPSM* publishes reports that focus on specific areas or interests, as described below. Please submit new work to the appropriate section.**

*Ethical Issues in Palliative Care* couple a case description that includes an observation or experience with important ethical implications to a brief narrative review that provides a bioethical analysis. The maximum length is 2500 words (not including Abstract or references) and an Abstract is not required. Suggested headings include Introduction, Case Description, Defining Issues and Ethical Analysis, Conclusion of the Case, Comment, and References.

*Humanities: Art, Language, and Spirituality in Health* presents experiences and observations that epitomize the humanistic concerns and challenges encountered in the care of seriously ill patients and their families. Articles may be case descriptions or personal accounts. The maximum length is 2500 words and an Abstract is not required. Authors interested in submitting work to this section are strongly encouraged to write the Managing Editor to indicate this interest and describe the planned submission. Feedback about the proposed submission will be provided by an Editor of this section.

*Therapeutic Reviews* present and critically evaluate the use of specific drugs and drug classes used in palliative care. This section represents an ongoing collaboration between *JPSM* and the Editors of <https://www.palliativedrugs.com>, at which additional content is provided. Authors interested in submitting similar content should consider other sections of *JPSM*, including Reviews or Special Articles.

*Methodological Reviews for Hospice and Palliative Care Research.* For this section of the Journal, we are interested in manuscripts addressing important methodological issues that are particularly relevant to hospice and palliative care research. Examples include, but are not limited to: measurement methods for important outcomes, study recruitment and retention strategies, research design, research innovations, meaningful stakeholder engagement, and analytic methods. The maximum length is 3500 words (not including Abstract or references). A narrative Abstract is required and limited to 250 words. Text should be divided into sections: Abstract, Introduction, Methods, Results, Discussion, Disclosures and Acknowledgments, and References.

*Educational Exchange* describes innovations related to pedagogy in palliative care. The maximum length is 2500 words and an Abstract is not required. Authors interested in submitting work to this section are strongly encouraged to write the Managing Editor to indicate this interest and describe the planned submission. Feedback about the proposed submission will be provided by an Editor of this section.

*Media Reviews* Books, monographs, films, and other materials submitted for review should be sent to the editorial office of the Journal, c/o David Newcombe, *Journal of Pain and Symptom Management*, 20 North Street, Plymouth, MA 02360, USA.

## **Manuscript Submission**

The *JPSM* uses a web-based online manuscript submission and review system. Please go to <https://www.editorialmanager.com/JPSM/default.aspx> to submit your manuscript electronically. The website guides authors stepwise through the creation and uploading of the various files.

All correspondence, including the Editor's decision and request for revisions, will be by e-mail. Authors may send queries concerning the submission process, manuscript status, or journal procedures to the Editorial Office at [JPSM@Stellarmed.com](mailto:JPSM@Stellarmed.com).

### **Submission checklist**

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

#### **Ensure that the following items are present:**

One author has been designated as the corresponding author with contact details:

- E-mail address
- Full postal address

All necessary files have been uploaded:

*Manuscript:*

- Include keywords
- All figures (include relevant captions)
- All tables (including titles, description, footnotes)
- Ensure all figure and table citations in the text match the files provided
- Indicate clearly if color should be used for any figures in print

*Graphical Abstracts / Highlights files* (where applicable)

*Supplemental files* (where applicable)

Further considerations

- Manuscript has been 'spell checked' and 'grammar checked'
- All references mentioned in the Reference List are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Internet)
- A competing interests statement is provided, even if the authors have no competing interests to declare
- Journal policies detailed in this guide have been reviewed
- Referee suggestions and contact details provided, based on journal requirements

For further information, visit our [Support Center](#).

### **Ethics in publishing**

Please see our information pages on [Ethics in publishing](#) and [Ethical guidelines for journal publication](#).

### **Conflict of interest**

All authors MUST disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential conflicts of interest include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. A conflict of interest form is integrated into the submission process and must be completed before your submission is finalized. See also <https://www.elsevier.com/conflictsofinterest>.

### **Submission declaration**

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis or as an electronic preprint, see <https://www.elsevier.com/postingpolicy>), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere including electronically in the same form, in English or in any other language, without the written consent of the copyright-holder. This information may be included in the cover letter.

### **Use of inclusive language**

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Content should make no assumptions about the beliefs or commitments of any reader; contain nothing which might imply that one individual is superior to another on the grounds of age, gender, race, ethnicity, culture, sexual orientation, disability or health condition; and use inclusive language throughout. Authors should ensure that writing is free from bias, stereotypes, slang, reference to dominant culture and/or cultural assumptions. We advise to seek gender neutrality by using plural nouns ("clinicians, patients/clients") as default/wherever possible to avoid using "he, she," or "he/she." We recommend avoiding the use of descriptors that refer to personal attributes such as age, gender, race, ethnicity, culture, sexual orientation, disability or health condition unless they are relevant and valid. These guidelines are meant as a point of reference to help identify appropriate language but are by no means exhaustive or definitive.

### Editor's note regarding race

In an effort to critically review the Journal's standards and practices, we are implementing the following guidance principles for the treatment of race and racial disparities in manuscripts that are submitted for consideration:<sup>1</sup>

- Race should be clearly defined, and the rationale for including race as a variable should be clearly stated;
  - Authors should address systemic racism, calling it out by name and identifying the form it takes (e.g. internalized, personally mediated, institutionalized);<sup>2</sup>
  - Authors should not present 'mistrust' as a proximal cause of inequities or disparities, without exploring the contribution of systemic racism to mistrust;
  - Manuscripts should avoid genetic arguments that are grounded in race;
  - Analysis and interpretation of race as an explanatory variable should utilize Critical Race Theory or an equivalent construct that moves beyond simple descriptions of disparities and facilitates planning and action.<sup>3</sup>
1. Boyd RW, Lindo EG, Weeks LD, McLemore MR. On racism: A new standard for publishing on racial health inequities. Health Affairs Blog, July 2, 2020. Available at: [https://www.healthaffairs.org/doi/10.1377/hblog20200630.939347/full/?utm\\_medium=social](https://www.healthaffairs.org/doi/10.1377/hblog20200630.939347/full/?utm_medium=social). Access verified July 29, 2020.
  2. Jones CP. Levels of Racism: A theoretic framework and a gardener's tale. American Journal of Public Health. 200; 90:1212-1215.
  3. Ford CL, Airhihenbuwa CO. Critical race theory, race equity, and public health: Toward antiracist praxis. American Journal of Public Health. 2010; 100:S30-S35

### Copyright

Upon acceptance of an article, authors will be asked to complete a 'Journal Publishing Agreement' (see [more information](#) on this). An e-mail will be sent to the corresponding author confirming receipt of the manuscript together with a 'Journal Publishing Agreement' form or a link to the online version of this agreement.

Subscribers may reproduce tables of contents or prepare lists of articles including abstracts for internal circulation within their institutions. [Permission](#) of the Publisher is required for resale or distribution outside the institution and for all other derivative works, including compilations and translations. If excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has [preprinted forms](#) for use by authors in these cases.

For gold open access articles: Upon acceptance of an article, authors will be asked to complete a 'License Agreement' ([more information](#)). Permitted third party reuse of gold open access articles is determined by the author's choice of [user license](#).

### Author rights

As an author you (or your employer or institution) have certain rights to reuse your work. [More information](#). Manuscripts should be submitted exclusively to the *Journal of Pain and Symptom Management*. Manuscripts are reviewed and edited with the understanding that the authors are transferring all copyright ownership to the American Academy of Hospice and Palliative Medicine.

### Elsevier supports responsible sharing

Find out how you can [share your research](#) published in Elsevier journals.

### Role of the funding source

You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement then this should be stated.

### Open access

Please visit our [Open Access page](#) for more information.

### Language (usage and editing services)

Manuscripts should be written in proper English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's WebShop <https://webshop.elsevier.com/language-editing-services/language-editing/> or visit our customer support site <https://service.elsevier.com> for more information.

### Confidentiality/Informed Consent/IRB or Ethics Committee Review

It is the author's responsibility to ensure patient anonymity in case reports and elsewhere. Identifying information such as names, initials, hospital numbers, and dates must be avoided. Reports of studies involving human subjects must include a statement verifying:

1) that all patients/other participants provided written informed consent or that an institutional review board/ethics committee determined that informed consent was not required; and 2) the study was approved by the investigator's institutional review board/ethics committee.

### Submission

Our online submission system guides you stepwise through the process of entering your article details and uploading your files. The system converts your article files to a single PDF file used in the peer-review process. Editable files (e.g., Word, LaTeX) are required to typeset your article for final publication. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

### Clinical Trial Registration

JPSM requires that human clinical trials are registered before enrollment in order for the results to be published in the journal. Most Phase II and Phase III trials should be registered at either the National Institute of Health site at <http://www.clinicaltrials.gov>, the International Standard Randomized Controlled Trials site at <http://www.controlled-trials.com>, or an equivalent national site for public reporting of trials. For questions about the requirement to register at <http://www.clinicaltrials.gov>, please consult the Checklist and Elaboration for Evaluating Whether a Clinical Trial or Study is an Applicable Clinical Trial, which is available on the site. The Methods section of the paper reporting the results of a clinical trial should contain a statement about where the registration information is available to the public.

### Submit your article

Please submit your article via <https://www.editorialmanager.com/JPSM/default.aspx>.

### Peer Review

Manuscripts submitted to the *Journal of Pain and Symptom Management* undergo initial editorial review. Selected manuscripts are sent for external peer review. Note that reviewers are not blinded as to the author's identity.

### Manuscript Preparation

Submission items include a cover letter and all elements of the manuscript (including title page, key words, running title, manuscript text, disclosures and acknowledgments, references, tables and figures). Complete instructions for electronic artwork submission can be found at [www.elsevier.com/artwork](http://www.elsevier.com/artwork).

### Preparing Electronic Files

Text and graphics may be submitted as separate files in the following formats:

**Text:** Use Microsoft Word, WordPerfect, WordPro or Rich Text Format (.rtf). Check the accuracy of all file conversions.

**Graphics:** Create digital artwork after consulting the [Artwork and media instructions](#) page, which contains appropriate instructions. Please note that Elsevier allows the submission of MS Office files (Word, PowerPoint, Excel) provided that they meet certain criteria (see information given on Electronic Artwork website). It is preferred to save files in JPEG or TIFF format. Label figures as referenced in text and include a list of figure legends.

### Essential title page information

The title page must include: all authors' full first and last names, degrees, and current institutional affiliations, cities and countries; the name, address, and e-mail address of the designated corresponding author; and a list of the number of tables, figures, and references and the word count for the submission.

### Abstract, Key Message, Key Words, and Running Title

**Abstract:** A concise, **structured** abstract of not more than 250 words is required for Original Articles, Review Articles, Brief Reports, and Brief Methodological Reports. The abstract should have the following headings:

Context, Objectives, Methods, Results, and Conclusion. For Clinical Notes, Palliative Care Rounds, Ethical Issues in Palliative Care, and Special Articles, the Journal will accept either a structured or narrative abstract of no more than 250 words. For Brief Quality Improvement Reports, a *structured* abstract of no more than 150 words is required; headings are: Background, Measures, Intervention, Outcomes, Conclusions/Lessons Learned. Letters should not have abstracts. Abstracts should be on a separate page and follow the title page.

**Key Message:** Between the Abstract and the Introduction, we strongly suggest including a *Key Message* statement. This statement, limited to 50 words, should synopsise the work and highlight its significance. Example: Key Message: This article describes a prospective cohort study that describes the prevalence of breathlessness in a previously unstudied population--patients with .... The results indicate that the symptom is highly prevalent, worsens over time, and leads to functional impairment that may be amenable to better symptom control." References should not be included in this *Key Message*.

**Key Words:** Immediately after the abstract, please provide a maximum of 6 key words, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These key words will be used for indexing purposes.

**Running Title:** Please provide a running title of no more than 45 characters and spaces.

NOTE: Abstracts, key words and running title must be included with the Word document of the submission, not just provided online.

### Disclosures and Acknowledgments

For ALL types of manuscript submissions, except Letters, authors must complete the ICMJE Form for Disclosure of Potential Conflicts of Interest, which can be found here: <http://www.icmje.org/conflicts-of-interest/>. In addition, a Disclosure/Conflict of Interest section should be placed after the text and before the References. It must include a disclosure/conflict of interest statement that refers to all the authors. Please either indicate the lack of conflict (i.e., nothing to disclose) or list possible conflicts for each named author. The statement should be consistent with the ICMJE form. Conflicts of Interest include financial or other relationships that could be perceived to influence the manuscript. If uncertain as to what might be considered a potential conflict of interest, authors should err on the side of full disclosure. An Acknowledgments section, if included, should be placed after the Disclosure/Conflict of Interest section, just before the references. It may include the authors' expressions of gratitude, including mention of individuals who contributed to the work but whose involvement was not sufficient to warrant authorship.

### Formatting of funding sources

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

### Units

Follow internationally accepted rules and conventions: use the international system of units (SI). If other units are mentioned, please give their equivalent in SI.

### Artwork

#### Illustrations

Black-and-white photographs or line drawings are preferred. Separate typed legends should accompany each figure. Every figure must be cited in the text. If original artwork/photos are used, permission must be obtained from the artist or photographer and credit must be given. If subjects of photographs are persons and they are identifiable, permission must be obtained.

#### Electronic artwork

##### General points

- Make sure you use uniform lettering and sizing of your original artwork.
- Embed the used fonts if the application provides that option.
- Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.

- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.
- Provide captions to illustrations separately.
- Size the illustrations close to the desired dimensions of the published version.
- Submit each illustration as a separate file.
- Ensure that color images are accessible to all, including those with impaired color vision.

A detailed [guide on electronic artwork](#) is available.

**You are urged to visit this site; some excerpts from the detailed information are given here.**

#### *Formats*

If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format.

Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):

EPS (or PDF): Vector drawings, embed all used fonts.

TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.

TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of 1000 dpi.

TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale), keep to a minimum of 500 dpi.

#### **Please do not:**

- Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
- Supply files that are too low in resolution;
- Submit graphics that are disproportionately large for the content.

#### **Tables**

Type each table double-spaced on a separate page, number in order of appearance, and give a brief descriptive title. Every table must be cited in the text. Explanatory information should be placed in footnotes; note that the Journal uses superscript, italic Arabic letters for footnotes, not other symbols, e.g., asterisks. If the data shown are from another source, acknowledgment must be given and permission obtained. **Note: Lengthy tables may be published online only, with a link to the Journal website indicated in the print article text. The determination regarding online publication only will be made by the Editor-in-Chief.**

#### **References**

Number references in order of their use in the text; do not alphabetize. Identify references in the text with Arabic numerals inside parentheses. When listing authors in the reference list: Five authors or less, list all five authors; six authors or more, list the first three authors followed by et al. For abbreviations of journal names, refer to *List of Journals Indexed in Index Medicus*. Provide inclusive page numbers. Reference accuracy is the responsibility of the author(s). Please do not use EndNote to compile your reference list.

Examples of Reference Style:

#### *Journal Article*

Hatler CW, Grove C, Strickland S, Barron S, White BD. The effect of completing a surrogacy information and decision-making tool upon admission to an intensive care unit on length of stay and charges. *J Clin Ethics* 2012;23:129-138.

#### *Book Chapter*

Taylor C, Walker S. Compassion: luxury or necessity? In: Cobb M, Puchalski CM, Rumbold B, eds. *Oxford textbook of spirituality in healthcare*. New York: Oxford University Press, 2012:135-144.

#### *Book*

Cassell EJ. *The nature of suffering and the goals of medicine*, 2nd ed. New York: Oxford University Press, 2004.

#### *Online Citations*

World Health Organization. Definition of palliative care. 2008. Available from: <http://www.who.int/cancer/palliative/definition/en/>. Accessed July 27, 2013.

#### *Citation in text*

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

#### *Reference links*

Increased discoverability of research and high quality peer review are ensured by online links to the sources cited. In order to allow us to create links to abstracting and indexing services, such as Scopus, CrossRef and

PubMed, please ensure that data provided in the references are correct. Please note that incorrect surnames, journal/book titles, publication year and pagination may prevent link creation. When copying references, please be careful as they may already contain errors. Use of the DOI is highly encouraged.

A DOI is guaranteed never to change, so you can use it as a permanent link to any electronic article. An example of a citation using DOI for an article not yet in an issue is: VanDecar J.C., Russo R.M., James D.E., Ambegh W.B., Franke M. (2003). Aseismic continuation of the Lesser Antilles slab beneath northeastern Venezuela. *Journal of Geophysical Research*, <https://doi.org/10.1029/2001JB000884>. Please note the format of such citations should be in the same style as all other references in the paper.

#### *Data references*

This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

#### *Journal abbreviations source*

Journal names should be abbreviated according to the [List of Title Word Abbreviations](#).

#### **Research data**

This journal encourages and enables you to share data that supports your research publication where appropriate, and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the [research data](#) page.

#### *Data linking*

If you have made your research data available in a data repository, you can link your article directly to the dataset. Elsevier collaborates with a number of repositories to link articles on ScienceDirect with relevant repositories, giving readers access to underlying data that gives them a better understanding of the research described.

There are different ways to link your datasets to your article. When available, you can directly link your dataset to your article by providing the relevant information in the submission system. For more information, visit the [database linking page](#).

For [supported data repositories](#) a repository banner will automatically appear next to your published article on ScienceDirect.

In addition, you can link to relevant data or entities through identifiers within the text of your manuscript, using the following format: Database: xxxx (e.g., TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

#### *Mendeley Data*

This journal supports Mendeley Data, enabling you to deposit any research data (including raw and processed data, video, code, software, algorithms, protocols, and methods) associated with your manuscript in a free-to-use, open access repository. During the submission process, after uploading your manuscript, you will have the opportunity to upload your relevant datasets directly to *Mendeley Data*. The datasets will be listed and directly accessible to readers next to your published article online.

For more information, visit the [Mendeley Data for journals page](#).

#### *Data statement*

To foster transparency, we encourage you to state the availability of your data in your submission. This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on ScienceDirect. For more information, visit the [Data Statement page](#).

#### **Proofs**

One set of page proofs (as PDF files) will be sent by e-mail to the corresponding author. Elsevier now provides

authors with PDF proofs which can be annotated; for this you will need to download Adobe Reader version 7 (or higher) available free from <http://get.adobe.com/reader>. Instructions on how to annotate PDF files will accompany the proofs (also given online). The exact system requirements are given at the Adobe site: <http://www.adobe.com/products/reader/tech-specs.html>.

If you do not wish to use the PDF annotations function, you may list the corrections (including replies to the Query Form) and return them to Elsevier in an e-mail. Please list your corrections quoting line number. If, for any reason, this is not possible, then mark the corrections and any other comments (including replies to the Query Form) on a printout of your proof and return by fax, or scan the pages and e-mail. Please use this proof only for checking the typesetting, editing, completeness and correctness of the text, tables and figures. Significant changes to the article as accepted for publication will only be considered at this stage with permission from the Editor. We will do everything possible to get your article published quickly and accurately – please let us have all your corrections within 48 hours. It is important to ensure that all corrections are sent back to us in one communication: please check carefully before replying, as inclusion of any subsequent corrections cannot be guaranteed. Proofreading is solely your responsibility. Note that Elsevier may proceed with the publication of your article if no response is received.



**Appendix B. Certificate of Ethical Approval (Systematic Literature Review)**

## **Certificate of Ethical Approval**

Applicant: Holly Millard  
Project Title: Health and social outcomes of online Acceptance and Commitment therapy for Chronic Primary pain: A Narrative Synthesis

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval: 08 Mar 2021  
Project Reference Number: P120260

## Appendix C. Diagnostic Criteria Chronic for Primary Pain from ICD-11 (World Health Organisation, 2020)

### MG30.0 Chronic primary pain

#### *All ancestors up to top*

- [21 Symptoms, signs or clinical findings, not elsewhere classified](#)
- [General symptoms, signs or clinical findings](#)
  - [General symptoms](#)
    - [Pain](#)
      - [MG30 Chronic pain](#)
        - [MG30.0 Chronic primary pain](#)

Hide ancestors 

#### **Description**

Chronic primary pain is chronic pain in one or more anatomical regions that is characterised by significant emotional distress (anxiety, anger/frustration or depressed mood) or functional disability (interference in daily life activities and reduced participation in social roles). Chronic primary pain is multifactorial: biological, psychological and social factors contribute to the pain syndrome. The diagnosis is appropriate independently of identified biological or psychological contributors unless another diagnosis would better account for the presenting symptoms.

#### **Exclusions**

- Acute pain ([MG31](#))

#### **Coded Elsewhere**

- Complex regional pain syndrome ([8D8A.0](#))

#### **Coding Note**

Other chronic pain diagnoses to be considered are chronic cancer-related pain, chronic postsurgical or posttraumatic pain, chronic neuropathic pain, chronic secondary headache or orofacial pain, chronic secondary visceral pain and chronic secondary musculoskeletal pain.

## Appendix D. Caldwell et al. (2011) Process of Quality Assessments Outline



## Appendix E. Quality Assessment Scoring - Principal Assessor

Quality framework		Buhrman et al. (2013)	Gentili et al. (2021)	Lin et al. (2017)	Ljótsson et al. (2014)	Rickardsson et al. (2020)	Rickardsson et al. (2021)
1.	Does the title reflect the content?	2	2	2	2	2	2
2.	Are the authors credible?	2	2	2	2	2	2
3.	Does the abstract summarise the key components?	2	2	2	2	2	2
4.	Is the rationale for undertaking the research clearly outlined?	2	2	2	2	2	2
5.	Is the literature review comprehensive and up to date?	2	2	2	2	2	2
6.	Is the aim of the research clearly stated?	1	2	1	2	2	1
7.	Are all the ethical issues identified and addressed?	2	2	1	1	2	2
8.	Is the methodology justified?	2	2	2	2	2	2
Quantitative							
9.	Is the study design clearly identified, and is the rationale for choice of design evident?	2	2	2	2	2	2
Qualitative							
9.	Are the philosophical background and study design identified and the rationale for choice of design evident?						
10.	Is there an experimental hypothesis clearly	1	1	1	1	1	1
	10. Are the major concepts identified?						

stated? Are the key variables clearly defined?							
11. Is the population identified?	11. Is the context of the study outlined?	1	2	1	1	2	2
12. Is the sample adequately described and reflective of the population?	12. Is the selection of participants described and the sampling method identified?	2	2	2	1	2	2
13. Is the method of data collection valid and reliable?	13. Is the method of data collection auditable?	2	2	2	2	1	2
14. Is the method of data analysis valid and reliable	14. Is the method of data analysis credible and confirmable?	2	2	2	2	2	2
15. Are the results presented in a way that is appropriate and clear?		2	2	1	2	2	2
16. Is the discussion comprehensive?		2	2	2	2	2	2
17. Are the results generalizable?	17. Are the results transferrable?	2	2	2	1	1	2
18. Is the conclusion comprehensive?		2	2	2	2	1	1
<b>Total Score</b>		<b>33</b>	<b>35</b>	<b>31</b>	<b>31</b>	<b>32</b>	<b>33</b>

Quality framework		Scott et al. (2018)	Scriven et al. (2019)	Trompetter et al. (2015a)	Trompetter et al. (2015b)	Trompetter et al. (2016)	Yang et al. (2017)
1.	Does the title reflect the content?	2	2	2	2	2	2
2.	Are the authors credible?	2	2	2	2	2	2
3.	Does the abstract summarise the key components?	2	2	2	2	2	2
4.	Is the rationale for undertaking the research clearly outlined?	2	2	2	2	2	2
5.	Is the literature review comprehensive and up to date?	2	2	2	2	2	2
6.	Is the aim of the research clearly stated?	1	2	0	1	0	2
7.	Are all the ethical issues identified and addressed?	2	2	1	0	1	2
8.	Is the methodology justified?	2	2	2	2	2	2
Quantitative 9.	Is the study design clearly identified, and is the rationale for choice of design evident?	2	1	2	2	2	2
Qualitative 9.	Are the philosophical background and study design identified and the rationale for choice of design evident?						
10.	Is there an experimental hypothesis clearly stated? Are the key variables clearly defined?	2	1	2	2	0	1
10.	Are the major concepts identified?						

11. Is the population identified?	11. Is the context of the study outlined?	1	2	2	2	2	2
12. Is the sample adequately described and reflective of the population?	12. Is the selection of participants described and the sampling method identified?	2	1	2	2	2	2
13. Is the method of data collection valid and reliable?	13. Is the method of data collection auditable?	2	2	2	2	2	2
14. Is the method of data analysis valid and reliable	14. Is the method of data analysis credible and confirmable?	2	2	2	2	2	2
15. Are the results presented in a way that is appropriate and clear?		1	2	2	0	1	2
16. Is the discussion comprehensive?		2	2	2	1	1	2
17. Are the results generalizable?	17. Are the results transferrable?	2	1	1	1	2	1
18. Is the conclusion comprehensive?		0	2	0	0	0	2
<b>Total Score</b>		<b>31</b>	<b>31</b>	<b>30</b>	<b>27</b>	<b>27</b>	<b>34</b>

## Appendix F. Quality Assessment Scoring – Secondary Assessor

Quality framework	Buhrman et al. (2013)	Gentili et al. (2021)	Lin et al. (2017)	Ljótsson et al. (2014)	Rickardsson et al. (2020)	Rickardsson et al. (2021)
1. Does the title reflect the content?	2	2	2	2	2	2
2. Are the authors credible?	2	2	2	2	2	2
3. Does the abstract summarise the key components?	2	2	2	2	2	2
4. Is the rationale for undertaking the research clearly outlined?	2	2	2	2	2	2
5. Is the literature review comprehensive and up to date?	2	2	2	2	2	2
6. Is the aim of the research clearly stated?	1	2	2	2	2	1
7. Are all the ethical issues identified and addressed?	2	2	1	1	2	2
8. Is the methodology justified?	2	2	2	2	2	2
Quantitative 9. Is the study design clearly identified, and is the rationale for choice of design evident?	2	2	2	2	2	2
Qualitative 9. Are the philosophical background and study design identified and the rationale for choice of design evident?						
10. Is there an experimental hypothesis clearly	1	1	1	1	1	1
10. Are the major concepts identified?						



stated? Are the key variables clearly defined?							
11. Is the population identified?	11. Is the context of the study outlined?	1	2	1	1	2	2
12. Is the sample adequately described and reflective of the population?	12. Is the selection of participants described and the sampling method identified?	2	2	2	1	2	2
13. Is the method of data collection valid and reliable?	13. Is the method of data collection auditable?	2	2	2	2	1	2
14. Is the method of data analysis valid and reliable	14. Is the method of data analysis credible and confirmable?	2	2	2	2	2	2
15. Are the results presented in a way that is appropriate and clear?		2	2	1	2	2	1
16. Is the discussion comprehensive?		2	2	2	2	2	2
17. Are the results generalizable?	17. Are the results transferrable?	2	2	2	1	1	2
18. Is the conclusion comprehensive?		1	2	2	2	1	1
<b>Total Score</b>		<b>32</b>	<b>35</b>	<b>32</b>	<b>31</b>	<b>32</b>	<b>32</b>

Quality framework		Scott et al. (2018)	Scriven et al. (2019)	Trompetter et al. (2015a)	Trompetter et al. (2015b)	Trompetter et al. (2016)	Yang et al. (2017)
1.	Does the title reflect the content?	2	2	2	2	2	2
2.	Are the authors credible?	2	2	2	2	2	2
3.	Does the abstract summarise the key components?	2	2	2	2	2	2
4.	Is the rationale for undertaking the research clearly outlined?	2	2	2	2	2	2
5.	Is the literature review comprehensive and up to date?	2	2	2	2	2	2
6.	Is the aim of the research clearly stated?	1	2	0	1	0	2
7.	Are all the ethical issues identified and addressed?	2	2	1	0	1	2
8.	Is the methodology justified?	2	2	2	2	2	2
Quantitative 9.	Is the study design clearly identified, and is the rationale for choice of design evident?	2	2	2	2	2	2
Qualitative 9.	Are the philosophical background and study design identified and the rationale for choice of design evident?						
10.	Is there an experimental hypothesis clearly stated? Are the key variables clearly defined?	2	1	2	2	0	1
10.	Are the major concepts identified?						

11. Is the population identified?	11. Is the context of the study outlined?	1	2	2	2	2	2
12. Is the sample adequately described and reflective of the population?	12. Is the selection of participants described and the sampling method identified?	2	1	2	2	2	2
13. Is the method of data collection valid and reliable?	13. Is the method of data collection auditable?	2	2	2	2	2	2
14. Is the method of data analysis valid and reliable	14. Is the method of data analysis credible and confirmable?	2	2	2	2	2	2
15. Are the results presented in a way that is appropriate and clear?		2	2	2	1	1	2
16. Is the discussion comprehensive?		2	2	2	1	1	2
17. Are the results generalizable?	17. Are the results transferrable?	2	1	2	1	2	1
18. Is the conclusion comprehensive?		0	2	0	0	0	2
<b>Total Score</b>		<b>32</b>	<b>33</b>	<b>31</b>	<b>28</b>	<b>27</b>	<b>34</b>

**Appendix G. Inter-rater Reliability Coefficient (Kappa) Scoring**

<b>Paper</b>	<b>Kappa Score (<math>\kappa</math> value)</b>	<b>Significance (<math>p</math> value)</b>
Buhrman et al. (2013)	.824	.000
Gentili et al. (2021)	1.000	.000
Lin et al. (2017)	.852	.000
Ljótsson et al. (2014)	1.000	.000
Rickardsson et al. (2020)	1.000	.000
Rickardsson et al. (2021)	.824	.000
Scott et al. (2018)	.832	.000
Scriven et al. (2019)	.824	.000
Trompetter et al. (2015a)	.833	.000
Trompetter et al. (2015b)	.889	.000
Trompetter et al. (2016)	1.000	.000
Yang et al. (2017)	1.000	.000
<b>Overall</b>	<b>.907</b>	<b>.000</b>

## Appendix H. Author Guidelines for The Clinical Supervisor

### *About the Journal*

*The Clinical Supervisor* is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's [Aims & Scope](#) for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

*The Clinical Supervisor* accepts the following types of article: original articles.

Dedicated exclusively to the art and science of clinical supervision, *The Clinical Supervisor* is an interdisciplinary, refereed journal that provides a unique forum for the examination of essential theoretical underpinnings, competencies, and skills for supervision of practitioners and students. Empirical (both quantitative and qualitative), theoretical, and reflective scholarship is welcome.

### *Open Access*

You have the option to publish open access in this journal via our Open Select publishing program. Publishing open access means that your article will be free to access online immediately on publication, increasing the visibility, readership and impact of your research. Articles published Open Select with Taylor & Francis typically receive 32% more citations\* and over 6 times as many downloads\*\* compared to those that are not published Open Select.

Your research funder or your institution may require you to publish your article open access. Visit our [Author Services](#) website to find out more about open access policies and how you can comply with these.

You will be asked to pay an article publishing charge (APC) to make your article open access and this cost can often be covered by your institution or funder. Use our [APC finder](#) to view the APC for this journal.

Please visit our [Author Services website](#) or contact [openaccess@tandf.co.uk](mailto:openaccess@tandf.co.uk) if you would like more information about our Open Select Program.

\*Citations received up to Jan 31st 2020 for articles published in 2015-2019 in journals listed in Web of Science®.

\*\*Usage in 2017-2019 for articles published in 2015-2019.

### *Peer Review and Ethics*

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be double blind peer reviewed by independent, anonymous expert referees. Find out more about [what to expect during peer review](#) and read our guidance on [publishing ethics](#).

## ***Preparing Your Paper***

### *Structure*

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

### *Word Limits*

Please include a word count for your paper.

A typical paper for this journal should be no more than 30 pages, inclusive of the abstract, tables, references, figure captions.

### *Style Guidelines*

Please refer to these [quick style guidelines](#) when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Please note that long quotations should be indented without quotation marks.

### *Formatting and Templates*

Papers may be submitted in Word format. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

[Word templates](#) are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us [here](#).

All parts of the manuscript should be typewritten, double-spaced, and have margins of at least one inch on all sides. Manuscript pages should be numbered consecutively throughout the paper and include a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Authors are to avoid abbreviations, diagrams, and reference to the text in the abstract.

### *References*

Please use this [reference guide](#) when preparing your paper.

To help you improve your manuscript and prepare it for submission, Taylor & Francis provides a range of editing services. Choose from options such as English Language Editing, which will ensure that your article is free of spelling and grammar errors, Translation, and Artwork Preparation. For more information, including pricing, [visit this website](#).

#### *Checklist: What to Include*

1. **Author details.** All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. [Read more on authorship](#).
2. Should contain an unstructured abstract of 100 words.
3. You can opt to include a **video abstract** with your article. [Find out how these can help your work reach a wider audience, and what to think about when filming](#).
4. Between 3 and 8 **keywords**. Read [making your article more discoverable](#), including information on choosing a title and search engine optimization.
5. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:  
*For single agency grants*  
 This work was supported by the [Funding Agency] under Grant [number xxxx].  
*For multiple agency grants*  
 This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
6. **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. [Further guidance on what is a conflict of interest and how to disclose it](#).
7. **Biographical note.** Please supply a short biographical note for each author. This could be adapted from your departmental website or academic networking profile and should be relatively brief (e.g., no more than 200 words).
8. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). [Templates](#) are also available to support authors.
9. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a [recognized data repository](#) prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
10. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about [supplemental material and how to submit it with your article](#).
11. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for color, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PDF, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our [Submission of electronic artwork](#) document.

12. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
13. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about [mathematical symbols and equations](#).
14. **Units.** Please use [SI units](#) (non-italicized).

### ***Using Third-Party Material in your Paper***

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on [requesting permission to reproduce work\(s\) under copyright](#).

### ***Submitting Your Paper***

This journal uses ScholarOne Manuscripts to manage the peer-review process. If you haven't submitted a paper to this journal before, you will need to create an account in ScholarOne. Please read the guidelines above and then submit your paper in [the relevant Author Center](#), where you will find user guides and a helpdesk.

Please note that *The Clinical Supervisor* uses Crossref™ to screen papers for unoriginal material. By submitting your paper to *The Clinical Supervisor* you are agreeing to originality checks during the peer-review and production processes.

On acceptance, we recommend that you keep a copy of your Accepted Manuscript. Find out more about [sharing your work](#).

### ***Data Sharing Policy***

This journal applies the Taylor & Francis [Basic Data Sharing Policy](#). Authors are encouraged to share or make open the data supporting the results or analyses presented in their paper where this does not violate the protection of human subjects or other valid privacy or security concerns.

Authors are encouraged to deposit the dataset(s) in a recognized data repository that can mint a persistent digital identifier, preferably a digital object identifier (DOI) and recognizes a long-term preservation plan. If you are uncertain about where to deposit your data, please see [this information](#) regarding repositories.

Authors are further encouraged to [cite any data sets referenced](#) in the article and provide a [Data Availability Statement](#).

At the point of submission, you will be asked if there is a data set associated with the paper. If you reply yes, you will be asked to provide the DOI, pre-registered DOI, hyperlink, or other persistent identifier associated with the data set(s). If you have selected to provide a pre-registered DOI, please be prepared to share the reviewer URL associated with your data deposit, upon request by reviewers.



Where one or multiple data sets are associated with a manuscript, these are not formally peer reviewed as a part of the journal submission process. It is the author's responsibility to ensure the soundness of data. Any errors in the data rest solely with the producers of the data set(s).

### ***Publication Charges***

There are no submission fees, publication fees or page charges for this journal.

Color figures will be reproduced in color in your online article free of charge. If it is necessary for the figures to be reproduced in color in the print version, a charge will apply.

Charges for color figures in print are \$400 per figure (£300; \$500 Australian Dollars; €350). For more than 4 color figures, figures 5 and above will be charged at \$75 per figure (£50; \$100 Australian Dollars; €65). Depending on your location, these charges may be subject to local taxes.

### ***Copyright Options***

Copyright allows you to protect your original material, and stop others from using your work without your permission. Taylor & Francis offers a number of different license and reuse options, including Creative Commons licenses when publishing open access. [Read more on publishing agreements](#).

### ***Complying with Funding Agencies***

We will deposit all National Institutes of Health or Wellcome Trust-funded papers into PubMedCentral on behalf of authors, meeting the requirements of their respective open access policies. If this applies to you, please tell our production team when you receive your article proofs, so we can do this for you. Check funders' open access policy mandates [here](#). Find out more about [sharing your work](#).

### ***My Authored Works***

On publication, you will be able to view, download and check your article's metrics (downloads, citations and Altmetric data) via [My Authored Works](#) on Taylor & Francis Online. This is where you can access every article you have published with us, as well as your [free eprints link](#), so you can quickly and easily share your work with friends and colleagues.

We are committed to promoting and increasing the visibility of your article. Here are some tips and ideas on how you can work with us to [promote your research](#).

**Appendix I. Certificate of Ethical Approval (Empirical)****Certificate of Ethical Approval**

Applicant:

Holly Millard

Project Title:

The experiences, strengths and challenges of online supervision for Trainee Clinical Psychologists and clinical supervisors during the Covid-19 pandemic

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

03 July 2020

Project Reference Number:

P107427

## Appendix J. Informed Consent Form



### Participant Consent Form

**Please complete this form if you agree to take part in this project**

The experiences, strengths, and challenges of online supervision for Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic.

**Name of Lead Researcher:** Holly Millard, Trainee Clinical Psychologist

You are invited to take part in this research study which is seeking to understand the experiences, strengths, and challenges of online supervision for Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic. Before you decide to take part, you are asked to read the accompanying Participant Information Sheet.

Please email any questions to the Lead Researcher (see contact details below) if anything is unclear or if you would like more information about any aspect of the research. It is important that you feel able to take time to decide whether or not you wish to take part. If you are happy to participate please confirm your consent by circling **YES** against each other statements below and sign and date the form.

<b>1</b>	I confirm that I have read and understood the <u>Participant Information Sheet</u> for the above study and have had the opportunity to ask questions and these have been answered satisfactorily	<b>YES</b>	<b>NO</b>
<b>2</b>	I understand my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the Lead Researcher and the Research Support Office <u>at any time</u> up to 31 <sup>st</sup> March 2021	<b>YES</b>	<b>NO</b>
<b>3</b>	I understand that all the information I provide will be held securely and treated confidentially, except if I disclose myself or someone else is at risk of harm.	<b>YES</b>	<b>NO</b>
<b>4</b>	I am happy for the information I provide, including any quotes, to be used (anonymously) in academic papers and other formal research outputs	<b>YES</b>	<b>NO</b>
<b>5</b>	I am happy for the interview to be audio/video recorded	<b>YES</b>	<b>NO</b>
<b>6</b>	I agree to take part in the research project.	<b>YES</b>	<b>NO</b>
<b>7</b>	I would like to receive a short summary of the results of the project when it is completed in 2021.		

Thank you for your participation in this study. Your help is very much appreciated.

Participant's Name	Date	Signature
Researcher	Date	Signature

**Contact details:**

Lead Researcher: Holly Millard

Email: millardh@uni.coventry.ac.uk

## Appendix K. Participant Information Sheet – Trainee Clinical Psychologists



### **Participant Information sheet (Trainee Clinical Psychologists)**

#### **The experiences, strengths, and challenges of online supervision for Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic.**

You are being invited to take part in a research project. Before you decide it is important that you understand why the research is being done and what it would involve for you. This information sheet will explain more about this research project and what it will involve if you decide to take part. Please ask if there is anything you would like explained further, or if you have any questions. Please also take time to consider whether you wish to take part.

#### **Information about the project**

The Covid-19 pandemic has changed the way that psychologists are expected to work within their services, and the introduction of online therapy and supervision represents a new way of working for many. Understanding the advantages and disadvantages of engaging in online supervision can inform guidelines and future ways of working. The purpose of the study is to explore the experience, strengths, and challenges of online supervision for both Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic.

The project is being completed for educational purposes as part of the lead researcher's Doctorate in Clinical Psychology training.

#### **Why have I been chosen?**

You are invited to participate in this study because you are a Trainee Clinical Psychologist receiving clinical supervision online.

#### **Do I have to take part?**

No – it is entirely up to you. If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. You are free to withdraw your information from the project data set at any time up to 31<sup>st</sup> March 2021, which is around one month before submission of the thesis. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and

reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please contact the Lead Researcher (contact details are provided below). You can also contact the Research Support Office [[ethics.hls@coventry.ac.uk](mailto:ethics.hls@coventry.ac.uk)] and provide your name and the name of the study / researcher so that your request can be dealt with promptly in the event of the Lead Researcher's absence. You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you in any way.

### **What do I have to do?**

You will be asked to engage in an interview and answer a number of questions regarding your experience of online supervision during the Covid-19 pandemic. If it is not possible to conduct a face to face interview due to Covid-related government guidance, the interview will take place remotely, using telephone, Skype, Microsoft Teams, or another secure videoconferencing application. Your responses will be audio/video recorded (and will require your consent for this), so the location should be in a fairly quiet area. The interview may take up to 90 minutes to complete.

After the interview, the lead researcher will transcribe the recording and make detailed notes about what you have said. The notes and recording will be treated confidentially. They will be kept in a locked cabinet or on a password protected University OneDrive account. Your name will not be attached to the recording or the notes. Although brief extracts from the interview may be used in the writing up of the research, these will use a pseudonym (false name) and will not disclose your identity.

### **What are the possible benefits of taking part?**

There will be no direct benefit to you for taking part in the study. However, by sharing your experiences and possible advantages and disadvantages you will be supporting the development of the research and hopefully guiding future work and informing guidelines.

### **What are the possible disadvantages and risks of taking part?**

This study has been reviewed and approved through Coventry University's Ethics Committee. There are no significant risks associated with participation. However, talking about your experiences of supervision may change your perception of your current supervision. In the case that you do feel distressed or concerned following your participation, you are advised to contact your GP or university support. In addition, a list of further sources of support is provided on the Debrief Form.

### **Withdrawal options**

You can choose to withdraw at any point before the interview and you can also end the interview at any time. You can also withdraw your data by the end of March 2021 by contacting the Lead Researcher, Holly Millard (using the contact details below). You do not have to give a reason for withdrawing.

### **Data Protection and Confidentiality**

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. All information collected about you will be kept confidential. Your consent information will be kept separately from your interview responses in order to minimise the risk of a data breach. Any emails to and from participants will be deleted from the Lead Researcher's inbox and the deleted/trash box folders. Any documents received by emails will, however, be saved on a password-protected University OneDrive account. The information you provide during the interview will be transcribed into written form, after which the audio/video recording will be deleted. Once the project is finished, all data will be anonymised and saved on a password-protected OneDrive account, accessible to supervisors only, and stored by Coventry University for 5 years in-line with normal procedures for doctorate-level research materials.

In certain exceptional circumstances where you or others may be at significant risk of harm, the Lead Researcher may need to report this to an appropriate authority. In accordance with the (UK) Data Protection Act 2018. This would usually be discussed with you first.

Examples of exceptional circumstances when confidential information may have to be disclosed are:

- The researcher believes you are at serious risk of harm, either from yourself or others
- The researcher suspects a child may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- As a statutory requirement e.g. reporting certain infectious diseases
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism

### **What if I wish to access my information?**

Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with

the General Data Protection Regulation and the Data Protection Act 2018. You also have other rights including rights of correction, erasure, objection, and data portability. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit [www.ico.org.uk](http://www.ico.org.uk). Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer - [enquiry.ipu@coventry.ac.uk](mailto:enquiry.ipu@coventry.ac.uk).

Additionally, you can find out more about how we use your information by contacting Professor Nigel Berkeley using the details at the bottom of this information sheet.

### **What will happen to the results of this study?**

The results of this study will be used by the Lead Researcher, Holly Millard, as part of her research thesis for the Doctorate in Clinical Psychology programme. The results of this study may be put forward for publication in relevant journals, reports or conferences. A copy of the results will be made available to all participants who would like to see them.

You will be asked at the time of your interview whether you would like to receive a short summary of the research findings. This will be then be emailed to you upon completion of the study in September 2021.

### **Who do I contact if I wish to make a formal complaint on any issue?**

If you are unhappy with any aspect of this research, please first contact the Lead Researcher, Holly Millard. If you have any further concerns and/ or would like to make a formal complaint please contact either the research supervisor Dr Tom Patterson or the Associate Dean for Research, Professor Nigel Berkeley.

Holly Millard

Lead Researcher

Coventry University

Email: [millardh@uni.coventry.ac.uk](mailto:millardh@uni.coventry.ac.uk)

Dr Tom Patterson

Acting Programme Director

Coventry University

Coventry, CV1 5FB

Email: [t.patterson@coventry.ac.uk](mailto:t.patterson@coventry.ac.uk)

Professor Nigel Berkeley

Associate Dean for Research

Coventry University

Coventry, CV1 5FB

Email: [asx023@coventry.ac.uk](mailto:asx023@coventry.ac.uk)

**Thank you for taking time to read this information**



## Appendix L. Participant Information Sheet – Clinical Supervisors



### **Participant Information sheet (Clinical Supervisors)**

#### **The experiences, strengths, and challenges of online supervision for Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic.**

You are being invited to take part in a research project. Before you decide it is important that you understand why the research is being done and what it would involve for you. This information sheet will explain more about this research project and what it will involve if you decide to take part. Please ask if there is anything you would like explained further, or if you have any questions. Please also take time to consider whether you wish to take part.

#### **Information about the project**

The Covid-19 pandemic has changed the way that psychologists are expected to work within their services, and the introduction of online therapy and supervision represents a new way of working for many. Understanding the advantages and disadvantages of engaging in online supervision can inform guidelines and future ways of working. The purpose of this study is to explore the experiences, strengths, and challenges of online supervision for both Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic.

The project is being completed for educational purposes as part of the Lead Researcher's Doctorate in Clinical Psychology training.

#### **Why have I been chosen?**

You are invited to participate in this study because you are a qualified Clinical Psychologist and are currently providing supervision online.

#### **Do I have to take part?**

No – it is entirely up to you. If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. You are free to withdraw your information from the project data set at any time up to 31st March 2021, which is around one month before submission of the thesis. You should note that your data may be used in the

production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please contact the Lead Researcher (contact details are provided below). You can also contact the Research Support Office [[ethics.hls@coventry.ac.uk](mailto:ethics.hls@coventry.ac.uk)] and provide your name and the name of the study / researcher so that your request can be dealt with promptly in the event of the Lead Researcher's absence. You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you in any way.

### **What do I have to do?**

You will be asked to engage in an interview and answer a number of questions regarding your experience of online supervision during the Covid-19 pandemic. If it is not possible to conduct a face to face interview due to Covid-related government guidance, the interview will take place remotely, using telephone, Skype, Microsoft Teams, or another secure videoconferencing application. Your responses will be audio/video recorded (and will require your consent for this), so the location should be in a fairly quiet area. The interview may take up to 90 minutes to complete.

After the interview, the lead researcher will transcribe the recording and make detailed notes about what you have said. The notes and recording will be treated confidentially. They will be kept in a locked cabinet or on a password protected University OneDrive account. Your name will not be attached to the recording or the notes. Although brief extracts from the interview may be used in the writing up of the research, these will use a pseudonym (false name) and we will not disclose your identity.

### **What are the possible benefits of taking part?**

There will be no direct benefit to you for taking part in the study. However, by sharing your experiences and possible advantages and disadvantages you will be supporting the development of the research and hopefully guiding future work.

### **What are the possible disadvantages and risks of taking part?**

This study has been reviewed and approved through Coventry University's Ethics Committee. There are no significant risks associated with participation. However, talking about your experiences of supervision may change your perception of your current supervision. In the case that you do feel distressed or concerned following your participation, you are advised to contact your GP for support and advice. In addition, a list of further sources of support is provided on the Debrief form.

### **Withdrawal options**

You can choose to withdraw at any point before the interview and you can also end the interview at any time. You can also withdraw your data by the end of March 2021 by contacting the Lead Researcher, Holly Millard (using the contact details below). You do not have to give a reason for withdrawing.

### **Data Protection and Confidentiality**

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. All information collected about you will be kept confidential. Your consent information will be kept separately from your interview responses in order to minimise the risk of a data breach. Any emails to and from participants will be deleted from the Lead Researcher's inbox and the deleted/trash box folders. Any documents received by email will, however, be saved on a password-protected University OneDrive account. The information you provide during the interview will be transcribed into written form, after which the audio/video recording will be deleted. Once the project is finished, all data will be anonymised and saved on a password-protected OneDrive account, accessible to supervisors only, and stored by Coventry University for 5 years in-line with normal procedures for doctorate-level research materials.

In certain exceptional circumstances where you or others may be at significant risk of harm, the lead researcher may need to report this to an appropriate authority. In accordance with the (UK) Data Protection Act 2018. This would usually be discussed with you first.

Examples of exceptional circumstances when confidential information may have to be disclosed are:

- The researcher believes you are at serious risk of harm, either from yourself or others
- The researcher suspects a child may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- As a statutory requirement e.g. reporting certain infectious diseases
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism

### **What if I wish to access my information?**

Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation and the Data Protection Act 2018. You also have other

rights including rights of correction, erasure, objection, and data portability. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit [www.ico.org.uk](http://www.ico.org.uk). Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer - [enquiry.ipu@coventry.ac.uk](mailto:enquiry.ipu@coventry.ac.uk).

Additionally, you can find out more about how we use your information by contacting Professor Nigel Berkeley using the details at the bottom of this information.

### **What will happen to the results of this study?**

The results of this study will be used by the Lead Researcher, Holly Millard, as part of her research thesis for the Doctorate in Clinical Psychology programme. The results of this study may be put forward for publication in relevant journals, reports or conferences. A copy of the results will be made available to all participants who would like to see them.

You will be asked at the time of your interview whether you would like to receive a short summary of the research findings. This will be then be emailed to you upon completion of the study, estimated to be in September 2021.

### **Who do I contact if I wish to make a formal complaint on any issue?**

If you are unhappy with any aspect of this research, please first contact the Lead Researcher, Holly Millard. If you have any further concerns and/ or would like to make a formal complaint please contact either the research supervisor Dr Tom Patterson or the Associate Dean for Research, Professor Nigel Berkeley.

Holly Millard  
Lead Researcher  
Coventry University  
Email: [millardh@uni.coventry.ac.uk](mailto:millardh@uni.coventry.ac.uk)

Dr Tom Patterson  
Acting Programme Director  
Coventry University  
Coventry, CV1 5FB  
Email: [t.patterson@coventry.ac.uk](mailto:t.patterson@coventry.ac.uk)

Professor Nigel Berkeley  
Associate Dean for Research  
Coventry University  
Coventry, CV1 5FB  
Email: [asx023@coventry.ac.uk](mailto:asx023@coventry.ac.uk)

**Thank you for taking time to read this information**

## Appendix M. Debrief Form – Trainee Clinical Psychologists



### **Participant Debrief sheet-** **Trainee Clinical Psychologists**

Thank you for taking part in this study, your contribution is very helpful to us.

The aim of the research is to understand the experiences, strengths, and challenges of online supervision for both Trainee Clinical Psychologists and Clinical Supervisors

#### **Current and previous research**

The Covid-19 pandemic has changed the way that mental health professionals are required to work and deliver care (BPS, 2020). Increasingly services are being asked to deliver therapeutic services online via digital or telephone platforms, inevitably clinical supervision is also being delivered online.

Trainee Clinical Psychologists and other professionals have previously found online supervision to be helpful and beneficial when mixed with face to face contact. Online supervision has demonstrated similar outcomes to face to face supervision in some circumstances.

However, little qualitative research has been conducted within the UK to consider online supervision from both the Trainee Clinical Psychologist and a Clinical Supervisor's perspective. This project seeks to understand the experiences of both Trainee Clinical Psychologists and Clinical Supervisors, as well as the strengths and challenges of online supervision. Additionally, exploring online supervision within the challenging context of the Covid-19 pandemic should inform and support supervision and best practice guidelines.

#### **Continued support**

We understand that answering questions regarding your supervision experience during a difficult time may be challenging.

Initially, we would recommend that any support regarding your supervision should be sought from your appraisal/personal tutor within your doctoral course. Should you need any additional support regarding your mental health please contact your GP who will also be able to advise you about alternative support in your area.

The following sources of support are available for NHS staff during the Covid-19 pandemic:

- A free wellbeing support helpline available from 7am-11pm, seven days a week on

**0300 131 7000**

- A 24/7 text helpline can be accessed by texting FRONTLINE to **85258**
- Headspace, Unmind and Sleepio apps are available free of charge for NHS workers using their NHS email address.

### **Withdrawing from the Research**

If you have changed your mind about taking part in this research project, you are welcome to withdraw your data up to the 31<sup>st</sup> March 2021. After this time, your data will be anonymised and transcribed for the purposes of the research project. Please contact the Lead Researcher, Holly Millard using the details below, if you wish to withdraw within the allocated time frame.

### **Research Team Contact details:**

Holly Millard

Dr Tom Patterson

Lead Researcher

Acting Programme Director

Coventry University

Coventry University

Coventry, CV1 5FB

Coventry, CV1 5FB

Email: [millardh@uni.coventry.ac.uk](mailto:millardh@uni.coventry.ac.uk)

Email: [t.patterson@coventry.ac.uk](mailto:t.patterson@coventry.ac.uk)

If you are interested in this area of research, you may like to access the following article:

Jordan, S. E., & Shearer, E. M. (2019). An exploration of supervision delivered via clinical video telehealth (CVT). *Training and Education in professional psychology*, 13(4).  
<http://dx.doi.org/10.1037/tep0000245>

**Thank you again for your participation**

## Appendix N. Debrief Form – Clinical Supervisors



### **Participant Debrief sheet-** **Clinical Supervisors**

Thank you for taking part in this study, your contribution is very helpful to us.

The aim of the research is to understand the experiences, strengths, and challenges of online supervision for both Trainee Clinical Psychologists and Clinical Supervisors

#### **Current and previous research**

The Covid-19 pandemic has changed the way that mental health professionals are required to work and deliver care (BPS, 2020). Increasingly services are being asked to deliver therapeutic services online via digital or telephone platforms; inevitably clinical supervision is also being delivered online.

Trainee Clinical Psychologists and other professionals have previously found online supervision to be helpful and beneficial when mixed with face to face contact. Online supervision has demonstrated similar outcomes to face to face supervision in some circumstances.

However, little qualitative research has been conducted within the UK to consider online supervision from both the Trainee Clinical Psychologist and a Clinical Supervisor's perspective. This project seeks to understand the experiences of both Trainee Clinical Psychologists and Clinical Supervisors, as well as the strengths and challenges of online supervision. Additionally, exploring online supervision within the challenging context of the Covid-19 pandemic should inform and support supervision and best practice guidelines.

#### **Continued support**

We understand that answering questions regarding your supervision experience during a difficult time may be challenging.

Initially, we would recommend that any support regarding your supervision should be sought from your own clinical or managerial supervisor. Should you need any additional support regarding your mental health please contact your GP who will also be able to advise you about alternative support in your area.

The following sources of support are available for NHS staff during the Covid-19 pandemic:

- A free wellbeing support helpline available from 7am-11pm, seven days a week on

**0300 131 7000**

- A 24/7 text helpline can be accessed by texting FRONTLINE to **85258**
- Headspace, Unmind and Sleepio apps are available free of charge for NHS workers using their NHS email address.

### **Withdrawing from the Research**

If you have changed your mind about taking part in this research project, you are welcome to withdraw your data up to the 31<sup>st</sup> March 2021. After this time, your data will be anonymised and transcribed for the purposes of the research project. Please contact the Lead researcher, Holly Millard using the details below, if you wish to withdraw within the allocated time frame.

### **Research Team Contact details:**

Holly Millard

Dr Tom Patterson

Lead Researcher

Acting Programme Director

Coventry University

Coventry University

Coventry, CV1 5FB

Coventry, CV1 5FB

Email: [millardh@uni.coventry.ac.uk](mailto:millardh@uni.coventry.ac.uk)

Email: [t.patterson@coventry.ac.uk](mailto:t.patterson@coventry.ac.uk)

If you are interested in this area of research, you may like to access the following article:

Jordan, S. E., & Shearer, E. M. (2019). An exploration of supervision delivered via clinical video telehealth (CVT). *Training and Education in professional psychology*, 13(4).  
<http://dx.doi.org/10.1037/tep0000245>

**Thank you again for your participation**



## Appendix O. Research Poster – Trainee Clinical Psychologists



The poster features a dark blue background with a large, expressive yellow brushstroke. A white-outlined hexagon in the upper center contains a yellow megaphone icon and the text: "Have you been receiving online supervision during the Covid-19 pandemic?". To the right of the hexagon, a yellow circle contains the text: "If so, this research project will be relevant to you if:". Below this, three white-outlined boxes are arranged horizontally, each containing a criterion for participation. At the bottom, a paragraph describes the research project, followed by contact information for Holly Millard, including an email address. A statement of ethical approval is also present. The logos for Warwick University and Coventry University are in the bottom right corner.



**Have you been receiving online supervision during the Covid-19 pandemic?**

If so, this research project will be relevant to you if:

- You are a trainee clinical psychologist receiving supervision
- You are receiving supervision online through any videoconferencing platform
- You are interested in contributing to research through a 60-90 minute interview

This research project will be exploring the experiences, strengths and challenges of online supervision for Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic.

If you would like more information or are interested in participating please contact Holly Millard (Trainee Clinical Psychologist) on [millardh@uni.coventry.ac.uk](mailto:millardh@uni.coventry.ac.uk)

This study has been approved by Coventry University Research Ethics Committee

## Appendix P. Research Poster – Clinical Supervisors

**Have you been providing online supervision during the Covid-19 pandemic?**

If so, this research project will be relevant to you if:

- You are a clinical psychologist providing supervision for a trainee clinical psychologist
- You are providing supervision online through any videoconferencing platform
- You are interested in contributing to research through a 60-90 minute interview

This research project will be exploring the experiences, strengths and challenges of online supervision for Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic.

If you would like more information or are interested in participating please contact Holly Millard (Trainee Clinical Psychologist) on [millardh@uni.coventry.ac.uk](mailto:millardh@uni.coventry.ac.uk)

This study has been approved by Coventry University Research Ethics Committee

WARWICK  
UNIVERSITY

Coventry  
University

## Appendix Q. Interview Schedule – Trainee Clinical Psychologists



### **The experiences, strengths, and challenges of online supervision for Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic.**

#### **Interview schedule for Trainee Clinical Psychologists**

Hello, I want to talk to you today about your clinical supervision during the Covid-19 pandemic and to hear your thoughts, reflections, and experiences of online supervision.

- How have you experienced the move to online supervision?
- What has the impact of online supervision been on;
  - Boundaries,
  - Supervisory relationship,
  - Providing feedback,
  - Establishing supervision as a safe base,
  - Structure of supervision sessions
  - Consistency of supervision
- What have been the strengths or advantages, if any, of online supervision from your perspective?
  - Strengths/ advantages associated with your professional development
  - Strengths/ advantages associated with your clinical/ client work
  - Strengths/ advantages associated with your personal development
- What have been the barriers or disadvantages, if any, of online supervision from your perspective?
  - Barriers/ disadvantages with your professional development
  - Barriers/ disadvantages associated your clinical/ client work
  - Barriers/ disadvantages associated with your personal development
- Is there anything else you would like to add?
  - Based on your experience of online supervision, is there anything that we have not covered that you feel would be important to mention?

Additional/ general prompts (if required):

- Can you tell me a bit more about that?
- Can you think of/ give me an example of that?
- I'd like to bring you back to what you were saying about... can you tell me some more about that?

## Appendix R. Interview Schedule – Clinical Supervisors



### **The experiences, strengths, and challenges of online supervision for Trainee Clinical Psychologists and Clinical Supervisors during the Covid-19 pandemic.**

#### **Interview schedule for Clinical Supervisors**

Hello, I want to talk to you today about facilitating clinical supervision within the Covid-19 pandemic and to hear your thoughts, reflections, and experiences of providing online supervision.

- How have you experienced the move to online supervision?
- What has the impact of online supervision been on;
  - Boundaries,
  - Supervisory relationship,
  - Providing feedback,
  - Establishing supervision as a safe base,
  - Structure of supervision sessions
  - Consistency of supervision
- What have been the strengths or advantages, if any, of online supervision from your perspective?
  - Strengths/ advantages associated with the trainee's professional development
  - Strengths/ advantages associated with the trainee's clinical/ client work
  - Strengths/ advantages associated with the trainee's personal development
- What have been the barriers to or disadvantages, if any, of online supervision from your perspective?
  - Barriers/ disadvantages with trainee's professional development
  - Barriers/ disadvantages associated with the trainee's clinical/ client work
  - Barriers/ disadvantages associated with the trainee's personal development
- Is there anything else you would like to add?
  - Based on your experience of online supervision, is there anything that we have not covered that you feel would be important to mention?

Additional/ general prompts (if required):

- Can you tell me a bit more about that?
- Can you think of/ give me an example of that?
- I'd like to bring you back to what you were saying about... can you tell me some more about that?

**Appendix S. Quality Checklist for Thematic Analysis (Braun & Clarke, 2006, p.96)**

Process	No.	Criteria	Evident (yes or not)
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'	Yes
Coding	2	Each data item has been given equal attention in the coding process	Yes
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive, and comprehensive	Yes
	4	All relevant extracts for each theme have been collated	Yes
	5	Themes have been checked against each other and back to the original dataset	Yes
	6	Themes are internally coherent, consistent, and distinctive	Yes
Analysis	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described	Yes
	8	Analysis and data match each other – the extracts illustrate the analytic claims	Yes
	9	Analysis tells a convincing and well-organised story about the data and topic	Yes
	10	A good balance between analytic narrative and illustrative extracts is provided	Yes
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly	Yes
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated	Yes
	13	There is a good fit between what you claim you do, and what you show you have done – i.e. described method and reported analysis are consistent	Yes
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis	Yes
	15	The researcher is positioned as <i>active</i> in the research process; themes do not just 'emerge'	Yes



# Appendix T. Evidence of Coding Stage of Analysis – Trainee Clinical Psychologist

Participant:

Date:

22 been encouraged to maybe think about, what I've learned and go ahead and kind of  
 23 truck on with it as they say. Erm, I suppose just for the limited amount of research  
 24 supervision that I've had online, it has worked really well, I think just in terms of the  
 25 accessibility, because that's something that I found harder to access research  
 26 supervision. But, erm, yeah, I think in terms of the clinical supervision, the pandemic  
 27 has affected all aspects of the work in that you're doing most of it remotely, erm, and  
 28 yeah, I actually forgetting your question.

↳ pandemic impacted all  
of work inc slv

29 I: No, that's alright, don't worry

30 P: Sorry for my rambling

31 I: No, that's not a problem, I guess, I was, so my next questions kind of the impact of  
 32 online supervision on a few different aspects of online supervision. So, what's the  
 33 impact of online supervision been on the boundaries that you have in supervision?

34 P: Ok, erm, I suppose, I've experienced it as maybe, in some ways as more of a  
 35 formal setting. So, erm, I, I suppose, it's, sometimes I liken it to almost like public  
 36 speaking as, so it's like you have maybe one or more faces in front of you, on a  
 37 screen, erm, you're, I find that I'm really focussing on what I'm saying in the moment  
 38 and you're at the same time, trying to understand maybe nonverbal cues and  
 39 people's expressions. And you know if there's a natural silence that fell across the  
 40 screen, I tend to think you know is there something wrong with the technology, so I, I

additional  
pressures of  
being online

41 think that has impacted in my boundaries in that maybe I've responded to that in a  
 42 way, where I have become quite formal in my speech, or erm, I've been quite, what  
 43 would you say, quite decisive in what I say. Erm, I definitely, it has impacted on the  
 44 amount that I say, and I think that I say less, erm, through the screen and I definitely

increased  
need for  
personal  
boundaries

↓  
increase  
containment

↓  
screen impacts  
what can be  
shared?

Participant:

Date:

45 I suppose act in a more formal way. And to me I would understand that as maybe  
 46 being a bit more boundaried, like a little bit more kind of stricter with my boundaries.

47 I: Mm, when you say, you say less, what do you mean by that?

48 P: Erm, less talking is it?

49 I: Yeah, yeah

50 P: I suppose, I don't feel that it's really, online it's an environment where you can  
 51 speak as informally, or as maybe on topics that I would maybe consider would be  
 52 really useful for relationship building. So, I've found that even on a Monday morning  
 53 on the team meeting online, erm, we don't tend to ask people how their weekends  
 54 were. And now just last week we've moved to face to face team meetings and that's  
 55 something that we do talk about. So when it feels more like a formal setting, it feels  
 56 like I erm, sometimes, I feel like I don't want to say anything unless it's very  
 57 purposeful or adds a lot of value or a lot of meaning or, it's very well thought through  
 58 as such. *online means sharing something of value.*

*Can't speak informally online  
loss of depth of connection online  
any think shared must be of value.*

59 I: Yeah, that makes a lot of sense, erm and I guess added to that, what do you think  
 60 the impact of online supervision's been on your supervisory relationship?

61 P: Erm, ok, well in terms of my clinical supervisor because I met him and got to know  
 62 him for about the first three months, erm through online supervision. I think it  
 63 definitely slowed down the pace of our relationship building, I found it, I suppose we  
 64 both found it, much more difficult to get to know each other. Erm definitely that more  
 65 kind of formal aspect of, of online for me impacted that, erm, just speaking about  
 66 erm, professional issues at hand and not feeling like I can maybe act or speak in a  
 67 more informal way. And that's my way that usually, that I tend to build relationships,  
*online impacts openness + perception of others*

*slw slows r/ship building*



## Appendix U. Evidence of Coding Stage of Analysis – Clinical Supervisor

Participant:

Date:

- 71 that kind of thing. But I do think it maybe, perhaps the remote side of things lends  
 72 itself maybe more to a I'll bring a list and we'll go through the list. Whereas you might  
 73 bring a, you might be able to in the room be able to comment a bit more, oh gosh  
 74 you look a bit upset when we're talking about that or there's something that you pick  
 75 up on being in the same place. So, I think maybe missing out a little bit on that  
 76 process stuff, I think that's probably where it's been affected.
- 77 I: Yeah absolutely, that makes so much sense, thank you. Erm so I guess I'm  
 78 interested in thinking about the kind of core aspects of supervision and kind of how  
 79 online supervision may or may not have impacted them. So, what's the impact of  
 80 online supervision been on the kind of boundaries in your supervision?
- 81 P: (SIGH) Mm, I don't know I'm not sure that it has really, I'm just trying to think  
 82 because you know I suppose there is that classic thing of do you, do you put a  
 83 background blur on or not and that kind of thing. Yeah, I think I guess as a  
 84 supervisor, I tend, I like to be, not oversharing but quite open about my context and I  
 85 think that's helpful you know. One of my sorts of guiding model is sort of a systemic  
 86 approach and I think it's important to locate ourselves in our context so that we can  
 87 understand our interactions kind of thing. So, I would always try and be having that  
 88 conversation about key aspects of me kind of who I am, Social Graces that kind of  
 89 thing, so I would be doing that. So, I don't, I personally don't feel that uncomfortable  
 90 at them seeing aspects of my home life, my bookshelf behind me and that kind of  
 91 stuff. Erm, and I would tell people that I'm a mother and that kind of thing so if my  
 92 kids interrupt me it doesn't matter so much, I guess. But you know I think it does, it  
 93 does impact I think obviously, there's no getting away from the fact that you are in  
 94 your own homes often and all of that what that might entail kind of thing. And, and  
 95 with this last trainee that I had, I would say that wasn't much of an issue but with the

distance  
impacts  
vulnerability  
+ connection  
re process

slvisor  
boundaries  
with  
trainee

appropriate  
amount  
for  
slvisor  
to  
share



Participant:

Date:

- 96 trainee I supervised I felt was an exceptionally private individual actually to the point  
 97 that, you know I think sometimes we had to have some quite frank conversations *difficulty*  
 98 about reflective practise and why I might be asking her a little bit more or to express *reflecting*  
 99 a little bit more. And I can imagine for her that might have felt like a crossing of *for some*  
 100 boundaries you know to actually be practising remotely and be doing the supervision *impact on*  
 101 remotely. Erm, I think in other ways maybe it sorts of lends itself to strengthening *personal*  
 102 boundaries in some way just in terms of sort of keeping to time. I don't know you've *boundaries*  
 103 kind of got your little clock at the top and that kind of things so maybe in some *strengthen*  
 104 senses that's quite helpful. I do often think though, I think there can be a risk of *in time*  
 105 blurring of boundaries that I notice sort of, that every conversation starts with oh *boundaries*  
 106 gosh I'm sorry I'm late or because it was a bit glitchy. And sometimes I've been *blurring*  
 107 quite, as a supervisor gosh I'm eating into someone's supervision time by saying oh *at*  
 108 my emails broke and I got caught on a phone call and, in a way that we maybe *boundaries*  
 109 wouldn't if we were in body sort of going into a room and sort of no this is your space *difficult*  
 110 and I'm here to contain what's going on for you and you don't need to hear my crap *for supervisor*  
 111 basically. So, I don't know and maybe a bit of that leaking in, I don't know. *to provide*  
 112 I: Yeah, and that's really interesting thank you. And what's the impact of online, *containing*  
 113 you've kind of briefly mentioned this already but what' the impact of online *space*  
 114 supervision on the kind of supervisory relationship?  
 115 P: Mm, I guess it's a little slower to develop because I guess that online supervision *breaks*  
 116 is going hand in hand with often a bit of an online placement as well. So, you're *relationship*  
 117 missing out on that, erm, I work in a sort of split neuro and older adult mental health *develops*  
 118 team to a lot of what we do, a lot of the client work would be in people's homes. So, I *slowly*  
 119 actually kind of really, really value those shared car journeys because you can learn  
 120 a lot about each other and actually you can get to the realness as well. You know if

## Appendix V. Additional Quotes to Support Themes

Theme	Subtheme	Participant and Line numbers	Quote
<b>Effects on the Mechanics of Supervision</b>	Consistency and Structure: Unaffected or Improved	Clinical Supervisor 1006, Lines 121-123	Erm, has it changed the structure, I think I have a tendency to be quite unstructured anyway, erm, and the kind of setting a loose agenda and seeing what comes up. So, I don't think it did massively change the structure, no.
		Clinical Supervisor 1015, Lines 173-174	I think, it has been really consistent, yeah, we've booked in a time, we've stuck to the time and erm we've tended to do it at the beginning of the day.
		Trainee Clinical Psychologist 1016, Lines 70-75	I don't think it's really impacted the structure to much, I think it's really easier because you've got the clock there, in the corner. So, you're able to kind of tell the time easier and keep on track to make sure you're, you're going through everything without having that weird sorry I'm just going to look at my watch. So, I guess it's been positive with the structure, but I think the overall structure hasn't really changed.
		Trainee Clinical Psychologist 1011, Lines 185-187	Erm, I was always having it consistently as in like, that I would have it ever week, but I think like the setting, and like finding a room and the consistency of that way, yes that's been better.
	Influence on Observations & Feedback	Clinical Supervisor 1015, 108-110	So, I think that the way that feedback has ended up being, has been much more structured, which in a way is helpful, it's helpful to focus on the particular learning needs.
		Clinical Supervisor 1005, Lines 133-134	I do think it's a deficit not being able to observe and be observed and been in vivo kind of situation.
		Trainee Clinical Psychologist 1012, Lines 247-249	Erm, yeah, I guess so, I guess similar, less opportunities to be observed, less opportunities for joint working, so I can see how she works and how we work together.

<b>Context Influences the Content</b>	Technology Difficulties Hinder Reflection	Trainee Clinical Psychologist 1007, Lines 85 & 88-89	Erm, I think she's if anything, I've got more feedback; So, I definitely got a lot more feedback on like, live observation stuff, for sure. Erm, yeah.
		Trainee Clinical Psychologist 1031, Lines 82-783	I guess one of the things that has been difficult has been observations erm, so it's been quite difficult to give feedback on clinical work in that way.
		Trainee Clinical Psychologist 1016, Lines 137-139	The disadvantages of online supervision, I think technology issues. I think you lose that flow when the signal goes or someone freeze and I think that when there are technology issues it can just practically eat away at time, spent in supervision.
		Trainee Clinical Psychologist 1031, Lines 268-270	I think things like tech issues definitely, we had a couple of times where we were in the middle of a really valuable or important conversation and the technology flaked out or it sort of was a lag and then oh you haven't heard me for the last 30 seconds.
		Trainee Clinical Psychologist 1018, Lines 64-67	Yes, so I've had a couple of observations that he's had to like bail out of because of erm, technical problems, like he's lost sound and things like that. So, we've moved to, erm I'm just recording my sessions so that he can then do it, but I don't get as much, the feedback isn't as immediate then.
	Change in Clinical Conversations	Clinical Supervisor 1019, Lines 26-27	Yeah, so I think, erm, in a positive side of it is that we've had a lot more conversation about staff wellbeing than we might have typically done.
		Clinical Supervisor 1027, Lines 41-46	So I suppose that meant that some of our supervision discussions were supporting my supervisee's emotions around erm, kind of, hope for people or hopelessness, kind of frustrations. Erm, and how to, you know how do we move forwards considering this, you know, am I able to challenge this person's emotions when they're feeling like they're feeling because of the pandemic you know those sorts of issues.
	Increased Focus on Self-care	Clinical Supervisor 1029, 167-168	Erm, and I think its kept self-care and just the workload planning really at the front of my mind as a supervisor.

<b>Process Differences - Us</b>	Development of the Relationship	Clinical Supervisor 1029, 180-182	There's a human there that needs, that needs looking after that there's a lot going on for. But erm I've become extra mindful of it with the added pressure of working from home and working remotely.
		Clinical Supervisor 1004, Lines 7-9	Yeah, so erm, I was in a position where I already need my trainee from the six months prior to moving online so we had met face to face and we'd developed a therapeutic, therapeutic (sigh), supervisory relationship, erm before moving online.
		Clinical Supervisor 1027, Lines 77-80	It felt just as easy to have that supervisory relationship online as it would have done in the room. I guess we were, had the benefit of already knowing each other really well and having worked together for six months.
		Clinical Supervisor 1028, Lines 15-16	I think, I think it's fair to say it felt very strange, it felt very weird trying to sort of establish that normal sort of supervisory relationship
		Clinical Supervisor 1028, Lines 115-116	Mm, I guess it's a little slower to develop because I guess that online supervision is going hand in hand with often a bit of an online placement as well.
	Shifting Boundaries	Clinical Supervisor 1006, Lines 60-61	You know I think those sorts of things, it makes it a lot, erm, a lot harder to keep a very firm boundary around it.
		Clinical Supervisor 1004, Lines 50-51	In some ways it actually helped enhance boundaries because without travel and room booking, the, it was kind of easier to meet
		Clinical Supervisor 1015, Lines 53-55 & 56	People are seeing into your house and you're seeing into theirs. And you've got to be really thoughtful around what you've got in the background... just making sure it's tidy, so it feels professional.
		Clinical Supervisor 1019, Lines 37-38 & 40	Erm, so I would say probably because, they can see my house, erm in a way that I wouldn't typically have trainees in my house...so yeah there's definitely been some boundary blurring.
		Clinical Supervisor 1028, Lines 104-106	I do often think though, I think there can be a risk of blurring of boundaries that I notice sort of, that every conversation starts with oh gosh I'm sorry I'm late or because it was a bit glitchy.

Loss of Presence	Clinical Supervisor 1009, Lines 325-327	Yeah, I think it, I think it can be a positive to see people in a more relaxed environment. Erm, and you can sometimes get more of a sense of how someone is really doing, because they're slightly less in work mode to an extent.
	Trainee Clinical Psychologist 1011, Lines 96-98	Erm, and I guess in terms of personal professional, erm obviously like she can see into my house and I can see a bit into hers but I don't really feel like, I don't feel like that's an intrusion at all for me.
	Trainee Clinical Psychologist 1007, Lines 213-219	Erm, she's also quite, she's quite informal which I think lends well to remote supervision, thinking of supervisors who I've had in the past who are much more strict and boundaried and formal and professional. I like can't imagine having supervision with them remotely, because also remotely she's in my house (laughter) and my room, and I think that probably, like her as a person, would contribute to the ease that it's run with, in a way that I think different supervisors it would have felt quite odd.
	Trainee Clinical Psychologist 1016, Lines 23-25	So, it's become kind of more boundaried in that way. But I think that not having a specific place and time and with technology has meant that people are a bit later or erm or being in like a home environment there are more disruptions to supervision.
	Trainee Clinical Psychologist 1031, Lines 55-57	So, I guess, sometimes supervision was more boundaried practically because also you've got the timer at the top of a Teams call so you know how long you've been talking for.
	Clinical Supervisor 1015, Lines 278-279	Reading people's body language and like small delays in sound and how that affects relationships and trust and things like that.
	Clinical Supervisor 1019, Lines 287-289	Yeah, I've not changed anything in terms of how I deliver it, but I think you're always on the lookout, for cues about how it's landed and anything to do with that is always harder online.
	Clinical Supervisor 1020, Lines 156-158	Well, it does feel like face to face still but there'll still be something lost, you get to know more about that person if you are sharing a room with them.

Clinical Supervisor 1021, Lines 222-223	Yeah, erm, like I say not being in the room with her, not being able to see each other in our, in our whole.
Clinical Supervisor 1004, Lines 24-25	Definitely acknowledgement of how different it was and the sense of loss of the presence erm of being in the room together.
Clinical Supervisor 1028, Lines 71-76	But I do think it maybe, perhaps the remote side of things lends itself maybe more to a I'll bring a list and we'll go through the list. Whereas you might bring a, you might be able to in the room be able to comment a bit more, oh gosh you look a bit upset when we're talking about that or there's something that you pick up on being in the same place. So, I think maybe missing out a little bit on that process stuff, I think that's probably where it's been affected.
Clinical Supervisor 1009, Lines 60-63	I guess, there's a lot of non-verbal stuff that you rely on without realising you're relying on it. So, I can't really see most of her body language apart from chest up, I suppose. I can't see, like you can see if someone's anxious if they're maybe jiggling their legs or fiddling with their fingers.
Clinical Supervisor 1027, Lines 206-207	In a room together where you can just be a bit, it flows a bit easier. It's a bit more clunky online.
Trainee Clinical Psychologist 1012, Lines 99-100	Yeah, erm, I guess sometimes it felt a little bit distant because we weren't in the same room.
Trainee Clinical Psychologist 1018, Lines 137-139	Erm because it is very different communicating online, you don't get the, as many of the natural cues and the non-verbal.
Trainee Clinical Psychologist 1022, Lines 38-41	With other supervisors when it's face to face and maybe this is just more about me, it feels more meaningful when it can be face to face and you've got social cues kind of directly in front of you, rather than just behind a screen. Yeah so that felt and I wouldn't say it's detached but just not as, as meaningful maybe.

Loss of Endings	Trainee Clinical Psychologist 1023, Lines 205-208	Maybe the quality of the information that I'm giving isn't as full as it could have been because I've not got information about how it felt in the room or their body language or whether or why they might be distracted because you can only see someone's face if someone's looking at the side of the screen.
	Trainee Clinical Psychologist 1002, Lines 248-250	Just because you can't pick up on all the nonverbal cues, or if she's being quite expressive and then technology will cut out or her video will go off, or her audio will start crackling. So yeah, I feel like it's been limited that way.
	Trainee Clinical Psychologist 1008, Lines 64-67	Yeah, I definitely think so for me, and it's no reflection on my supervisor, it's just that I think there is something about kind of having that same room you go to and I don't know to be being with someone feels a bit more safe. And I think being so distant and kind of not even having at the end of supervision walking anywhere.
	Clinical Supervisor 1006, 297-208	Erm, I just couldn't see how we could have a satisfactory ending online.
	Clinical Supervisor 1015, Lines 412-413	I, the first thing that springs to mind is oh she's not going to have leaving drinks, you know those are, the ways that you mark erm, the endings.
	Clinical Supervisor 1019, Lines 309-311	So, I won't get to see her in person before she finishes which is really tough because she's been with us for a year. So, yeah it feels like a bit of a non-ending.
	Clinical Supervisor 1020, Lines 187-189	So yeah, I think it would impact upon it, I think it would make it feel, yeah just not as kind of personable. It maybe takes a bit of the warmth out of it a little bit, actually giving presents to people if they're leaving.
	Clinical Supervisor 1027, Lines 287-288	Erm, but I think that, she talked about them feeling just a bit odd that way. Erm, yeah, there's definitely something lost in terms of an ending online.

**Process- Differences  
- Me**

Is the Supervision Good  
Enough?

Clinical Supervisor 1028,  
Lines 423-425

Endings, really weird, really, it felt horrible actually because, we were reflecting in our team meeting it was just kind of a damp squib it was just we said ok, now we'll all close our laptops.

Trainee Clinical  
Psychologist 1012, 292-  
296

So, it's not quite going to be the same type of ending that it normally would. Erm, so that feels a bit strange really, I imagine that when we have our last supervision it will be like oh right, we're on Teams, not going to see you again, bye. It's a bit, you know wave and it feels a bit (sigh), what's the word, feels like you've not got that stereotypical closure around the erm.

Trainee Clinical  
Psychologist 1022, 265-  
268

Erm, yeah and I guess the final goodbye in the nicest way possible there was no kind of emotive farewell, it was just kind of like it's the end of placement now. And I wonder if that's because the rapport could only go so far from it being a virtual placement.

Trainee Clinical  
Psychologist 1016, Lines  
206-208

That was a really strange process of saying goodbye, erm and having an ending to what's been a kind of just, like, it's been a time where both of us have learnt a lot and developed a lot and it feels like a strange way to end.

Trainee Clinical  
Psychologist 1008, Lines  
223-228

That was a weird ending too, it was just kind of the end of a MS Teams call, like oh bye then. Just a bit weird and I feel like having that closure I don't know how that's going to be with this supervisor because I'm not sure, I just feel like I haven't got a good read of the relationship, I feel like it's quite good. Even on video, it's not always to get the nonverbals and suss out where people are at, so I just think it's going to be an interesting ending but I'm not sure how exactly yet.

Clinical Supervisor 1015,  
Lines 280-282

There will be reasons that I can't quite put my fingers on but there's something about doing it online that even though I know it's not my choice and I know it's not my fault makes me think I'm not doing it good enough.

Clinical Supervisor 1019,  
Lines 355-356

So, erm, I think that it's not great, thinking that you've not been able to offer the best placement.



Experiencing and Managing Uncertainty	Clinical Supervisor 1028, Lines 404-407	I think it was better to go with it and I think we made it ok enough, it was good enough. You know its not ideal, we would all like things to be different and at the same time, this is how it is at the moment.
	Clinical Supervisor 1021, Lines 176-179	Because she was on her own at home, I wasn't there to do any of that hand holding stuff throughout the placement, erm, so, yeah to build up that resilience of feeling really, really anxious and uncontained and just like what are we doing here.
	Clinical Supervisor 1021, Lines 17-19	Erm so quite unnerving, quite unsettling erm, and took a lot of erm, I guess a lot more thought and consideration than just welcoming a trainee onto site like you normally would.
	Clinical Supervisor 1009, Lines 207-209	I do worry about next time I l'm not, I feel really unsure of how to create that safe base with my next trainee.
	Clinical Supervisor 1009, Lines 554-557	But, like I say with our next intake I feel more worried about it because I feel like I will come out of it feeling less confident in my judgement that their hopefully safe to practise going forward, because I've had eyes on them less.
A Sense of Responsibility	Clinical Supervisor 1006, Lines 36-37	Because people erm, don't have that chat to someone in the office relationship and it's kind of all comes to your supervisor.
	Clinical Supervisor 1021, Lines 240-241	Which is probably why I put so much time, energy, and effort into it, yeah, just trying to make it the best experience possible for her as I could.
	Clinical Supervisor 1009, Lines 168-170	So its things like that just trying to, I think I have to hold her in mind more, erm in a more proactive way which again isn't a bad thing but in terms of your mental load, it's another thing to be thinking about.
A Helping Hand for Vulnerability	Trainee Clinical Psychologist 1012, Lines 50-52	And, erm, it felt a little bit more light-hearted in some ways. So actually, I think that helped with the relationship building with someone new.
	Trainee Clinical Psychologist 1012, Lines 277-280	I've enjoyed it, I've found it safer, I've found it, I could probably be a bit more open about things, erm, it's probably something around vulnerability there because I can feel more open because there's that

		distance so I can be vulnerable but in a safe way, protecting myself type way.
	Trainee Clinical Psychologist 1023, Lines 59-61	But also, that I feel kind of closer to my supervisors in the sense that they're more real, they have more human stuff going on that you can see.
	Trainee Clinical Psychologist 1023, Lines 102-107	I wonder if there's something that there's something about that it was new to her as well, that it had a bit of a leveller and so it didn't feel like, there was this weird power dynamic that you sometimes have because she was, like oh God, I've never supervised remotely before, it's so weird that I'm never going to meet you. Erm, so we were maybe on a little more of a level pegging, which I tend to find more comfortable than having that really rigid, hierarchy type thing.
	Trainee Clinical Psychologist 1031, Lines 222-225	And there's something very human about like both doing supervision in your respective kitchens or in my kitchen and her office and having like the cat pop in for example. Yeah, I think also it was easier with some of the more emotional content somehow.
An Obstacle to Vulnerability	Trainee Clinical Psychologist 1018, Lines 45-47	I guess it's a bit lacking just in erm, in that distance. Like it doesn't always feel like you have a supervisor there, or I know he's there and he's very accessible it just he's like a picture on a screen versus a real human being.
	Trainee Clinical Psychologist 1018, Lines 83-86	But I also feel like there are some things that I feel like I wouldn't want to share online versus in person. It just feels a lot more impersonal, erm so like if say something personal came up, I think that it would definitely impact me going to my Clinical Supervisor, I would maybe go to somebody else instead.
	Trainee Clinical Psychologist 1008, Lines 76-78	Erm, but yeah, I do feel kind of less close to her than I might do for other supervisors and I think that will probably have something to do with how little I've shared about my own experiences.

Hurdles to Reflection	Trainee Clinical Psychologist 1010, Lines 64-67	Erm definitely that more kind of formal aspect of, of online for me impacted that, erm, just speaking about erm, professional issues at hand and not feeling like I can maybe act or speak in a more informal way. And that's my way that usually, that I tend to build relationships.
	Trainee Clinical Psychologist 1018, Lines 98-102	We just, erm, getting through things and then being done. He always does ask me if there are other things we want to bring but I just, erm, get the sense that it's err, you know we spend a lot of time talking about cases and other adminy things and letters and things like that. But, erm, less so on all of the other things that you would want to maybe think about bringing to supervision.
	Trainee Clinical Psychologist 1022, Lines 235-238	Erm, I guess without being asked those questions, I hadn't really thought much about the idea of having to reflect on supervision. Because at the minute you're kind of just getting on with it and I think since the pandemic we've all been kind of thrown into this practise of just getting on with things.
	Trainee Clinical Psychologist 1002, Lines 80-83	So, I'm finding the time that we do have available is being taken up by more trivial things rather than being able to get kind of a meatier discussion around my clients and my cases. So, I'm having, I've booked in some extra reflective supervisions, so we can do that a bit more as well.
	Trainee Clinical Psychologist 1008, Lines 47-51	Whereas because we don't have that I feel like I've got one hour's supervision a week and I need to go through all the kind of more managerial stuff as well. The kind of this is my caseload, this is what I'm doing with them and it's kind of gets kind of mode of supervision rather than moving to the more kind of reflective stuff.
	Trainee Clinical Psychologist 1010, Lines 361-366	Yes, yes, no I would say it doesn't suit it in the same way, you know just, my style as a supervisee in clinical supervision, isn't very structured or formal and it's erm, it's more about, thinking about the relationships I have with clients but as well as that the relationship I have with my supervisor and what's happening in the room, there and then with them as well. So, I think, that an online platform really restricts the amount of analysis you can do on the relationship really.

---