There’s nothing as practical as a good theory. Employing psychological theory reflexively to improve the quality of supervisor training in clinical psychology

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Introduction

Ever since Freud first developed psychoanalytic training procedures in the 1920s, the training of psychological therapists has relied heavily on the experience of clinical supervision (Binder 1997). In essence this involves a novice working with an experienced practitioner to “learn the ropes” of their chosen trade much along the lines of the traditional relationship between a craftsman and his apprentice. However the practice of psychotherapy is often a private pursuit in which therapist and client hold a series of intimate conversations on highly personal matters. Opportunities for trainees to directly observe their supervisors in action (and vice-versa) are likely to be limited. As a consequence the supervisory process tends to rely heavily on the trainee’s reports of the therapeutic exchanges in which s/he has been involved. This “arm’s length” method of promoting professional competence puts considerable intellectual and ethical demands on both supervisor and supervisee.

In an era of “evidence-based practice” one might have expected that this initial model would have subsequently been shaped by a continuing flow of feedback from empirical studies into the educational effectiveness of the key variables involved in clinical supervision. However like most other components of the professional education of clinical psychologists, the usefulness of the “old ways” has been largely assumed rather than critically investigated. This pattern is in stark contrast to the research resources that have been committed to large-scale outcome studies in psychotherapy. As a result of this effort the product (ie various brands of psychological therapy) has developed a solid scientific evidence base to guide practitioners. By comparison the means of production (ie professional training programmes) still seems determined by long-standing custom and practice. It is not that nobody bothers to write about the important questions associated with clinical supervision. There is a formidable literature on the topic though this consists mainly of reflective and theoretical papers rather than well-designed empirical studies. As a consequence one influential review paper concluded in the
late 90s that any supervisor wishing to found their practice on defensible empirical research findings was essentially "blowing in the wind" (Ellis and Ladany 1997). How then should clinical psychology training courses prepare their supervisors for this central, but minimally investigated, role?

**Supervisor training**

Our initial tactic in Leeds was to recognise that those who attended our supervisor training workshops already had substantial personal evidence on which to draw. They had themselves been supervised, often within recent memory as most of those enrolling for these events will have been qualified for only 2 or 3 years. So we invited participants to reflect on their experiences as a supervisee and identify which episodes had helped and which had hindered their professional progress. In the spirit of user empowerment we pushed the now fashionable line that consumers of services know best what suits their particular needs and preferences. We also anticipated current enthusiasms for recognising transferable skills, and asked new supervisors to consider the several ways in which their mature and evolving psychotherapeutic abilities could be applied to their new educational role. Listening skills; alliance building; collaborative problem-solving; empathic understanding – what more was there to learn when you stopped and thought about it? That indeed was the essence of the 3 day introduction to supervision series of workshops which we slowly shaped over a 15 year period. The content was stimulating (involving a winning combination of theoretical musings and enticing group exercises) and was generally well-received. We even travelled around the country selling (or more accurately sharing) our wares. We were proud of the opportunity we provided for our would-be supervisors to stop and think about the role they were about to adopt. Furthermore I think we recognised that we had unwittingly constructed a rite of passage that became a marker for the first post-qualification rung on the professional development ladder of local clinical psychologists.

**A few awkward questions**

Reassuring though this model of "let's think about how much you already know about supervision" was for all concerned in our training workshops, its shortcomings could not be overlooked indefinitely. By emphasising the similarities between the roles of therapist and supervisor and inviting our workshop attenders to forge conceptual links between the two activities
we had conveyed a profoundly unhelpful message. We could have been heard to say something like “a good therapist equals a good supervisor”. While there is some truth in the assertion that supervisors who cannot “hack it” in the consulting room are unlikely to be perceived by their trainees as credible role-models, the logical stance is that clinical competence is a necessary but not sufficient pre-requisite for becoming an effective supervisor. A new role needs new skills. By concentrating on recognition of existing knowledge we had unwittingly implied that “this supervision stuff is easy – you know most of it already”. There is a peculiar satisfaction to be derived from leaving a post-qualification update event with the conviction that you have encountered nothing that is novel or challenging to your existing construct system. Some call it professional complacency.

If the point of education is to make a difference, what difference were our workshops making? What did participants learn? What skills did they acquire? What impact, if any did their training experience have on their subsequent practice as supervisors? These are all uncomfortable questions that we could not easily duck without resorting to unconvincing rhetoric about adult learners and the obligations of autonomous professionals (Norman 1999).

The limits of reflection

Boud et al (1985) defined reflection as “a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations”. This summary statement both fairly describes the invitation we offered to those attending our workshops and provides some strong hints as to why we eventually became frustrated by the limitations imposed by that philosophy.

The light shed by reflective analysis points backwards. Fresh understandings may have emerged from the exercises we set our would-be supervisors but their implications for future practice were left largely unstated. Furthermore the essence of reflective learning struck us as a process of personal enquiry. It was not for us as tutors to tell experienced colleagues what conclusions to draw from their deliberations. In what some may see as a travesty of the adult learner model we restricted our responsibility as educators to laying out a veritable smorgasbord of learning opportunities with which to tempt our workshop
participants. What lessons they learned from those activities and whether they carried any of those lessons into their subsequent working lives was, to put it bluntly, up to them! In retrospect it's surprising we got away with it for so long...

We surely had some moral responsibility to define the aims of the endeavour more precisely and to take measures to check whether workshop participants had acquired those understandings that we considered were fundamental to effective supervisory practice. Furthermore there was never an empirical base for our fallacious assumption that once health professionals have acquired any new competence through participation in a formal CPD programme, they would automatically transfer that skill or understanding into their regular clinical practice (Davis et al 1995).

An intriguing paper describing the consequences of a “motivational interviewing” training programme for counsellors in the USA (Miller and Mount 2001) suggests a more likely outcome. Those attending these events were undoubtedly satisfied customers. They were confident in their new-found abilities and appreciative of the professionalism of the workshop organisers. What’s more they universally reported that they were putting the principles of motivational interviewing into practice when followed-up 4 months later. However the evidence from direct observation of therapy and assessment of client outcomes painted a much less convincing picture. The bald conclusion of this telling audit exercise was that these counsellors were doing nothing different and hence making no difference in their clients’ lives. But as they thought they were now “qualified” in motivational interviewing, they were singularly unlikely to seek out the further training that direct sampling of therapeutic performance strongly suggested they still required. This is not an isolated finding. Indeed the belief that “continuing education improves the effectiveness of clinicians” has been described as one of the most prevalent professional myths about mental health services (Bickman 1999).

The New Broom

Our response to these concerns has been something of a “back to basics” approach. We have sought to determine what skills our novice clinical supervisors need to acquire as a matter of priority, and to consider how
we can best check they can demonstrate these competences both on our workshops and, crucially, in their subsequent professional practice.

There is a linguistic art to defining learning outcomes that can even experienced educators can struggle to master, but before meeting that semantic challenge we needed to agree what the core aims of our workshops should be. This consensus of opinion would ideally be acceptable to all the parties with a legitimate investment in supervisor training - new and experienced clinical supervisors; clinical psychology managers; NHS commissioners of training; staff on clinical psychology training programmes across the UK; supervisees; and indeed the clients who use clinical psychology services and are the presumed ultimate beneficiaries of the whole supervisor training enterprise. This has proved a complex, but we think, ultimately achievable task.

**Developing a consensus regarding learning objectives**

The learning objectives for Introductory Supervisor Training (IST) for qualified clinical psychologists have been developed using formal consensus development methods following an iterative process. The three main approaches employed to promote consensus development were the Delphi approach, nominal group technique and consensus development conferences/panels (Bowling, 2002). The learning objectives (LOs) have been developed using variants of these three methods, plus a quantitative evaluation to ensure a thorough investigation and consultation with a number of different stake-holders.

Formal consensus development methods are considered to have a number of advantages over the traditional large group discussion format, including avoiding dominance and ensuring the equal weighting of all participants' opinions in the decision-making process. (Jones, 1995). Since we had good reason to anticipate that different courses and stakeholders would have a disparate sense of priorities we embarked on a national action research programme intended to point the way to an agreed set of LOs for supervisor training across the UK. This process is illustrated in Figure 1.
Figure 1: The Processes in Consensus Development for Learning Objectives for Introductory Supervisor Training
**Phase 1: Delphi technique**

The first phase in the development of the learning objectives involved the completion of a Delphi survey by Green and Dye (2002) of a number of different stake-holders in clinical psychology, to ascertain what they felt were the most (and least) essential components of IST. This took the form of a two-round postal survey during which 50 members of an expert panel were invited to express a view on the relative pertinence of 45 potential components of introductory workshops for supervisors. A wide variation in the number of issues felt relevant for IST was found but some common agreement around the most essential elements was evident. For example the item "considering when and how to fail a placement" was almost unanimously endorsed. These results were disseminated throughout the national training community and had a discernible impact on the curriculum of several supervisor training programmes (including our own). There was however, no guarantee that all programmes had implemented these results in a uniform manner and there was little evidence of an evolving consensus across the country regarding learning objectives for IST.

**Phase 2: Modified Nominal Group technique**

Following the establishment of a project to promote the development and recognition of supervisory skills (hereafter known by its memorable acronym DROSS) a group of clinical tutors from North Britain embarked on a detailed survey of current practice in supervisor training paying special attention to the aims, objectives and learning outcomes around which workshops were organised. The first stage of this phase of the study involved a modified version of the nominal group approach pioneered by the RAND Corporation in the 1970s and 80s (Murphy et al, 1998) to democratise organizational decision-taking. Rather like the Delphi Technique nominal groups operate by sharing information between panel members in a manner that minimises opportunities for powerful members of a group to exercise disproportionate influence on the outcome of discussions. In our version the consultation followed a carefully designed sequence:

1. An expert panel was established consisting of a nominated member from each Programme that had membership of the DROSS group.
2. Panel members were asked to submit their key areas of learning in IST and their identified learning objectives.
3. These key areas and related LOs were listed and presented at an annual conference in clinical psychology involving trainers and supervisors/clinicians.

4. As a result of discussion within this wider community of clinical psychology trainers an extended list of LOs was produced.

5. All delegates at the conference were asked to choose their top five essential learning objectives ranked in order of importance by assigning five votes to the most important and one to the least important in true Eurovision Song Contest style.

6. This exercise resulted in a prioritised list of learning objectives that was passed back to the original DROSS sub-group for further refinement.

**Phase Three: Professional Consensus Development Panels and Survey**

DROSS subsequently produced a working document summarising the consultation process and providing a provisional educational framework for future supervisor training in clinical psychology. To test the utility and practicality of the LOs this working document was circulated to all programmes involved in the DROSS network who were asked to comment on the following questions:

1. Does your training meet these learning objectives?
2. Are they clear and easy to understand and apply?
3. Are there areas that your training does not include and you do not feel are important for introductory training?
4. Are there any gaps?
5. Would it be possible for you to use these objectives to produce learning outcomes for your training?

Further consultation within and without the DROSS group resulted in some minor changes to the initial working document until we felt confident that a general professional consensus had been reached as a result of consultation with a substantial proportion of the UK training community in clinical psychology (including both academics and supervisors). The outcome of this lengthy iterative process was a list of 26 learning objectives consisting of 17 LOs linked to understanding and application, eight linked to attitudes and one linked to capabilities (see appendix A).

It was deemed that the next step was to consult more widely with other stakeholders from around the country.
Phase Four: Quantitative investigation

Would the priorities enshrined in this hard-won agreement be shared by others with an important stake in supervisor training? Members of the DROSS network approached representatives of the following interested parties in their locality:

- Service users
- Current trainees
- New supervisors
- Experienced supervisors

A questionnaire was sent asking individuals to rate how essential they considered each of the 26 LOs are for IST. Individuals were also asked to identify any gaps in LOs. A total of 54 responses were gained from the following groups:

- 11 trainee clinical psychologists
- 23 from a group of mainly experienced supervisors
- 19 from a group of mainly newly experience supervisors

These three groups were analysed together (Group One).

- One response from service users (compiled by a group of individuals)

Results

Group One

The results for Group One show the lowest mean score for a LO is 3.368 (LO13- ‘Have skills and experience of using a range of supervisory approaches and methods’). The highest mean is 4.717 (LO18- ‘Has the attitude: respects trainees’). Twelve LOs were rated less than 4 and 14 rated higher than 4 {3 = significant importance, 4= highly significant importance, 5 = essential}. There were no significant differences between the responses of these three groups (t-test) on any LO.

Comparing Group One & Service User Group

In comparing Group One with the service user group, the service user group rated 4 LOs as 5 (essential). These LOs came 1st, 2nd, 7th and 9th in the means for Group One. They rated 2 LOs as 2 (some importance: their lowest rating) and these were rated 23rd and 24th out of 26 by Group One. WHICH ARE THEY?


**Gaps**

Ten responders gave ideas for gaps (at least 4 trainees and the service user group). These included: responsiveness to trainee needs; flexibility; openness and transparency; communication skills; understanding course commitments; impact of continual assessment; attitude that trainees have to find their own style; awareness of personal issues and impact on role of supervisor. However, no ‘gap’ was repeated on more than one questionnaire and some responders openly acknowledged that the point they had raised was probably already covered in the LOs.

**Implications**

The results suggested that no changes to the LOs were necessary at this point and that the consensus has been upheld by these multiple stakeholders.

**Delivering the goods**

Having established a working consensus on the competences that we wished novice supervisors to acquire during their introductory training, two further links in the assumptive educational chain still need to be constructed. The first requirement is that we can demonstrate that those attending our workshops have learned the lessons that we had in mind for them. Have they absorbed the essential factual information we hope to have conveyed? Has the opportunity to practise skills such as delivering constructive criticism in role-play exercises offered enough rehearsal time to reach necessary standards of the proficiency? This is “first base”. However even were we in a position to present compelling evidence of the levels of competence displayed by our aspirant supervisors in the workshop setting, the job would still only have been half completed. The empirical literature on the unimpressive impact of continued professional education in medicine (Davis et al 1992) provides a salutary reminder that the simplistic presumption that skills learned on training courses will automatically transfer into service improvements is rarely well-founded. The road to hell is paved with good intentions. So the next link in the chain that needs to be secured is the development of a sound strategy to encourage our supervisors to get out there and actually practise what we preach.

We already know what is likely to happen if no such measures are taken. Clinical psychologists who attended a three day series of Introduction to Supervision workshops reported on the final day that they had achieved
or exceeded all the educational goals that they had set for themselves (figure 2)

Figure 2

![Bar Chart](chart1.png)

Participants then set themselves a revised set of goals concerned with applying the lessons they had learned about good supervisory practice in their subsequent working lives. When these goal attainment scales were reviewed three months later (see figure 3) the novice supervisors reported that they had most frequently failed to meet their expected targets. (Gaston, Hughes and Green 2004).

Figure 3

![Bar Chart](chart2.png)
The explanations for this disappointing pattern of results varied. Sometimes supervisors attributed their failure to follow-through with intended changes to their usual working habits to external factors such as competing demands on their time (e.g., pressure to reduce waiting lists). Other explanations candidly acknowledged that it had proved harder than anticipated to maintain the motivation to practise new skills away from the supportive climate of the workshop setting.

**Commitment to change**

Within the field of continuing medical education, deliberate attempts have been made to maintain doctors’ enthusiasm for acting on advice received at training events by adopting a strategy termed “commitment to change” (Mazmanian and Mazmanian 1999, Dolcourt 2000). This highly pragmatic approach requires learners to make a public commitment to implement a specified change in their ways of working (for example, revising their usual prescribing practice) and to state explicitly how invested they are in making good on their word. This sense of resolve is further reinforced when the trainer contacts each learner some 30-45 days later with a reminder of the commitment they made. Finally, learners must report progress made towards their stated goals at a pre-ordained time. The expectation is clearly that the new behaviours will have been incorporated in the doctor’s schedule – and if not, why not?!

Mazmanian and colleagues have conducted randomly controlled trials that suggest this can be a simple and highly effective intervention (Mazmanian et al. 1998). The approach has an attractively pragmatic quality but also makes theoretical sense. The public “commitment to change” acts as a way of maximising cognitive dissonance if goals are not met (Festinger 1957).

It remains to be seen whether this minimal addition to our workshop programme can have the same demonstrable impact on the supervisory skills of UK clinical psychologists that Mazmanian reported with regard to the prescribing practices of US physicians. We too are in the process of conducting a randomly controlled trial comparing outcomes of a traditional commitment to change intervention (identification of specific behavioural changes + statement of level of commitment + subsequent reminder of intentions from workshop organiser) with a simpler control intervention (goal attainment scaling + email contact). Provisional analysis suggests that the “commitment to change” approach has been well-received by workshop participants who consider their resolve to become
effective supervisors has been strengthened by the intervention. However the empirical gains in comparison with the control group have not thus far hit statistically significant levels (Clarke 2006).

The baby and the bathwater

The commitment to change approach has some of the attractive appeal of a decent after-sales service. You are not only sold a product but someone takes care to check subsequently that both it and you are subsequently working properly. The format works best when relatively simple educational messages are being conveyed and there is an easily achieved consensus on the best way to tackle a given problem. For example an authoritative meta-analysis of outcome research for anti-depressant medications might lead to a recommendation that GPs switch their prescribing pattern from drug A to drug B because symptomatic improvement is likely to be very similar but drug B has noticeably less distressing side-effects. A straightforward behavioural change such as this can also be easily tracked through surgery records so any audit investigating the effectiveness of a training initiative would not have to rely solely on doctors' self-reports about their prescribing practices.

The learning objectives for introductory supervisor training listed in appendix, are not so easily operationalised. For example LO14 states that new supervisors should “have knowledge of ethical issues in supervision and an understanding of how this may affect the supervisory process, including power differentials.” This kind of moral sensitivity can, and should, lead to a wide range of behavioural outcomes. Furthermore, by its very definition, it is rare for there to be an evident right answer to an ethical dilemma (though there might be a greater consensus on what would constitute a highly inappropriate response). So the effective supervisor is at heart a “reflective practitioner” who can tolerate uncertainty and explore alternative understandings. Our challenge as evaluators has been to try and capture the flexibility of sophisticated supervisor performance within the “teach it, test it” philosophy of competence-based training.

In an attempt to achieve these potentially incompatible aims we have drawn on Kagan's notion of Interpersonal Process Recall (IPR) as applied to the process of supervision (Kagan and Kagan 1997). At an early stage of his academic career Kagan allegedly had responsibility for keeping a videotaped archive of presentations made in his university by visiting star
lecturers. Several of these high-fliers chose to review their tapes with Kagan and he noted how frequently this stimulus provoked spontaneous reflections on the thoughts and feelings that the speaker had experienced while giving their presentation. Kagan used this insight to build something of an industry of IPR training programmes in settings as diverse as the military and big business to promote the development of social sensitivity and self-awareness. The basic method involves an individual observing a recording of some interpersonal exchange in which they have been involved (in our case a recent supervision discussion). They view the tape with a facilitator (in our case one of the tutors from the training programme) and then stop the action at a point where some significant memory has been triggered. They then share those recollections with the facilitator who asks a series of non-directive questions to encourage the learner to reflect further on that moment of experience (Inskipp and Procter 1993 see appendix B). In Kagan’s IPR model facilitators do not contribute their own thoughts on what they have observed. We have not been able to exercise such iron self-control! Rather we have adapted the framework so that the tutor can offer their own reflections on the material they have seen and the comments made by the novice supervisor. The intention is not to provide an expert commentary but to open up some fresh conversational avenues to explore in the same spirit that reflecting teams try to foster in family therapy (Andersen 1987). Just as the family gets to decide which therapeutic suggestions to pursue and which to ignore, so the learner in our version of IPR determines any implications for future practice that might flow from this discussion. We have also added a further element to the video review. The “real life” conduct of the supervisor displayed on the tape and the ideas raised in the subsequent conversation offer highly credible evidence on which both tutor and learner can draw to confirm that important learning objectives, such as the ability to maintain a supervisory alliance (LO6), have been achieved.

Conclusion

So a journey that started with our dissatisfaction with the limitations of reflective learning has ended with a rediscovery of its merits and relevance. However we have not just ended up where we began. Rather we would argue that the evolution of our supervisor training modules has illustrated the pragmatic integration of a number of psychological theories to build a coherent and defensible training package.
References

Andersen T (1987)
The reflecting team: dialogue and meta-dialogue in clinical work
Family Process, 26, 415-428


Clarke L (2006)
Testing the commitment to change approach in supervisor training
Paper presented at DROSS conference, York

Davis D, Thompson M, Oxman A, and Haynes R (1992)
Evidence for the effectiveness of CME: A review of 50 controlled trials
JAMA 268, 1111-1117

Changing physician performance: a systematic review of the effect of continuing education strategies
JAMA 274, 700-705

Dolcourt J (2000)
Commitment to change: a strategy for promoting educational effectiveness. Journal of Continuing Education in the Health Professions 20,4, 156-163

Festinger L, Riecken H and Scacher S (1956)
When Prophecy Fails
Minneapolis, University of Minnesota Press

Making the Most of Supervision,
Twickenham, Cascade publications


Interpersonal Process Recall: Influencing Human Interaction
In Watkins C (ed) Handbook of Psychotherapy Supervision, New York, Wiley

Information about Barriers to Planned Change: A Randomized Controlled Trial Involving Continuing Medical Education Lectures and Commitment to Change
Academic Medicine 73, 882-886

Mazmanian PE and Mazmanian PM (1999)
Commitment to Change: Theoretical Foundations, Methods and Outcomes
Journal of Continuing Education in the Health Professions 19, 200 - 207

Miller W and Mount K (2001)
A small study of training in motivational interviewing: Does one workshop change clinician and client behaviour?
Behavioural and Cognitive Psychotherapy 29, 457-471


Norman G (1999)
The adult learner: A mythical species. Academic Medicine 74, 886-889

Appendix A
Introductory Supervisor Training

Learning Objectives

The following are the key learning objectives for Introductory Supervisor Training for clinical psychologists and related professions. It is recommended that clinical psychologists should attend this training 1-2 years post qualification. It is also recommended that the training should be for a minimum of 3 days (ideally spread over time to allow for the practical application of the training). The learning objectives include knowledge, understanding and the development of key skills, attitudes and the capability to generalise and synthesise these components.

It is envisaged that Programmes will use the learning objectives to develop their individual training packages. This will include specified learning outcomes tailored to each Programme.

Understanding and Application

1. Have knowledge of the context (including professional and legal) within which supervision is provided and an understanding of the inherent responsibility.
2. Have an understanding of the importance of modelling the professional role, e.g. managing boundaries, confidentiality, accountability.
3. Have knowledge of developmental models of learning which may have an impact on supervision.
4. Have knowledge of a number of supervision frameworks that could be used for understanding and managing the supervisory process.
5. Have an understanding of the importance of a safe environment in facilitating learning and of the factors that affect the development of a supervisory relationship.
6. Have skills and experience in developing and maintaining a supervisory alliance.
7. Have knowledge of the structure of placements including assessment procedures for disciplines at different levels of qualification up to doctorate level, and the expectations regarding the role of a supervisor.
8. Have skills and experience in contracting and negotiating with supervisees.
9. Have an understanding of the transferability of clinical skills into supervision and the similarities and differences.
10. Have an understanding of the process of assessment and failure, and skills and experience in evaluating trainees.
11. Have skills and experience in the art of constructive criticism, ongoing positive feedback and negative feedback where necessary.
12. Have knowledge of the various methods to gain information and give feedback (e.g. self report, audio and video tapes, colleague and client reports).
13. Have skills and experience of using a range of supervisory approaches and methods.
14. Have knowledge of ethical issues in supervision and an understanding of how this may affect the supervisory process, including power differentials.
15. Have an understanding of the issues around difference and diversity in supervision.
16. Have an awareness of the on-going development of supervisory skills and the need for further reflection/supervision training.
17. Have knowledge of techniques and processes to evaluate supervision, including eliciting feedback.

Attitudes (Value base)
1. Respects trainees
2. Sensitive to diversity
3. Committed to empowerment of supervisees
4. Values the ethical base guiding practice
5. Believes in balancing support and challenge
6. Committed to a psychological knowledge based approach to supervision
7. Recognises need to know own limitations
8. Supports principle of life-long learning

Capabilities
1. The capability to generalise and synthesise supervisory knowledge, skills and values in order to apply them in different settings and novel situations.

Appendix B

Questions for Interpersonal Process Recall
As you recall specific interactions or situations select one or two questions which seem appropriate:

What thoughts were going on in your mind?
What were you feeling?
Any emotions below the surface?
What did you sense in your body? Where specifically?
How were you breathing?
Were you still, rigid, moving, fidgety?
Was there anything you wanted to do?
What did you think the client was thinking about you?
What did you want the client to think/feel about you?
Does the client remind you of anyone?
Did you have any images passing through?
What did you imagine the client wanted from you?
Were there any risks involved?
Did you have any fantasies about the outcomes?
Did you have any fantasies about the client?
Who are you for the client at the moment?
Who is the client for you at the moment?

At the end of the session:
Anything you did that pleased you?
Anything you did that is ordinarily difficult for you?
What enabled you to do it this time?
What kind of image were you aware of projecting?
Is that the image you wanted to project?
What would you now choose to say, in retrospect?

From: Inskipp and Proctor (1993)