ATTACHMENT IN CLINICAL SUPERVISION: RELATIONSHIPS BETWEEN ATTACHMENT STYLES AND THE SUPERVISORY WORKING ALLIANCE

By

Shakir Iqbal Khan

29-FSS/PHDPSY/F12

Supervised by

Prof. Dr. Muhammad Tahir Khalily

Department of Psychology

Faculty of Social Sciences

International Islamic University Islamabad

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CERTIFICATION

This is certified that we have read the thesis submitted by Mr. Shakir Iqbal, bearing Registration No. 29-FSS/PHDPSY/F12. It is our judgment that this thesis is of sufficient standard to warrant its acceptance by International Islamic University, Islamabad, for awarding the degree of Ph.D in Psychology.

Committee:

External Examiner-I
Dr. Javed Iqbal,
Officer's Colony,
House No. E-32, Phase-II,
Lane No. 4, Wah Cantt.

External Examiner-II
Dr. Uzma Masroor,
Associate Professor,
Air University, Department of
Psychology, Islamabad

Internal Examiner
Dr. Nazia Iqbal,
Assistant Professor
Department of Psychology,
International Islamic University,
Islamabad

Supervisor
Dr. Muhammad Tahir Khalily,
Professor Department of Psychology,
International Islamic University,
Islamabad

Acting Chairman,
Department of Psychology,
International Islamic University,
Islamabad

Dean,
Faculty of Social Sciences,
International Islamic University,
Islamabad

CERTIFICATE

It is certified that PhD dissertation titled "**Attachment in Clinical Supervision: Relationships Between Attachment Styles and The Supervisory Working Alliance"** prepared by Shakir Iqbal Khan has been approved for submission to International Islamic University Islamabad, Pakistan.

Prof. Dr. Muhammad Tahir Khalily

Supervisor

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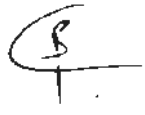

Shakir Iqbal Khan

Dated: _____

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TABLE OF CONTENTS

List of Tables

List of Figures

List of Annexures

List of Abbreviations

ECR-RS	Experiences in Close Relationships – Relationship Structures
IDM	Integrated Developmental Model
MSW	Master of Social Work
SWAI	Supervisory Working Alliance Inventory

Dedication

This Dissertation is lovingly dedicated to my respected Parents and my loving wife Dr. Ghazala who have been my-constant source of inspiration. I also dedicate this thesis to my lovely daughters Irha Khattak and Izza Khattak. They have given me the drive and discipline to tackle any task with enthusiasm and determination. Without their love and support, this dissertation would not have been made possible.

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All

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Allah alone, the most merciful and

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Abstract

Clinical supervision is integral component of clinical training of supervisees and the working alliance among supervisee and supervisor has an impact upon the effectiveness of supervision. In the current research dynamic of working alliance were explored with the perspective of attachment theory and qualitative interviews were conducted to better understand the factors effecting supervisory relationship other than attachment. Data was collected from 134 supervisees and 41 supervisors of clinical psychology from different universities of Pakistan. ECR-RS and SWAI were used to measure attachment and working alliance respectively. Results revealed that attachment anxiety and avoidance of supervisees is negatively related with their working alliance and is hindering process of their learning. Factors which explain deterioration of working alliance as emerged in qualitative analysis are dissatisfaction from structure of course, negative attitude of supervisors, unavailability of supervisors due to time constraints, physical barriers and experience of negative emotions in a learning process. Supervisors have more avoidance and anxiety than their supervisees; it was explained through impression of professionalism and new model was proposed for dual standard of ECR-RS scores in professional relationship. Limitations and implications are also provided.

Key Words: Working alliance, clinical supervision, attachment, professionalism.

Chapter-1

INTRODUCTION

The supervisor-supervisee relationship in pre-qualification clinical supervision set up is of vital importance to the professional training of graduate/master students in departments of clinical psychology in Pakistan. Therefore, it is essential to discover how supervisor-supervisee relationships are designed and retained. The present study discovered the supervisory relationship in pre-qualification clinical supervision by means of attachment theory. My own experience and observation in pre-qualification clinical supervision during my clinical internship, adding the experiences and observations shared by my colleagues, directed me to reproduce the nature of the supervisory alliance and how it comes to be understood during clinical training:

What does each person bring to the table? How does the supervisees' connection with the supervisor affect the progress of the supervisory alliance? How do perceptions of the other's style affect everyone's assessment of the alliance? Reproducing these questions and my own growth in supervision led me to think about the part of the supervisor as a safe base for professional development, a concept that originates from attachment theory to describe the importance of unquestioning relationships with the primary caregiver from which the infant can discover and grow (Ainsworth, Blehar, Waters, & Wall, 1978). Initially attachment theory was developed to describe infant-mother bonding using secure and insecure (anxious ambivalent and avoidant) attachment styles (Ainsworth et al., 1978), now since that, it has been used to conceptualize other interpersonal interactions across the lifespan (Bowlby, 1982).

To understand how early experiences with attachment figures (e.g., mother, father, or other primary caregivers) impact internal working models for successive relationship establishment (Bowlby, 1982); attachment theory is now used as a theoretical framework. Researchers have also

recognized that while an individual's attachment style may be related across relationships, there is also changeability within the individual's attachment patterns (Fraley, Heffernan, Vicary & Brumbaugh, 2011). Therefore, in addition to early measures created to conduct research on infant attachment styles, subsequent measures have been developed to measure adult attachment styles pertaining to romantic partners and other relationship-specific attachment figures. Over the last two decades, researchers have used these measures to explore the application of attachment theory to clinical supervisees' relationships with their supervisors, particularly during the early years of clinical training (Bennett, Mohr, Brintzenhofe, Szoc & Saks, 2008).

As supervised fieldwork has continued to assume a central role in the standard of clinical training, instruments such as the Supervisory Working Alliance Inventory (Efstation, Patton & Kardash, 1990) have been to developed to measure the degree to which the supervisory relationship offers the supervisee with support, and allows the supervisee to better understand his or her clients, in addition to the degree to which the supervisee recognizes with the supervisor. To recognize the viewpoint of each member of the dyad, equivalent forms of this measure were developed for clinical supervisees and supervisors. Moreover, the working alliance construct has been used to discover how the distinctive features of the supervisory working alliance link to the supervisee's development of self-efficacy. Although researchers have begun to discover the use of attachment theory to the clinical supervisory relationship, previous research has mainly considered the view of clinical supervisee rather than their supervisors. The present study designed to consider the perspectives of both supervisees and their supervisors to discover the relationship between the supervisors' and supervisees' attachments to each other, their perceptions of how the other would rate them on attachment measures, and their evaluations of the supervisory alliance. These relationships examined using data collected from both clinical supervisees and their supervisors.

Other relationships between attachment and the working alliance explored to better understand how both supervisees' and supervisors' attachment styles are associated with the supervisory alliance.

Relationship between Study Variables

A review of literature begun with the review of clinical supervision definition and its different models. The infant and adult attachment styles were reviewed. Successively, literature put on attachment theory to educational and workplace settings discussed, followed by exploration of the research on relationships between clinical supervisees and their supervisors, and ending with how the supervisory relationship has been studied about attachment styles. While the terms supervisees and supervisors used in the literature on supervisory relationships.

Clinical supervision

Clinical supervision is a mutual process in which not as much qualified member of staff develop his clinical practice skills through the skill of support and supervision from a more qualified supervisor. This mutual relation is considered a consistent, organized and comprehensive review of a supervisee's assignment with clients or patients. In other words, clinical supervision is an association between a qualified expert and one or more than one not as much qualified practitioner. Two experts of equivalent primacy and range of experience could also be involved in clinical supervision. Clinical supervision in this regard should not be confused with organizational or managerial supervision, which focuses on the worker's day-to-day organizational matters.

Clinical Supervision in Mental Health

Clinical supervision for mental health professionals appeared as "internships" in other disciplines. That is, a student/trainee with minimal skill/knowledge would learn the assignment by

noticing, accommodating, and getting opinion from a master member of the same discipline. A belief that a good "master "at work would be a good teacher/supervisor, is not right in this case. Today, we understand that clinical supervision and counseling use separate and distinct skills, despite some usual ones (e.g., the aptitude to involve in an interactive rapport). This means that no doubt a "master" clinician might be trained and skilled in supervisory knowledge to become a "master" supervisor. Furthermore, this impression of "master-trainee" supervision prompt the idea that approve the master as a "power".

It is obvious that to transfer clinical education and capabilities is not as trouble-free as the master-trainee model suggests (Falender & Shafranske, 2008). To observe the skilled clinicians in field is a beneficial training instrument but not adequate to support scholars in evolving skills as skilled clinicians. Progress is conditioned with the supervisee's involvement in counseling work and relationship, as well as the supervision itself. Thus, it is now documented that clinical supervision is a combination of interchanging supervisory models/theories between supervisor and supervisee to develop and make available a frame for it. Now to understand the process of clinical supervision, we are to look at different models in brief.

Psychotherapy-Based Supervision Models

As we know, clinical supervision is a training of perceiving, supporting, and getting feedback. This practice goes along with the plan and procedures of the psychotherapy model being used by the supervisor and supervisee. To fulfil this demand, different supervisory models developed according to these psychotherapy models to address it.

Psychotherapy-based models of supervision may give an impression of obvious addition of the therapy itself. "Theoretical orientation not only deals with inspection and assortment of clinical data for deliberation in supervision but also deals with idea and application of those data (Falender

& Shafaanske, 2008). Thus, there is a consistent drift of phrascology, concentration, and procedure from the counseling to the supervision sitting, and back again. Some examples of particular psychotherapy-based supervision models are briefly presented here.

Psychodynamic Approach to Supervision. As mentioned above, psychodynamic supervision is based on the clinical data derived from theoretical orientation (e.g., affective reactions, defense mechanisms, transference and counter transference, etc.). Frawley-O'Dea and Sarnat (2001) categorized psychodynamic supervision into three classes: patient-centered, supervisee-centered, and supervisory-matrix-centered.

Patient-centered in supervision session focuses on the patient's appearance and behaviors. The supervisor's role is moralistic, helping the supervisee understand and treat the patient's objects. According to this approach of supervision, supervisor is an authority who is uninvolved but has the comprehension and abilities to support the supervisee. (Frawley-O'Dea & Sarnat, 2001). Because the little focus on the supervisee or the supervisory process, very little conflict happens between supervisor and supervisee, if they both interpret the theoretical orientation in the same way, which reduces the supervisee's anxiety, making learning easier. On the other hand, if conflict develops using this model, supervision could be stuck and there would be no way to deal directly with it (Frawley-O'Dea & Sarnat, 2001).

Supervisee-centered psychodynamic supervision became popular in the 1950s, that focused on the subject matter and method of the supervisee's experience as a counselor (Frawley-O'Dea & Sarnat, 2001; Falender & Shafranske, 2008). Mainly supervisee's resistances, anxieties, and learning problems are focused in the process (Falender & Shafranske, 2008). The supervisor's role in this approach is still that of the authoritative, uninvolved expert (Frawley-O'Dea & Sarnat, 2001), but this approach has become more experimental than moralistic as more attention is paid

to the psychology of the supervisee (Falender & Shafranske, 2008). Several psychodynamic theories, including Ego Psychology, Self-Psychology, and Object Relations were adequate in supervisee-centered supervision (Frawley-O'Dea & Sarnat, 2001). Supervisee-centered supervision can inspire progress for the supervisee as he/she could able to understand his/her own psychological processes, but this can also be a limitation in that it makes the supervisee extremely vulnerable to stress under inspection.

The supervisory-matrix-centered approach unlocks more material in supervision as it deals with not only the material of the client and the supervisee, but also deals with examination of the relationship between supervisor and supervisee. (Peled-Avram, 2017)

In this approach of supervision, the supervisor's role is as participant, relational, reproductive, and process validator, and interpreter of relational themes that arise within either the therapeutic or supervisory dyads" (Frawley-O'Dea & Sarnat, 2001). This consists of a scrutiny of comparable process, which is defined as "the supervisee's interaction with the supervisor that parallels the client's behavior with the supervisee as the therapist" (Haynes, Corey, & Moulton, 2003).

Feminist Model of Supervision. Feminist theory confirms that an individual's experiences are reflections of society's institutionalized attitudes and values (Enns, 1996). Feminist therapists, then, try to understand the client's and their own experiences in the context of the society in which they live and often redefine mental illness because of repressive beliefs and behaviors (Haynes, Corey, & Moulton, 2003). Feminist therapy is also labeled as "gender-fair, flexible, interactional and life-span oriented" (Haynes, Corey, & Moulton, 2003).

The Ethical Rules for Feminist Therapists (Enns, 1996) highlights that therapists should recognize power discrepancies in the client-counselor relationship and work for perfect and effective use of personal, structural, and institutional power. It can be assumed that the same rules could be applied to supervise-supervisor relationship. That is, the supervisor-supervisee relationship struggles for equalitarian, possibly a relationship in which a supervisor maintains focus on the empowerment of the supervisee.

Cognitive-Behavioral Supervision. In cognitive-behavioral supervision a notable job for the supervisor is to communicate the techniques of the theoretical courses. Cognitive-behavioral supervision specifically focuses on supervisee's professional individuality and his/her reaction to the client (Haynes, Corey, & Moulton, 2003). Cognitive-behavioral procedures operated in supervision to establish a schema for supervision meetings, connecting from prior sessions, assigning homework to the supervisee, and concluding summaries by the supervisor (Liese & Beck, 1997).

Person-Centered Supervision. Carl Rogers developed person-centered therapy based on the reliance that the client can successfully settle life problems exclusive of explanation and supervision from the counselor (Haynes, Corey, & Moulton, 2003). So, it assumes that the supervisee can effectively grow as a counselor. In this model, supervisor is just a "collaborator" with the supervisee, somewhat than an expert.

The supervisor's role is to give a setting in which the supervisee can be open to his/her experience and completely involved with the client (Lambie, 2000).

In person-centered therapy, "the attitudes and personal characteristics of the therapist and the quality of the client-therapist relationship are the main factors of the results of therapy" (Haynes, Corey, & Moulton, 2003). Person-centered supervision implements this principle as well, trusting

deeply on the supervisor-supervisee relationship to enable effective learning and progress in supervision.

Developmental Models of Supervision

Generally, developmental models of supervision describe progressive stages of supervisee development from beginner to professional, each stage contains distinct characteristics and skills. For example, supervisees at the beginning stage would have incomplete skills and lack confidence as counselors, while middle stage supervisees might have more skill and confidence and have inconsistent feelings about perceived independence/dependence on the supervisor. A supervisee at the professional end of the developmental range is possibly to use good problem-solving skills and would be expected a good counselor and supervisor (Haynes, Corey, & Moulton, 2003).

In development approach to supervision, supervisors must correctly detect the supervisee's recent stage and give feedback and support suitable to that developmental stage, and equally enabling the supervisee's development to the next stage (Littrell, Lee-Borden, & Lorenz, 1979; Loganbill, Hardy, & Delworth, 1982; Stoltenberg & Delworth, 1987). To this end, a supervisor utilizes a collaborative process, as a "platform" (Zimmerman & Schunk, 2003), which enable the supervisee to produce new learning by using previous knowledge and skills. As the supervisee become master at each stage, the supervisor increases the platform to integrate knowledge and skills from the next advanced stage. During this process, the supervisee experiences new information and counseling skills, and the collaboration between supervisor and supervisee also encourages the development of advanced critical thinking skills. Importantly the process, as defined, seems linear, it is not. A supervisee may be in different stages at the same time; that is, the supervisee may be at mid-level development inclusively, but experience high anxiety when faced with a new client situation. (Guiffrida, Tansey & Miller, 2019)

Integrated Development Model. The most studied model of supervision is the Integrated Developmental Model (IDM) developed by Stoltenberg (1981) and Stoltenberg and Delworth (1987) and, lastly, by Stoltenberg, McNeill, and Delworth (1998) (Falender & Shafranske, 2004; Haynes, Corey, & Moulton, 2003). The Integrated Developmental Model defines counselor development in three stages:

• Levels 1 supervisees are usually entrance stage students who have high-level in motivation, yet of high rank in anxiety and scary of being evaluated;

• Level 2 supervisees are at mid-level, experience instable self-confidence and motivation, often relating their private mood to success with clients; and

• Level 3 supervisees are secure, stable in motivation; have true empathy strengthened by objectivity and use therapeutic self in intervention. (Falender & Shafranske, 2004) As mentioned prior, the IDM emphasizes on the point that the supervisor must utilize skills and approaches that parallel to the level of the supervisee. So, for example, when working with a level-1 supervisee, the supervisor must stabilize the supervisee's high rank anxiety and reliance by being helpful and dictatorial. Similarly, when supervising a level-3 supervisee, supervisor would highlight supervisee individuality and absorb in mutual testing. If a supervisor's responses were consistently mismatched to the developmental level of the supervisee, it would feasibly end in substantial complexity for the supervisee to reasonably master the recent developmental stage. For example, a supervisor who demands self-directed behavior from a level-1 supervisee is possibly to intensify the supervisee's anxiety. (Lambie & Blount, 2016).

Integrated developmental model is a strong and adaptable theoretical model of the developmental approach to supervision with a few drawbacks. For example, it concentrates mostly on the development of graduate students in training but pay little attention to post-degree

supervision. An added example, it gives controlled suggestions for definite supervision methods that are appropriate at each supervisee level (Haynes, Corey, & Moulton, 2003). Another developmental model projected by Ronnestad and Skovholt (1993, 2003) and Skovholt & Ronnestad (1992) addresses successfully the IDM's first weakness and provide an outline to define development across the life span of the counselor's career.

Ronnestad and Skovholt's Model. A longitudinal qualitative study was organized. One hundred counselors/therapists, ranging in experience (at the beginning of the study) from graduate students to professionals with an average of twenty-five years of experience were interviewed. Based on that study, a model was proposed by Ronnestad & Skovholt, (2003). They analyzed the resulting data in three ways, approaching with a stage model, a theme design, and a professional model of development and inactivity (Ronnestad & Skovholt, 2003). In the most current revision Ronnestad & Skovholt (2003), the model is contained of six stages of development. The first three phases (The Lay Helper, The Beginning Student Phase, and The Advanced Student Phase) unevenly parallel with the levels of the IDM. The last three phases (The Novice Professional Phase, The Experienced Professional Phase, and The Senior Professional Phase) are self-explanatory in terms of the relative occurrence of the phase in relation to the counselor's career.

Integrative Models of Supervision

Integrative models of supervision depended on more than one theory and technique (Haynes, Corey, & Moulton, 2003). Because of the large number of theories and methods that are related to supervision, a countless number of "integrations" are possible. In fact, because most counselors today practice integrative counseling, consequently integrative models of supervision are also widely practiced (Haynes, Corey, & Moulton, 2003). Two approaches to integration are described as technical eclecticism and theoretical integration.

Technical eclecticism is a collection of techniques that focuses on discriminations, selected from many approaches. This track claim to use techniques from different schools without their theoretical positions that laid them. In contrast, theoretical integration is not just a combination of techniques, rather it refers to a conceptual or theoretical creation. This track tries with the goal of constructing a conceptual outline that makes the best of two or more theoretical approaches to produce a product better off than that of a single theory (Haynes, Corey, & Moulton, 2003). Examples of Integrative supervision models consist of Bernard's (1979) discrimination model, Holloway's (1995) systems approach to supervision, Ward and House's (1998) reflective learning model and schema-focused model (Haynes, Corey, & Moulton, 2003).

Bernard's Discrimination Model. Currently, one of the most frequently used and researched integrative models of supervision is the Discrimination Model, initially published by Janine Bernard in 1979. This model is contained of three distinct emphases for supervision (i.e., intervention, conceptualization, and personalization) and three probable supervisor roles (i.e., teacher, counselor, and consultant) (Bernard & Goodyear, 2009). The supervisor could respond from one of nine ways (three roles x three foci) in any given moment. For example, the supervisor may play the role of instructor while focusing on a definite intervention used by the supervisee in the client session, or the role of counselor while focusing on the supervisee's conceptualization of the work. Response can be changed within and across sessions as it is always definite to the supervisee's needs. (Dantzler & Volkmann, 2018).

The supervisor initially assesses the supervisee's capability within the focus area, and then chooses the proper role from which to respond. Bernard and Goodyear (2009) care supervisors not to respond from the same focus or role out of personal preference, comfort, or habit, but instead to ensure the focus and role meet the most prominent needs of the supervisee in that moment.

Systems Approach. In the systems approach to supervision, the center of supervision is the relationship between supervisor and supervisee, which is mutually relating and intended at giving power to both members (Holloway, 1995). Holloway defines seven magnitudes of supervision, all linked by the central supervisory relationship. These magnitudes are, the functions of supervision, the tasks of supervision, the client, the trainee, the supervisor, and the institution (Holloway, 1995).

The function and tasks of supervision are at the forefront of interaction, while the last four dimensions signify unique circumstantial factors that are, according to Holloway, covert influences in the supervisory process. Supervision in any example is seen to be reflective of a unique combination of these seven magnitudes.

Attachment Overview

In its innovative form, attachment theory explains the infant's "attachment behaviors" with primary caregivers (Bowlby, 1958). Here concern is with the difference between attachment as a bond or continuing relationship between a young child and his mother and attachment behaviors through which such a bond is first shaped and then later serve to facilitate the relationship (Ainsworth et al., 1978). These primary attachment behaviors contain sucking, clinging, following, crying, and smiling (Bowlby, 1958). Attachment behaviors including differential smiling, crying and vocalization in the existence of the primary caregiver (the mother in early research) against other adults, and greeting the primary caregiver with behaviors such as clapping could be explained further by later researchers (Ainsworth, 1967). Additionally, behaviors such as "flight to the haven of safety" (Ainsworth, 1967) and "use of the mother as a secure base for exploration" (p. 8) have been theorized as adaptive behaviors developed during the first three years of life. Through these

behaviors, a child can gain increasing independence in a gradual process of leaving the mother and returning for support in successive approximations (Ainsworth, 1967).

The results of the Ainsworth Strange Situation Experiment were used to describe three infant attachment styles: secure, anxious-ambivalent, and avoidant (Ainsworth et al., 1978). An infant categorized as secure uses the mother "as a secure base from which to discover the unacquainted environment, just as at home he spends a great amount of his time in exploratory play" (Ainsworth et al., 1978). When their mother leaves the room, these infants become sad but is happy to see her when she returns. Anxious-ambivalent and avoidant attachment classifications are both considered insecure attachment styles. Anxious-ambivalent infants are described as "chronically anxious in relation to the mother, they tend to respond to the mother's departures in the separation episodes with immediate and intense distress; their attachment behavior has a low threshold for high intensity activation" (Ainsworth et al., 1978). These infants demonstrate elevated levels of separation anxiety. They exhibit distress in the mother's absence yet often resist contact upon her return; "They do not seem to have confident expectations of the mother's accessibility and responsiveness". Avoidant infants demonstrate approach-avoidance conflict; "they are both anxious as well as avoidant" (Ainsworth et al., 1978). These infants exhibit distress in the absence of the mother but avoid her upon her return. "The anxiety implicit in the [avoidant] attachment relationship surely must itself make the approach-avoidance conflict more extreme than it might otherwise be, for the attachment behavior of a nervous baby tends to be more willingly stimulated and at a more extreme level".

A fourth classification of infant attachment has been added, successively (Main & Solomon, 1990). Previously these infants, selected as "unclassifiable," were classified as "insecure-disorganized/disoriented;" as exemplified by "simultaneous display of contradictory

patterns" and "mutual inhibition of the attachment and exploratory behavioral systems". The initial three attachment categories left room for children with a disorganized attachment style to be falsely labeled as "secure "Due to these children's exhibition of behaviors that fall into both secure and insecure attachment types.

For instance, a disorganized infant may exhibit strong attachment-seeking behaviors such as reaching for the caregiver before suddenly turning away from and ignoring the caregiver. Disorganized infants in high-risk samples were more likely to have been abused than infants in low-risk control samples. Remarkably, disorganized infants in low-risk samples were more likely than infants in other categories to have parents with "still-unresolved attachment-related traumas". The said germinal authors initially concentrated on infants' attachments to their mothers, but extended attachment theory initially to include other attachment figures including fathers, grandparents, and childcare providers (Bowlby, 1982; Ainsworth, 1989). Correspondingly, Bowlby (1982) defines how early attachment experiences contribute to the development of inner "working models" of relationships that may continue throughout the life course.

Ainsworth (1989) proposes that secondary attachment figures such as an "understanding teacher or athletic coach" may also play a key role in the development of "working models of attachment". Ainsworth adds that, "In the case of older persons, attachment figures cast in the parental mold might include counselors, clerics or preachers, or therapists". While secondary attachment figures may be short-term, Ainsworth suggests that their "influence may continue to be valued and the representational model of the relationship may persist".

Adult Attachment

The use of attachment theory as a model of relationship patterns across the lifecycle has extended attachment theory well beyond the limits of infant-caregiver relationships. Early researchers applying three attachment styles (secure, avoidant, and anxious/ambivalent) to adults in romantic relationships found roughly the same distribution of attachment styles across two studies (56% secure, 24% avoidant, and 20% anxious/ambivalent) (Hazan & Shaver, 1987) as found in samples of infants from middle-class families (65% secure, 20-25% avoidant, and 10-15% anxious/ambivalent) (Campos, Barrett, Lamb, Goldsmith, & Stemberg, 1983). Furthermore, the researchers found that adults in each attachment classification inclined to reveal expectations of romantic relationship distinctive to their attachment classification (Hazan & Shaver, 1987).

For example, secure romantic partners "emphasized being able to accept and support their partner despite their partner's faults" whereas avoidant romantic partners "were characterized by fear of intimacy, emotional highs and lows, and jealousy". A meta-analysis of adult attachment classifications as measured by the Adult Attachment Interview (George, Kaplan & Main, 1987) indicated a distribution of 58% secure autonomous, 24% insecure-dismissing, and 18% insecure-preoccupied in non-clinical samples (Van IJzendoorn & Kranenburg, 1996). Researchers conducting a more recent analysis found distributions of 50% secure-autonomous, 32% insecure-dismissing, and 18% insecure-preoccupied in a small sample of 37 participants (Waters, Merrick, Treboux, Crowell, & Albersheim, 2000).

These researchers conducted a 20-year longitudinal study on the stability of attachment classifications over the life course and found 72% correspondence between infant attachment styles as classified using the Strange Situation and adult styles as classified using the AAI (Waters et al., 2000). Furthermore, participants who did determine a change in attachment style were more

possibly to have experienced "stressful life events" (e.g., parental loss and/or mental illness; than individuals who sustained their attachment classifications. Several three- and four-category measures of adult attachment have been developed and studied in relationship to other variables. For example, Brennan, Shaver and Tobey (1991) piloted a study with a sample of 840 college students to examine the relationship between attachment styles and parental drinking habits. The researchers used both a three-category (secure, anxious-ambivalent, avoidant) measure of adult attachment (Hazen & Shaver, 1987) and a four-category (secure, preoccupied, fearful, dismissing) measure of adult attachment (Bartholomew, 1990).

The researchers found that avoidant or anxious-ambivalent adult attachment styles, as measured by the three-category model, were more predominant among college students who grew up with an alcoholic parent than the general population. However, the researchers found that "subjects in the dismissing category also came from Hazen & Shaver's secure category, suggesting that some avoidant people with high self-esteem are enforced by the three-category model to misclassify themselves as secure, even though they are not likely to show secure behavior in close relationships" (Brennan et al., 1991,). Interpretations of these data advocate that four-categories such as those used in the Bartholomew model may offer a more correct measurement of adult attachment styles. The Experiences in Close Relationships Questionnaire (ECR) in its original form was developed as an adult attachment questionnaire to measure romantic relationships. Two scales were developed through factor analysis: avoidance and anxiety (Brennan, Clark & Shaver, 1998). The scales were used to group participants into four categories: secure (low avoidance, low anxiety), fearful (high avoidance, high anxiety), preoccupied (low avoidance, high anxiety), and dismissing (high avoidance, low anxiety.)

The measure was successively rescaled using item response theory to develop the Experiences in Close Relationships Questionnaire-Revised (ECR-R) (Fraley, Waller & Brennan, 2000), and use of the scale has extended beyond romantic relationships to include several types of "close" relationships. More in recent times, researchers have extended the application of attachment beyond traditional attachment relationships to other relationships that may motivate adult attachment styles. This extension has glowed the development of a new form of the ECR, the Experiences in Close Relationships – Relationship Structures Questionnaire (ECR-RS; Fraley, Heffernan, Vicary & Brumbaugh, 2011). This form of the questionnaire purposes to measure attachment styles about specific relationships and can be used to measure attachments to specific individuals (e.g., mother, a specific teacher or mentor) or individuals in specific role types (e.g., mother-like figures, basketball coaches).

Thus, as a measure of adult attachment, the ECR-RS is exclusively adjustable to assessing the attachment between clinical supervisees and supervisors in field placement settings. Furthermore, a comparison of the ECR-R and the ECR-RS found that the ECR-RS is a well judge of interpersonal (e.g., relationship quality ratings) and intrapersonal (e.g., depression ratings) characteristics, whereas the ECR-R is a well judge of personality traits (Fraley, Heffernan, Vicary & Brumbaugh, 2011). Therefore, the ECR-RS may offer the most utility in considering how attachments specific to the supervisory relationship relate to the quality of the working alliance.

Attachment in Education and Workplace

Attachment theory has been used to theorize relationships and styles of interaction (e.g., leadership) in the workplace (Hazen & Shaver, 1990) and educational settings (Kennedy & Kennedy, 2004). The application of attachment theory to an employment context was part of a wider movement to use theories in personality psychology to guess workplace outcomes (Harms,

2011). For example, researchers examining relationships between a group of professionals and their counselors found that team in which both individuals had a secure attachment style were most likely to achieve desired workplace outcomes; it was noted, however, that mismatched attachment styles between mentees and mentors did not preclude success (Germain, 2011). Attachment styles have also been associated with differences in counterproductive work behaviors (Richards & Schat, 2011), and styles of seeking feedback (Hepper & Carnelley, 2010). Similarly, attachment theory has been used to inform interactions between school-age students and teachers in educational settings (Kennedy & Kennedy, 2004). Kennedy and Kennedy encouraged educators to involve in self-reflection regarding their own attachment styles and the influence of their own attachment styles on their students. In a parallel manner, self-reflection about one's own attachment style in relation to a supervisor or supervisee could shed light on the working alliance, principally when the supervisor assumes the role of the primary counselor or educator for the supervisee.

The Supervisory Working Alliance

Clinical supervision departments of clinical psychology students in field settings is distinctively set up as both an educational and work experience in which the clinical supervisor is both an educator and workplace supervisor. As a part of the departments of clinical psychology training process, supervisees are routinely presented with clients' circumstances, which are unfamiliar and may require consultation. These situations often involve ethical dilemmas that supervisees have not previously confronted in a professional perspective (Dodd et al., 2007). In the face of ethical concerns during clinical fieldwork, Master of Social Work (MSW) supervisees in one study described that the resource to which they most commonly turned was supervision (75.2%), followed by peer consultation (45.7%), in-class discussion (38.0%), and agency

personnel (20.9%). However, in the identical study about these four types of resources, MSW supervisees reported that supervision had the lowest rate of being helpful or extremely helpful (71.1%), while peer consultation (94.9%), in-class discussion (91.8%), and agency personnel (81.5%) were found to be more consistently helpful. Considering MSW supervisees' demonstrated reliance on clinical supervision, consideration of these data raises questions concerning how to better understand the nature of supervisor-supervisee interactions, as well as what can be done to improve upon the perceived helpfulness of supervisory relationships.

Bordin (1983) and Holloway (1987) claimed that the working alliance established within the clinical supervisory relationship is a dynamic factor of clinical training and is fundamentally associated to the overall quality of the clinical training experience. Consequently, instruments have been developed to measure the strength of the supervisory alliance as. One measure that has been used to measure the usefulness of the supervisory relationship is the Supervisory Working Alliance Inventory (SWAI; Efstation et al., 1990). In acknowledgement of the inter subjective nature of the supervisory alliance, similar versions of this measure were developed for clinical supervisees and supervisors. The two versions of the measure inventory factors correlated to supervisees and supervisors' perceptions of the supervisory relationship, correspondingly, as related to two overall subscales: client focus and rapport (Efstation et al., 1990).

The degree to which supervision helps the supervisee to well diagnose his or her clients is measured by the client focus subscale. Whereas the degree to which the supervisee is supported by the supervisory alliance is measured by the rapport subscale. An additional subscale established for the supervisor version of SWAI using factor analysis, that suggests that supervisors as compare to supervisee may differently understand the factors that contribute to the working alliance. This

additional subscale is characterized as identification, that measures the degree to which the supervisor be certain of that the supervisee identifies with the supervisor. (Morrison & Lent, 2018).

High scores on the supervisee form of the rapport and client focus subscales were found to be a significant predictor of supervisees' sense of self-efficacy in executing clinical procedures (Efstation et al., 1990). These subscales were also found to be positively correlated with measures of supervisory styles (e.g., task oriented, interpersonally sensitive), demonstrating some convergent validity with the Supervisory Styles Inventory (Friedland & Ward, 1984 as cited in Efstation et al., 1990). Weak positive correlations (.03 to .36) between the supervisee and supervisee subscales demonstrated that although supervisees' and supervisors' evaluations of the working alliance are related, there is also significant difference in the evaluation of the working alliance within steam. This difference highlights the importance of measuring both supervisees' and supervisors' evaluation of the working alliance, rather than using data from only one member of the team.

Attachment and Supervision

Pistole and Watkins (1995) were among the first to propose that relationships between clinical psychologists and their supervisors could be hypothesized using an attachment framework. Consequently, researchers have studied aspects of clinical supervisory relationships through the lens of attachment. Bennett et al. (2008) found that 72 MSW students' relationship-specific attachment styles as measured using the ECR-RS were predictive of aspects of the working alliance, whereas global attachment styles were not. Most of the participants reported a secure global attachment style (low avoidance and low anxiety) but reported higher than average avoidance and anxiety about their relationship with their supervisor. Thus, relationship-specific attachment may be more predictive of variations in the working alliance than global attachment

styles. Alternatively, measures that assess participants' specific relationships may activate attachment styles more readily than similar measures that assess abstract relationships. (Mesrie, Diener & Clark, 2018).

In a sample of masters-level counseling students, researchers found that trainees' attachment styles accounted for 22.9% of the variance in working alliance rapport (Renfro-Michel & Sheperis, 2009). Neswald-McCalip (2001) provided qualitative evidence that supervisees' attachment styles shape both the supervisory relationship and the supervisees' experiences working with clients. Case examples of situations in which the supervisory working alliance provided supervisees with a secure base from which to develop a more secure working model of relationships were provided by the author. However, the conceptualization of supervision as a corrective model for insecure supervisees assumes that the supervisor can serve as a secure base. Like the trainee, the supervisor's own "emotional availability towards others is strongly associated with early attachment experiences" (Shemmings, 2006). Therefore, a supervisor who does not have a secure attachment style may not be able to provide a secure base to his or her supervisee t. In a study of 87 doctoral interns in psychology who participated in an online survey (Riggs & Bretz, 2006), participants were asked to rate both their own attachment styles and their perceptions of their supervisors' attachment styles. They were also asked to assess the working alliance in the supervisory relationship. Results indicated that supervisees' reports of their supervisors as secure predicted a stronger supervisory bond; whereas supervisees' self-reported attachment styles were not predictors of the working alliance. Authors of an Internet study of 259 British post-doctoral psychology interns reported comparable results (Dickson, Moberly, Marshall, & Rielly, 2011).

Only a few studies have recruited supervisor- supervisee dyads. One such study found that while supervisees' attachment styles were not predictive of the supervisory working alliance, supervisors' attachment styles were predictive of both their own ratings of the working alliance and the working alliance ratings of their supervisees (White & Queener, 2003). These findings proposed that while both the supervisor and supervisee carry their own attachment styles to the supervisory relationship, the supervisor's attachment style may be more significant in the supervisory working alliance and therefore may have more influence on the field component of the clinical training process. While these studies are beneficial in understanding the role of attachment in clinical supervisory relationships, they are also restricted in their designs and external validity. (McKibben & Webber, 2017). One limitation is that most of the studies utilized only supervisees as participants rather than recruiting matched pairs of supervisees and supervisors. "Attachment processes may be more directly related to the supervisory bond among less advanced supervisees, who apparently need more nurturance and interpersonal support than the clinical interns;" for example, in Riggs and Bretz' (2006) sample. Furthermore, participants should be recruited from a variety of stages of the clinical training process and without limitation to any single program.

Training and Learning

Goldstein and Ford (1993) conceptualized training as a scientific learning experience, proposed to pick up new directions, abilities and capabilities that result in an enhanced implementation. Furthermore, he referred to learning as a comparatively everlasting modification in actions, because of practice. It shows an expansion in understanding, knowledge or skills acquired by practice, which might include instruction, study, observation and training. It is a course that should not be analysed directly: a few might take up that by perceiving performance a few has

learned. Moreover, he argued that efficacy of training initiates from a discovering circumstance scientifically intended to bring about variations in enhancement of job performance and in the working environment (Kraiger et al. 1993). The transmission of knowledge is stated as 'the course to put on facts to innovative circumstances (Goldstein & Ford, 1993). In the training and educational area, training is explained as the degree to which skills, Facts and abilities 'are simplified, applied and sustained in the required fields. (Baldwin & Ford, 1988).

Salas and Cannon-Bowers (2001) acknowledged in their review of training, more than a few possible matters associated to transfer of training. Firstly. The report of the training framework, specifically since it sets prospects, positions, and inspirations for transfer. In the second place, transfer condition may have a significant influence on the level to which anew attained Knowledge, abilities and skills are exercised in the profession. Thirdly, postponements relating training and definite usage on job can cause in substantial skills' deterioration. Moreover, there are a few studies on the interpersonal setting of training, indicating that peer, societal, supercilious and subsidiary hold up all portray a vital part in transfer (Colquitt et al. 2000).

Early Theories of learning

The study of hominid knowledge was taken over during the last century by numerous approaches. Behaviourism, Ivan Pavlov gave the sight of human learning built on observable behaviour and classical conditioning, was additionally established by J.B. Watson, Thorndike and Hull achieved its top in the 1950s when B.F. Skinner's work on reinforcement and operant conditioning was established. This paradigm was critiqued for its reduction because it used a 'black box' view: Because a few cannot measure what is taking place in the brain, a few should limit reflexion, dimensions and theories to what is going in the stimulus and the response. Rogers (1986), criticised as:

'this approach tends to stress the active role of the teacher-agent;

the student learner is often seen as more passive' (p.46).

For instance, trainees' behaviour and appropriate responses can be reinforced by trainer and, while unpromising undesired behaviours. Although behaviourist theories emphasised the significance of the reinforcement process and stimulus, which are the base of other learning methods, they have not explained role of interior influences in activity of learning. Therefore, in the 1960s and 1970s, the behaviourist viewpoint was changed by further composite theories, i.e. humanistic and cognitive approaches. Increasing attention was given to the cognitive processes, and several psychologists focused on the thought processes which cause learning, resulting into new interpretations described as cognitive theories. As Greeno et al. (1996) described, cognitive learning theories highlight the part of over-all cognitive aptitudes, such as intellectual, problem solving and planning in conceptualizing theories and ideas, elevating concentrative capabilities. 'Learning is considered as a useful procedure of intangible development, most of times relating restructuring of notions in the learner's understanding, and development in wide-ranging cognitive abilities as meta-cognitive processes and problem-solving strategies, précised as the dimensions to replicate upon one's intellectual, and by this means to scrutinise and handle it. Simply describing as the learner is considered as performing a dynamic role and the mentor needs to take in the trainee in a dynamic process, for instance through feedback.

Memory is involved in learning as claimed by the cognitive psychologists, and along with memory, thinking, motivation and reflection have an important role in learning. Cognitive theorists believe that learning is internal process. Further the recommend that learner's capacity of learning, efforts made by the learner, processing depth (Craik & Lockhart, 1972) and existing knowledge of the learner determines the amount of learning (Ausubel, 1968). Theory of dual coding proposed

by Paivio (1986) suggests that when information is gained by visual and verbal stimuli it enhances the memory. However, constructivist psychologists think that a learner perceives and interprets the world and information as per his/her personal reality. He/she learns with processing and interpretation, observation and then personalise the information into knowledge (Cooper 1993). When the information is contextualised, it gives the best learning to the individual to attain meaning and for immediate application of the learning.

Bloom (1976) discriminated between learning in affective realm and learning in cognitive realm, the latter facilitating the cognitive functions growth in learning. He specified that, in conjunction with the cognitive phases in learning, the individual proceeds through four affective segments. First, the lowermost level of cognitive area is recognition and recall of knowledge; this includes the reception of a stimuli on the affective side, which is, attention is being paid by trainee to what a trainer is a trainee is saying. Second, comprehension come in the cognitive domain, which infers comprehension and exploration of information by trainee which is provided by the trainers more actively; which develops a growth of personal commitment on the affective side to the training, there a sense of satisfaction and a positive response emerges. Thirdly, applying of learned skills and knowledge is on the cognitive side, which is, applying it in real circumstances, for instance when interacting with clients. On the affective side, this relates to a calculation of value of the activity, for instance, the supervisee will decide whether to be a part of further training or to proceed course she or he is already studying. Interpreted another way, trainees prioritize the skills they are acquiring and manifest their commitment and preferences. Furthermore, Trainees explore new scenarios by breaching them down into analysis - fundamental elements and synthesis – put up new perceptions; supervisees on the affective side relate concepts with values identifies in early phases and they start making judgements. In the last, participants evaluate themselves in

cognitive domain by comparing knowledge and skills they have adopted with their goals. For instance, a supervisee may ask herself of himself whether she or he now eligible and competent to analyse and treat his or her clients. In the affective side participants assimilate the ethics they have recognised into a system, for instance a welcoming attitude towards a different clinical technique which is newly learnt by trainee, each supervisee in the end is identified as individual. Bloom (1976) brought the synthesis of cognitive elements and affective elements. He gave a multiaxial approach to learning, which is widely applied by many authors, for example Kraiger et al., (1993), have applied to the training situation,

The learning Models based on humanistic school of thought has refused to accept the view that automatic factors determine the learning process. Humanistic model rather suggest that supervisees create their own learning situation because people are in control of their lives. Several theorists, such as Abram Maslow, emphasized on affective realm and how trainee tries to control their own life processes (Rogers, 1996) hence recommending the worthiness of self-sufficiency. Supervisor plays a role in increasing the variety of experiences, that supervisees taking supervision can take benefit from range of experiences as per their preferred learning targets, therefore, supervisees' needs, goals and priorities play a vital role. Individuals create own learning by drawing one's feelings, ideas, experiences and judgement about events and people in his/her life as stated by Rogers (1996); response to any stimuli is not a learning. Supervisor is considered as facilitator of procedure, an instructor to help supervisee to conceptualize. Experimental and participative methods are most appropriate. Concluding the above concepts, humanistic and cognitive both models highlighted personal experiences as the most important, but no one have formulated, and appropriate theory related to its function in learning.

Integration based Current Theories

The way of processing experience is the heart of all learnings as stressed by integration-based theories. Experience is beginning of learning cycles which then leads to reflection and continues with action, this itself is a concrete experience for reflection (Rogers, 1996).

Perspective based on integration of learning processes by Kolb (1984) in his famous book 'Experiential Learning: Experience as the source of Learning and Development' he emphasised the cyclical pattern of learning is derived from the idea of experiential learning – from experience through conceptualization of action, reflection and further experiences.

Holistic integration perspective on learning which combines perception, experience, behaviour and cognition is the cause of the popularity of Kolb's model rather than an alternate to other commonly practiced approaches i.e. Cognitivism and behaviourism. Kolb explained this concept of learning as 'experiential' to highlight significance of experience in learning process. Moreover, he linked his theory with previous scientists i.e. Lewin, Piaget and Dewey etc. as he wanted to relate. Learning is described by these three authors as a procedure whereby ideas are continuously modified after being derived by experience. Six central viewpoints relate Kolb's theory with his forerunners. These are labelled below:

1. In diverge to the behaviourist methodology, Kolb (1984) defines learning as a process, rather than as a product. Lewin, Dewey and Piaget, 'describe learning as a process whereby experience continuously revises the resulting concepts. As experience interferes so the two thoughts are never the same' (Kolb, 1984); trainees, for example, nonstop adapt knowledge through their work with clients, and through exchanges with the trainer.

2. Kolb is agreed to Dewey's idea of continuousness: 'knowledge is nonstop resulting from and verified out in the experiences of the learner' (Kolb, 1984). The genuine intention of this

statement is that a learner go in a learning circumstances with a few concepts about the subject matter at part; they even now have some convictions. As a result, the trainer checks and tests the learner's convictions and speculations and then open the new, more advanced philosophies into the person's confidences systems, the learning method will be facilitated'. This is what Piaget found as 'integration' and 'substitution' (1973).

3.The three authors defined learning as a procedure, follow-on the determination of clashes between contrasting ways of dealing with the world, what Piaget called 'accommodation' and 'assimilation'. So, the person's cognitive development would point toward an accommodation of concepts about the exterior world, for example a trainee must change his or her present knowledge to make it suitable in an innovative learning environment. Add-on, it includes adjustment of experience into on hand theoretical structures, for example where a trainee stabs to integrate an anew learnt approach into his or her established way of working.

4. They all believed that learning is a complete (Kolb, 1984) process, which contains rational, sensation, perception and response.

5. Learning is relevant to an operation between the individual and the environment, each influences nonstop the other. When taking this in account, Kolb referred to Dewey's concepts. Agreeing to this opinion, a trainee's learning experience is ended exceptional not only by the material he or she is reviewing, but also by his or her parallel trainees, the trainer or the physical setting.

6. Following Piaget's (1973) clue, Kolb engrossed the firm associations between learning and facts. The vital to learning deceits in the common collaboration of the procedure of the adaptation of concepts or 'schemas' (new concepts with which to better experience the world), and the procedure of assimilating proceedings and experiences from the world into standing concepts

and schemas. Learning results from a stable strain between these two processes. In the following paragraph, I will express more details of the Kolb's model of learning, its bearing to the training and clinical supervision setting, as well as some of its limits.

Characteristics of Experiential Learning

Kolb (1984) suggested that individual's own involvement and being part of event and utilising his/her own experiences and participant's reflection to experience directly result in experiential learning. Learning is particularly effective because of holistic perspective of cognition, physical aspects and emotions of learner and learner centred perspective explains learning by doing that individuals learn best from their own experiences.

Experiential circle results in learning: knowledge is tested on in everyday after being gained by experiences. Facing and resolving the conflicts results in new learning. There are two noteworthy aspects for learning: to change practice we use feedback, and ideas are being tested by use of now and here experiences. As discussed above, the two aspects are integrated by Kolb into Piaget's (1973) to identify the role of cognitive development and Dewey's (1938) work to highlight the developmental nature of learning and into.

Four elements of experiential learning cycle 'Observation and reflection', 'planning for new situations', 'concrete experiences' and 'forming abstracts' are presented by Kolb (1984) as illustrate his model. He mentioned that learning cycle might start at any point from above mentioned four points, although these elements are likely to occur. Well-known Integral model suggested by Kolb is widely applied to a lot of learning situations in day to day life including education and training generally. For instance, applying knowledge on clients by trainee which they have acquired from trainers is a form of experiential way of learning. By this, the trainee will

transform the experience and information into new knowledge of new phenomenon or familiar subjects. (Rangel, Chung, Harris, Carpenter, Chiaburu, & Moore, 2015).

More precisely, in the concrete experience phase, trainees are entirely tied down to an experience, as for example working with their clients. In the first stage, the instructor engages the apprentices in a concrete experience. The experience might be a role-play, a live or video demo, a case study, or a monument. Then in the reflective observation stage, they pace back and reflect on their experience (the work they have done with clients). The learners are then invited to evaluate the experience from several viewpoints. They query themselves that might help in the replication of what occurred. This second stage is stated as reflective observation. Through the abstract conceptualisation stage, they unite their observations and reflections and change them into complete theories. In the third phase of abstract conceptualisation, the learners expand theories and look at designs. The trainer boosts the learners to discover worth for what they have observed, why it is noteworthy, and which inference can be sketched. This could take place, for example, through educational learning in a classroom situation or through supervision sessions. The fourth and final stage of this experiential model is active experimentation. Learners trial these theories and use them as foundations for new arrangements. This could be same for students who go to an assignment, or trainees who put on their anew learnt skills with clients (Sugarmann, 1985).

Factors that Influence Training and Learning

Training and transfer have been broadly studied, with some authors (for example Warr & Downing, 2000, Hook & Bunce, 2001) signifying that emotions perform a main part in the course, but no systematic study has been done of this part. Research on the training background is generally concentrated on pre-training characteristics, training methods and post-training settings.

Pre-training conditions

Agreeing to Salas and Cannon-Bowers (200 l), precursor training settings (or pre-training characteristics) are generally characterized as:

1. Trainees features, such as: cognitive ability, motivation, self-efficacy and emotion;
2. Variables that involve the trainee in the learning proceedings, such as motivation;
3. Preparation for training, as for example training orientation.

Trainees' features

A few critics (Warr & Downing, 2000), have jagged out that research in learning has concentrated on the attainment of declarative knowledge, which consists of data, for example moralistic material, and generally leads higher order development (Kraiger et al. 1993). As exemplified above in the overview to Kolb's theory (see p.40), cognitive procedures are not merely liable for fruitful learning and it is therefore suitable to study other approaches. For example, relational procedures in learning in a professional situation are undoubtedly significant: trainees act together with other individuals (fellow trainees and the trainer) and with a broader situation (colleagues at work). 'Affective' approaches (Weinstan & Mayer, 1986) are also believed to be pertinent. These are assumed to have not direct influence on learning, influencing motivation stages and anxiety management.

In an evaluation of the literature on the affective characteristics of learning, Boekaerts (1996) recapitulated the work of Hembree (1988). In a sequence of laboratory experiments, it was discovered that anxiety hinders with the task-relevant information required for handling dimensions in the working memory. Agreeing to Boekaerts (1996), this could clarify the point that nervous students apply unsuitable cognitive approaches for the attainment of fruitful learning results. Boekaerts also reviewed how anger can impact the functioning of secondary school

students. Students may get angry for various reasons, for example if the teacher rebukes them, or when they are not permitted to stop an exciting task. Such conditions are expected to intensify the stage of physiological excitement in the most students. He also observed that repressing and monitoring anger causes great stresses on the individual's processing volume and may hinder with task functioning. The influences of unhappiness, hopelessness, pleasure and joy have not yet been reviewed significantly in the classroom condition.

More than a few laboratory reports have discovered the influences of emotion on cognition and the point that emotions influence human cognition is generally documented in psychology (Damasio 1994, Ekman & Davidson, 1994). For example, Moore and Oaksford (2002) directed a study to observe how learning is adapted by the emotional status. They examined the long-term effects of emotion on cognition over a 12-day time. The participants· comprised of a total of 36 undergraduate psychology students. They were involved in five parallel experiments over a 5-day-period. The first four days of the experiment proceeded successively, with each participant setup through mood stimulation measures and then being requested to complete some learning tasks. In the fifth session, which happened after 12 days, partakers completed the learning tasks short of the mood stimulation measures, so that their retaining could be tested. The outcomes proposed that, in general, positive emotional statuses precedent to better performances and that intensified emotional statuses increase the establishment of long- term memory, while stimulated negative statuses precedent to duller performance. However, the study appeared to have little conservational validity, as the inferences cannot be simplified to naturally stirring conditions and are limited to the sample of undergraduate psychology students.

Warr and Downing (2000) critiqued the point that learning measures the vital, have been examined in laboratory situations. They directed a cross-sectional analysis determined on

adult/professional learners and proposed that three kinds of learning approaches are exercised when attaining novel material: reasoning, communicative and self-regulatory. Reasoning approaches contain practice, an intellectual replication of the existing information, and the organization of intellectual buildings that group the main foundations to be learned and unified. Fourteener, amongst the reasoning approaches, they believed the amplification procedures that are used to observe inferences and make contacts between new material and prevailing knowledge. Communicative approaches are supposed to be interactive help-seeking, for example asking for help, and looking for help and inflection from documents or other forms of written material. Self-regulatory approaches are motivation checking and emotion control. The last is stated as 'procedures to avoid anxiety and avert attention failures produced by the interruption of anxiety-related thoughts' (p.313). Warr and Downing (2000) desired to determine that these different learning approaches differ and are related with effective learning and success in knowledge attainment tasks. Predominantly appropriate for the present thesis, is one of the purposes of their study, which was measuring the effect of learning.

They studied anxiety on each of the three learning procedures stated above. Their study sample contained of 288 adults joining a course in training for work as vehicle technicians. Each course included almost 12 trainees. Multi-item-scales were operated to measure learning ability, motivation, anxiety and load prior to the course. To observe the learning approaches exercised by the trainees, a 54-item-questionnaire was directed at the end of the course. To explore those influences related to the use of each learning approach, the authors performed a regression analysis. They discovered that minus learning appeared for trainees who called using more practice, interactive help seeking, emotional control and motivational control. An earlier measure of learning anxiety was revealed to reason for the model.

Warr and Downing (2000) established that anxiety influenced learning strategies, with an additional positive correlation between strategies and learning resulting in less anxious trainees. For more anxious individuals, state of strategies used were particularly interrelated with lesser learning. Warr and Downing (2000) also observed that the emotional influence related to learning tasks appears superior in professionals involved in qualifying courses, making significant professional decisions and for whom improvements in their job probabilities may depend upon the success of their training course. Adult learners may be concerned with rare training events, in compare to college students who are frequently engaged in learning tasks. In this condition, learning can bring 'uncertainty, confusion and attitudes of weakness and loss of repute identity' (Atkins, 2002). The trainees may be 'remodeling' (Atkins, 2002) some of the skills that they previously have, and which will perform a new part both with clients, and in the arrangement where the trainee is employed.

In their meta-analysis on training motivation, Colquit et al. (2000) determined that anxiety lessens training motivation but has numerous effects that must be explored. Other than anxiety, as Boekarts (1996) said, the part of other emotions, for example grief, despair, pleasure and happiness, must be explored in a classroom/training condition and the significances of both positive and negative emotions should be discovered. He said that, for example emotions offer evidence about the situation, which is then characterised as 'complicated' or 'uncomplicated' (p.586) and students/trainees adjust their information processing behaviours accordingly. · For example, if a trainer makes sensations of anxiety the over-all training setting might be supposed as alarming and the trainee could act in a self-protective way, (e.g.: he or she might try to gratify the trainer).

Salas and Carmon-Bowes (2001) studied thirty years since the first description on training, in the Annual Review of Psychology, and discovered significant development in relations of both the science and the rehearsal of training. Current research is determined to observe the influences that simplify the transfer and request of anew learnt skills. Many influences appear to dominant the training and transfer, containing self-efficacy (Gist et al., 1991), role-play (Littlefield et al., 1999) and age (Mathies et al., 1992).

In a meta-analysis of training motivation, Colquitt et al. (2000) categorized the several influences into two different sets:

1. Environmental, for example supervisor help, structural circumstances, and values;
2. Personal characteristics, such as general intelligence, intellectual aptitude and self.

Furthermore, Milne et al. (2000a) approved an analysis of the research on the transfer of MHP training to the workplace. They recognised that, "trainer care", "use of experiential methods"," devotion to the broader work background and 'removal of blockades that interrupt the staff's practice of the anew learnt skills in psychosocial methods "were the main influences simplifying the application of novel skills when at work with clients' (p.268). They also recognized that the existence of these influences is a perfect situation for the application of new knowledge, skills and capabilities. A large number of experts studied the issue of learning and transfer of new skills to the workplace with the transfer definition as 'the range to which knowledge, skills and aptitudes are operated, simplified and sustained over time within a job setting' (Baldwin & Ford 1988). A vital fact been indicated as the difference between positive training and the successful transfer of training. Researchers considered the training successful if the participants met the training objectives. Transfer of training success story, however, is calculated dissimilar to achievement of the training purposes marks in better job presentation (Kraiger et al., 1993).

Evidently, if the job performance is not improved latter, the training is of slight worth to the constitution being paid it.

Several factors affect the process of learning and transfer of learning as evident by a more than a few theoretical and empirical studies in literature, counting trainee's psychological individual differences. Such as, emotions, intelligence and others have accepted as playing vital role acquiring new skills. Similar to other factors, emotions are important character of experience-based learning and these experiences are considered to enable adaption of knowledge. A study conducted by Warr and Downing (2000) on learning outcomes and learning strategies counting self-regulatory strategies. Such self-regulatory tactics cover emotional control, anxiety-linked thoughts causing attentiveness failure can be prevented by using such procedures.

Rationale of the Study

Psychology had made a considerable progress in Pakistan since 1947.A breakthrough in clinical psychology was made in 1983, when two specialized at Karachi and Lahore separately. But the development made in addition of accoutrements for training and grant of advance degree, however, had not been touched by the courtesy to quality of training and supervision.

Although, recently supervision training courses for counsellors and psychotherapists are increased and are to be found in different universities in Pakistan that offer considerable training courses in counselling or psychotherapy in pre-qualification supervision set up. There is still needing to increase interest in post-qualification supervision training courses that will attract other professional groups, such as nurses, occupational therapists, doctors, managers, social workers, as well as therapists and psychologists in future. A brief look at supervision training courses in universities, reveals that training may be offered for one- and two-years' diploma or even a

master's degree. But the range of courses is confusing, and no recognizable standards are set for supervisory practice.

Clinical supervision is a main factor of the training of psychologists and observing of services carried by beginner therapists in training settings. Within supervision, the supervisor supervises both supervisee development and client progress to develop the skills of the supervisee as well as to ensure capability of service delivery and protect clients. Giving the position of this effort to the development of clinicians and to the protection of clients, more researches are vital to understand the supervisor and supervisee contributions to the supervisory process. Recently it is admitted that clinical supervision is an understudied phenomenon within psychological research and publications.

Much of the existing previous studies on clinical supervision have pointed the crucial role of quality of supervisory relationship in contributing to both process and outcome of supervision. Because much of the previous work has been restricted to investigate supervisee variables and perceptions of this phenomenon, identifying the need for research on variables within the supervisory setting. Keeping this in view the present study used the views of Attachment Theory to explore individual differences of the supervisor and supervisee as they relate to behaviors in supervision. This study tested hypotheses developed from theory and prior research that assist to notify both our understanding of the variables that supervisors and supervisees transport to supervision and help inform training of future supervisors by explaining the relationship between attachment variables and working alliance.

Additionally, many mental health specialists qualified in psychosocial intercessions may not apply their recently learnt services with clients. One reason for this may be the part of emotions and other factors in training and its transfer. This study furthermore investigates the role of various

factors (i.e. emotions, learning barriers, course structure etc.) in training and its transfer in the process of clinical supervision

Conceptual Model

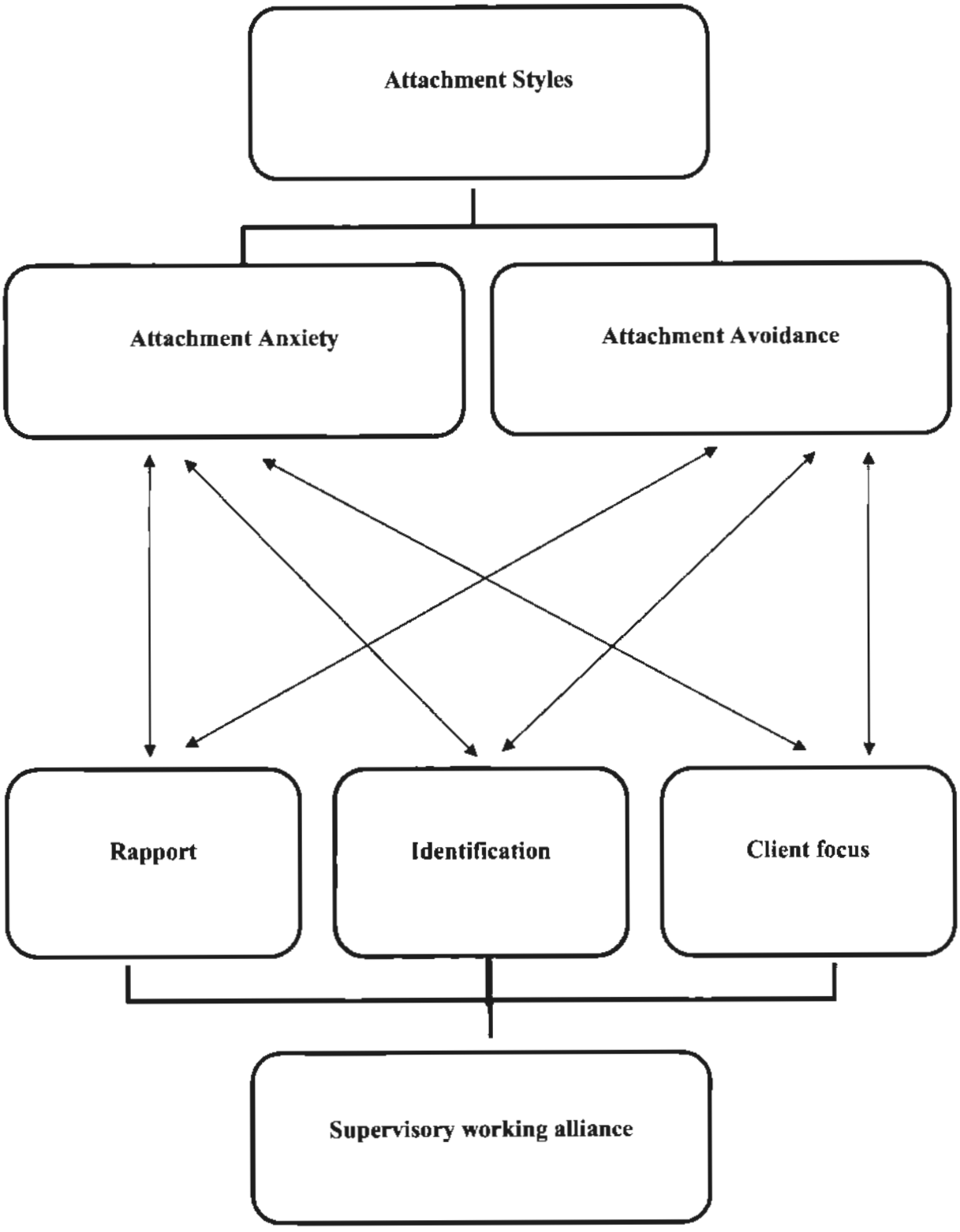

Figure 1. Conceptual framework of the study

Chapter II

METHOD

Objectives

1. To assess the relationship between attachments and working alliance among supervisees and supervisors.
2. To compare supervisors and supervisees Attachment, rapport, client focus and working alliance. And to detect the difference of perceived attachment of supervisees with supervisors (as rated by supervisors) and perceived attachment of supervisors with supervisees (as rated by supervisees)
3. To explore out the factors involved in better learning during clinical supervision and to explore the experience of supervisors and supervisees related to clinical supervision.
4. To describe the experience of emotions in training and transfer new skills in the process of clinical supervision.

Hypotheses

1. There will be negative relationship of working alliance with attachment anxiety and attachment avoidance
2. Working alliance will be negatively related with perceived attachment anxiety and perceived attachment avoidance
3. There will be positive relationship between client focus and rapport of supervisees' supervisory working alliance.
4. Supervisees with a secure attachment to their supervisors will rate higher working alliance with their supervisor.

5. Supervisees' attachment avoidance with the supervisor will be positive related with supervisees' attachment anxiety.
6. There will be positive relationship between Supervisees' perceptions of supervisors' attachment avoidance and their perceptions of supervisors' attachment anxiety.
7. There will be positive relationship between supervisors' self-rated attachment avoidance and their attachment anxiety with supervisees.
8. There will be positive relationship between supervisors' perceptions of supervisees' attachment avoidance and anxiety with supervisors.
9. There will be significant difference of supervisors and supervisees on attachment anxiety and attachment avoidance.
10. There will be significant difference of supervisees' perception of supervisors and supervisors' perception of supervisees on attachment avoidance and attachment anxiety.
11. There will be significant difference of rapport, client focus and working alliance between supervisors and supervisees.
12. There will be positive relationship between client focus and identification of supervisors' supervisory working alliance.

Operational Definitions

Attachment Styles. Attachment, as defined by Bartholomew and Horowitz (1991) is a two-dimension, dichotomized model of self and others. These two dimensions are combined to form four prototypes: secure, preoccupied, fearful and dismissing. High score on Experiences in Close Relationships: Relationship Structures Questionnaire (Fraley, Waller & Brennan, 2000) indicates higher attachment and low score on scale indicates lower attachment among participants

Secure Attachment Style. Secure attachment is to trust others and to have a strong sense of self. Therefore, individuals with secure attachment express a short level of anxiety and a low grade of avoidance.

Preoccupied Attachment Style. Preoccupied attachment is expressed by emotional state of worthlessness and a sense of dependence on others. Therefore, individuals with preoccupied attachment have a high grade of anxiety and a low grade of avoidance in relations.

Fearful Attachment Style. Fearful attachment is to feel unlovable and distrust others. Therefore, individuals with fearful attachment establish high grades of anxiety along with a high degree of avoiding handy relations.

Dismissing Attachment Style. Dismissing attachment is expressed by emotional state of personal achievement and a high sense of self-reliance with avoidance of near relations. Therefore, individuals with dismissing attachment have low anxiety with a high grade of avoidance.

Working Alliance. Bordin (1979) hypothesized the working alliance as containing of three inter-reliant mechanisms: goals, tasks, and bonds. He observed the supervisory working alliance as teamwork for modification that includes common contract and understanding between supervisor and supervisee on the (a) goals of supervision, (b) tasks of supervision, and (c) emotional link between the supervisor and supervisee. High score on Supervisory Working Alliance Inventory (Efstation et al., 1990) indicates higher working alliance and low score on scale indicates lower working alliance among participants.

Supervisor. The person at the department where a student is interning who is responsible for providing primary supervision to the student.

Supervisee. The student who is enrolled in any discipline and doing clinical internship under supervision.

Sample

Data from study participants ($N = 175$) collected and analyzed. These participants included 134 current clinical psychology students who are enrolled in the master's programs or in advance diploma at Institute of Clinical Psychology University of Karachi, Centre for Clinical Psychology University of Punjab Lahore, Department of Psychology University of Peshawar and the departments of clinical psychology of other universities, in addition to 41 of their clinical supervisors. All participants reported either (a) currently completing a clinical internship or field placement as part of the department of clinical psychology and (b) the clinical supervisor of an individual completing a clinical field placement as part of the department of clinical psychology. Participants who complete most of the survey but omitted answers to specific sections retained in the data set.

Instruments

Informed Consent Form. Informed consent was obtained, and once participants have answered the screening question affirmatively, meeting inclusion criteria, they were directed to fill a form, containing the Informed Consent. Participants asked to read instructions explaining the informed consent, and accept all terms of participation, that indicated agreement. After the agreement Participants were unable to move on to the survey unless this procedure was completed. All informed consent materials are developed in English.

Demographics. After signing an informed consent, participants directed to answer a brief demographic survey including standard information regarding social group membership (age, education)

Experiences in Close Relationships: Relationship Structures Questionnaire (ECRRS). The ECR-RS developed by Fraley, Waller & Brennan, (2000) contains 9 items that are

rated on a 7-point Likert scale of strongly disagree (1) to strongly agree (7). The ECR-RS contains two subscales, Avoidance (α = .88 to .92) and Anxiety (α = .88 to .91)

Supervisory Working Alliance Inventory (SWAI). The SWAI used as a measure of supervisees' and supervisors' satisfaction with the clinical supervisory relationship (Efstation et al., 1990). The supervisee's version contains 19 items that are rated on a 7-point Likert scale of "almost never" (1) to "almost always" (7). Two subscales are Client Focus (α = .97), Rapport (α = .77) and Identification (α = .77). The supervisor's version of the SWAI contains 23 items that are rated on a 7-point Likert scale of "almost never" (1) to "almost always" (7). Three subscales identified using factor analysis were Client Focus (α = .71), Rapport (α = .73), and Identification (α = .7).

Semi-structured affect in training/clinical supervision interview

A semi-structured interview was developed to describe the experience of training and transfer in clinical supervision. All the participants were interviewed using semi-structured questions.

Research design

The present study was conducted using a mixed method research design (qualitative and quantitative procedure) in the format of semi structured interview and survey questionnaire.

Procedure

Research participants were approached in different universities for data collection. They were ensured confidentiality of their responses by anonymity. Willing and motivated participants completed a screening question; participants who met the criteria of being either a supervisor or supervisee were then directed to review and sign an informed consent outlining the purpose and possible risks and/or benefits of participating in the study. Once informed consent was obtained,

participants were interviewed using semi-structured questions. Only one participant was interviewed at a time. Interview was finished when the repetitions of information increase and interviewer concluded this as saturation of information. After the obtaining qualitative data by interview, quantitative data was collected by survey method and they were able to complete the questionnaire. The survey was contained demographic questions, the scale of Experiences in Close Relationships – Relationship Structures Questionnaire (ECR-RS; Fraley, Heffernan, Vicary & Brumbaugh, 2011), and the Supervisory Working Alliance Inventory (SWAI; Efstation et al., 1990). Participants were asked to identify their role as either a supervisor or supervisee and were directed to complete measures differentially as follows.

Additionally, theoretically grounded semi-structured interview was developed to identify emotions, experiences of supervisees and supervisors. Interview as carried out face-to-face at the participant's work setting (usually a quiet office or room on site)

Analysis

Triangulation method was used to collect and analyze the data. The term triangulation refers to the practice of using multiple sources of data or multiple approaches to analyzing data to enhance the credibility of a research study. Originating in navigational and surveying contexts, triangulation aligns multiple perspectives and leads to a more comprehensive understanding of the phenomenon of interest. For the current study, Qualitative and Quantitative methods were used to obtain the data and analyze the responses of the participants.

Qualitative thematic analysis method used in this study to investigate how clinical supervision is affecting the learning process, clinical experiences, applying knowledge and skills in clinical sessions, supervisee's life, personality and emotions. Thematic analysis helps large data from different research participants to analyze and synthesize into a meaningful account.

Qualitative thematic analysis method provides an organized method for identifying themes within data and docs not constrained by single epistemological position (Boyatzis, 1998). To analyze qualitative data braun and clarke's (2006) guidelines were used. Buetow's (2010) saliency analysis as conceptualization of thematic analysis was integrated into this study, to identify the most salient themes.

'Bottom up' themes were developed by inductive thematic analysis of semantic information from qualitative data. Inductive approach is open to participants' experiences and not limited to seek views on themes suggested by the literature. Which helps to avoid biases and assumptions in literature being perpetuated and reduces the influence of researcher's pre-existing knowledge (Braun & Clarke, 2006). Retrospective interviews have reliability issues of recalling events/ information, Blane (1996) concluded that events/ information which is salient for participant are likely to be more easily recalled.

Pearson correlation used to measure relationship among attachment anxiety, attachment avoidance, perceived attachment anxiety perceived attachment avoidance, rapport, client focus supervisory working alliance and identification.

Descriptive statistics (Independent sample t test and One-Way ANOVA) has been used to analyze demographic variables for the entire sample, the supervisee subsample, and the supervisor subsample.

RESULTS

Table 1.

Sociodemographic characteristics of participants (N=175)

Variables	*F*	%	Mean	SD	Range
Supervisor	41	23.43			
Age			33.78	6.16	27-53
Education					
MS/M.Phil.	28	68.29			
Ph.D.	13	31.71			
Supervisee	134	76.57			
Age			24.59	2.31	23-27
Education					
Diploma	51	38.06			
MS/M.Phil.	83	61.94			

Demographic analysis shows two strata in data, 41(23.43) supervisors and 134(76.57) supervisees were included in sample, mean age of supervisors was 33.78 (SD= 6.16) Min 27 Max 53 however, mean age of supervisees was 24.59 (SD = 2.31) range 23-27. 51 (38.06) were being supervised in

diploma and 83 (61.94) were in MS/ M.Phil. Qualification of Supervisors were PhD 13(31.71) and 28 (68.29) had M.Phil.

Table 2.

Psychometric Properties of Study Major Variables

Measures	n	No. of items	A	Range		M	SD	Skew.	Kurt.
				Min	Max				
ECR-RS (Supervisor)	41	9	.73	12	44	32.73	6.91	-.96	1.22
Perceived ECR-RS (Supervisor)	41	9	.71	19	50	38.32	8.06	-.95	.57
SWAI (Supervisor)	41	23	.75	108	151	131.20	8.65	.40	1.27
ECR-RS (Supervisee)	134	9	.88	9	57	26.84	9.86	.58	.10
Perceived ECR-RS (Supervisee)	134	9	.82	9	54	29.51	8.47	-.12	.10
SWAI (Supervisee)	134	19	.96	50	133	100.08	20.50	-.96	.43

ECR-RS = Experiences in Close Relationships: Relationship Structures Questionnaire, SWAI = Supervisory Working Alliance Inventory,

Table 3 showed that ECR-RS (Supervisor) mean score was 32.73 (SD = 6.91) alpha reliability .73, minimum score was 12 while maximum score was 44. Perceived ECR-RS (Supervisor) mean score was 38.32 (SD = 8.06) alpha reliability .71, minimum score was 19 while maximum score was 50. SWAI (Supervisor) mean score was 131.20 (SD = 8.65) alpha reliability .75, minimum score was 108 while maximum score was 151. ECR-RS (Supervisee) mean score was 26.86 (SD = 9.86) alpha reliability .88, minimum score was 9 and maximum score was 57. Perceived ECR-RS (Supervisee) mean score was 29.51 (SD = 8.47) alpha reliability .82, minimum score was 9 and maximum score was 54. SWAI (Supervisee) mean score was 100.08 (SD = 20.50) alpha reliability .96, minimum score was 50 and maximum score was 133. The value of skewness (ranging from -.96 to .58) and kurtosis (ranging from .10 to 1.27) of all scales showed that the data were normally distributed.

Table 3.

Pearson correlation between the major study variables. The values above the diagonal represent Supervisors while values below the sample indicate Supervisees.

	1	2	3	4	7	8	9	10
1. Attachment Anxiety	-	.57**	-0.04	-0.04	-0.03	0.16	0.12	0.19
2. Attachment Avoidance	.54**	-	0.20	0.17	-0.22	0.10	-0.01	0.07
3. Perceived Attachment Anxiety	.57**	.42**	-	0.09	0.08	0.05	0.05	-0.01
4. Perceived Attachment Avoidance	.37**	.56**	.34**	-	0.12	0.24	0.22	0.19
7. Rapport	-.64**	-.38**	-.37**	-.28**	-	.75**	.87**	.50**
8. Client Focus	-.60**	-.37**	-.30**	-.33**	.84**	-	.95**	.66**
9. Supervisory Working Alliance	-.64**	-.39**	-.36**	-.31**	.98**	.94**	-	.79**
10. Identification	-	-	-	-	-	-	-	-

**. Correlation is significant at the 0.01 level.

Results in above diagonal of table 4 showed correlations among supervisors' sample which depicts that there is significantly positive correlation of attachment anxiety with attachment avoidance (r=.57, p<.01). Pearson correlation also showed that Rapport is positively correlated with client focus (r= .75, p<.01), SWAI (r=.87, =<.01) and identification (r= .50, p< 01). Results also showed that client focus

is positively correlated with SWAI (r=.95, p<.01) and Identification (r= .66, p= .01). Pearson correlation between other variables was non-significant.

Results in below the diagonal showed correlation among Supervisees' sample which depicts that there is significantly positive correlation of Attachment anxiety with attachment avoidance (r= .54, p<.01), perceived attachment anxiety (r= .57, p< .01) and perceived attachment avoidance (r= .37, p< .01), However, negatively correlated with Rapport (r= -.64, p< .01), Client focus (r= -.60, p< .01) and SWAI (r= -.64, p< .01). Moreover, attachment avoidance is positively correlated with perceived attachment anxiety (r= .42, p< .01) and Perceived attachment avoidance (r= .56, p< .01) and negatively correlated with rapport (r= -.38, p< .01), client focus (r= -.37, p< .01) and SWAI (r= -.39, p< .01). Furthermore, perceived attachment anxiety is positively correlated perceived attachment avoidance (r= .34, p< .01) but negatively correlated with rapport (r= -.37, p< .01), client focus (r= -.30, p< .01) and SWAI (r= -.36, p< .01). results also showed that perceived attachment avoidance is negatively correlated with rapport (r= -.28, p< .01), client focus (r= -.33, p< .01) and SWAI (r= -.31, p< .01). table 4 also indicated that rapport is positively correlated with client focus (r= .84, p< .01) and SWAI (r= .98, p< .01). results also showed that Client focus is positively correlated with SWAI (r= .94, p< .01)

Table 4.

t-test analysis between Supervisor and Supervisee, on variables of Attachment Anxiety, Attachment Avoidance, Perceived Attachment Anxiety, Perceived Attachment Avoidance, ECR-RS, Perceived ECR-RS, Rapport, Client Focus and SWAI.

Variables	Supervisor		Supervisee		*t(df)*	*p*	95% CI		Cohn's *d*
	M	SD	M	SD			LL	UL	
Attachment Anxiety	21.90	4.88	18.76	6.96	3.24(94.30)	.00	1.21	5.07	.52
Attachment Avoidance	10.83	2.84	8.08	4.17	4.81(97.65)	.00	1.61	3.88	.77
Perceived Attachment Anxiety	28.24	7.51	20.93	6.49	6.09(173)	.00	4.95	9.69	1.04
Perceived Attachment Avoidance	10.07	2.35	8.59	3.67	3.06(104.61)	.00	0.52	2.45	.48
Rapport	5.66	.45	5.21	1.11	3.75(160.55)	.00	0.21	0.68	.53
Client Focus	5.68	.46	5.36	1.14	2.65(160.91)	.01	0.08	0.57	.36
Supervisory Working Alliance	131.20	8.65	100.08	20.50	13.97(156.53)	.00	26.71	35.51	1.98

Table 5. An independent-samples t-test indicated that Attachment anxiety scores were significantly higher for Supervisors (M = 21.90, SD = 4.88) than Supervisee (M =18.76, SD = 6.96), t (94.30) = 3.26, p <.001, result also showed that there were significantly different between Supervisor (M = 10.83, SD = 2.84) and Supervisee (M =8.08, SD = 4.17), t (97.65) = 4.81, p <.001, on variable of Attachment avoidance. Furthermore, supervisor scored significantly high (M= 28.24, SD = 7.51) as compared to Supervisee (M= 20.93, SD= 6.49),

t (173) = 6.09, p < .001, on variable of Perceived attachment anxiety. Similarly, perceived attachment avoidance scores were significantly higher for supervisors (M= 10.07, SD= 2.35) than supervisee (M= 8.59, SD = 3.67), t (104.61) = 3.06, p < .001. Results also indicated that rapport scores were significantly higher for supervisors (M= 5.66, SD= .45) as compared to Supervisee (M= 5.21, SD= 1.11), t (160.55) = 3.75, p< .001. t-test also revealed that supervisors scored high (M= 5.68, SD= .46) than supervisee (M= 5.36, SD= 1.14), t (160.91) = 2.65, p< .01. and SWAI scores were high for supervisor (M= 131.20, SD= 8.65) as compared to Supervisee (M= 100.08, SD= 20.50), t (156.53) = 13.97, p< .001.

Qualitative analysis

Five main themes related to clinical supervision were identified: "Experience of learning", "learning barriers", "experience of applying", "relational aspects" and "emotion". These themes were frequent and highly salient within dataset for most participants. Themes titles have been assigned by the researcher to best describe emerged themes (Boyatzis, 1998). "learning and transfer" is a suitable synthesis of main themes and considered as global theme. Themes maps, and an overview are as below. (Braun & Clarke, 2006).

Learning and transfer: majority of research participants stated that learning and transfer is key factor of clinical supervision. Subthemes of "training / learning characteristics". "reaction to training", "structure of the course" and "attitudes" were identified.

Learning barriers: statements of participants concluded some factors significantly causing hurdles and difficulties in learning. Subthemes are "physical", "time and work related", supervisor's attitude" and "supervisee's skills"

Experience of applying: supervisees expressed their experience of applying acquired skills during supervision. Subthemes of "use of skills" and experience with client" were noticed.

Relational aspects: support during supervision and during sessions is one of key factor for optimal learning as reported by research participants. Subthemes of "supervisor's support/ support in course" and supportive environment" are made.

Emotions: emotional reactions of client, supervisee and supervisor to training and experiences were identified from the data. Subthemes are "emotions to trainee/ supervisor/ client", "emotions to supervision/ learning" and "no emotional events".

Themes and maps overview

Schematically mapped themes as recommended by Braun and Clarke (2006), with saliency and frequency (Buetow, 2010), Brief description of theme and first-level sub-themes given in table No. (5). (Bold: Salient themes)

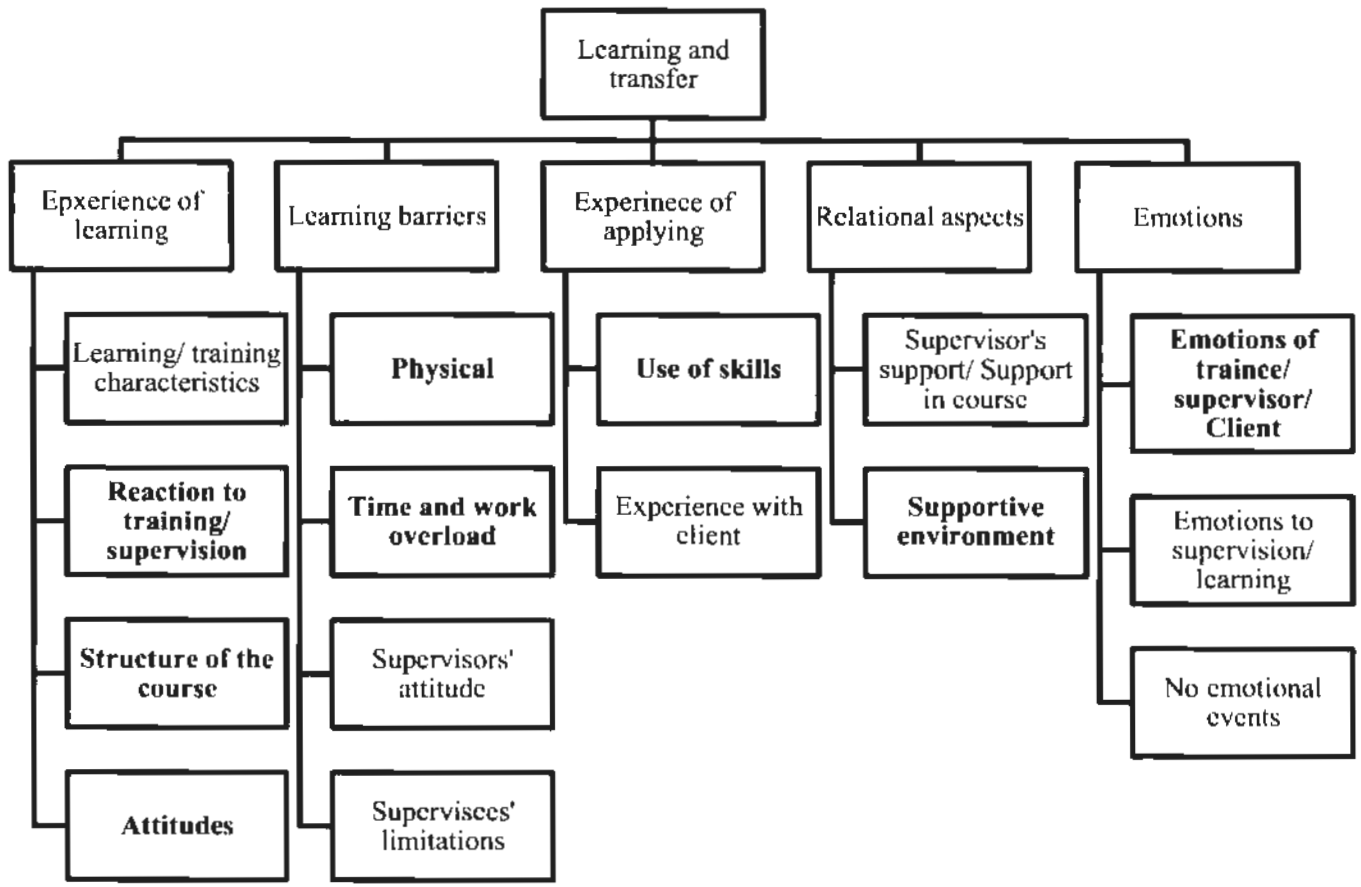

Figure: 2 Schematically mapped themes

Table 5

Themes overview

Global Themes	Themes	Sub-Themes	Typical quote	Frequency*	Saliency**
Learning and transfer	Experience of learning	Learning/ training characteristics	Clinical supervision is an opportunity to discuss and learn the ongoing difficulties in dealing with clients and how to address them in light of expertise of supervision (P151)	118	Low
		Reaction to training/ supervision	Interactive, supportive and cooperative, the learning was so good (P75)	162	High
		Structure of the course.	I think it needs to be more ethical and our training should incorporate our cultural content (P103)	146	High
		Attitudes	My clinical supervision session is supportive, but not very knowledgeable but overall attitude is good (P89)	139	High
	Learning barriers	Physical	The environment of training program might cause hurdle in session (P132)	132	High
		Time and work overload	Time and required number of cases are the barrier in my supervision course (P162)	154	High
		Supervisor's attitude	my supervisor is not concerned she is not paying attention and time to her trainees (P69)	113	Low
		Supervisee's limitations	My own self confidence and hesitation makes it difficult sometimes (P171)	85	Low

	Experience of applying	Use of skills	It is easy to apply the learned skills and techniques (P45)	158	High
		Experience with client	It was very hurting when I couldn't take properly session with client (P92)	68	Low
	Relational aspects	Supervisor's support/ Support in the course/	Supervisor gives us supportive and appropriate suggestions at time of difficulty (P54)	116	Low
		Supportive environment	Supportive and cooperative environment, the learning environment was good (P123)	135	High
	Emotions	Emotions of trainee/ supervisor/ Client	My own fear of discussing case with supervisor sometimes (P168)	129	High
		Emotions to supervision/ learning	I feel blessed to have such supportive supervision sessions (P78)	91	Low
		No emotional events	It's profession. Not emotional (P32)	56	Low

* Number of participants who identified the theme.

** Subjective importance of theme assigned based on the researcher's perceptions of how salient or important theme was for the participants

Training/ learning characteristics

Individuals involved in supervision process has reported certain characteristics for learning and training. They have expressed purpose and desired outcome of learning and training. Furthermore, factors involved in learning and training were highlighted by research participants:

> Supervised session gives opportunity of learning to trainee, develop professional and help of polish clinical expertise in dealing with clients with diversity from counseling (P12)

> Presentation of cases by supervisees with demonstration of technique on weekly basis in front of team of supervisor's help improve both supervision and training of supervisees. (P5)

> Training is learning understanding and implementation of the therapeutic techniques in a most effective way. (P31)

> It must be beneficial; the environment must be cooperative to enhance learning (P41)

> Clinical supervision session means you going to learn more information regarding the clinical setting (P51)

> The environment promotes learning the support and encouragement gives an opportunity to perform and practice (P142)

> Supervise the session of training by supervisor himself give the ideas told the trainee his mistakes/errors and motivate him (111)

> Person who is much competent in his/her field having proper knowledge but also consider client's cultural back ground and adopt according to his/her understanding level (P29)

It should be supportive, providing guidelines to trainee and also giving them respect (P170)

More demonstration based should be given for conducting effective treatment (P95)

The session teaches you practical application of therapeutic session with appropriate strategies (P125)

Better conversational skills and contact with supervisor, also if you are open about your concerns with supervisor (P161)

Group discussion and getting feedback from others encourages(P70)

Clinical supervision session is important for learning ICP achievable all goals e.g. the level of training is appropriate is all supervisors (P86)

There should be proper check and balance from university, department, that what a supervisor is teaching the trainees, there should be proper feedback taken from the supervisees about their supervisor and try to evaluate that in future (P99)

Supervisors should motivate their trainees (P88)

Supervisor should come at level of students and provide guidance the students should not be fearful when going to their supervisor (P72)

A supervisor must be empathetic (P145)

Sharing of own client's experiences and giving more knowledge with reference to therapies (P122)

Training provided by my supervisor is excellent she put her all efforts and made us capable of many things in clinical setting (P175)

Reaction to training/ supervision

A variety of reactions, comments and reflection of opinions about training and supervision were expressed by research participants:

It is a good learning opportunity for developing clinical skills (P150)

Learning and extremely helpful experience(P167)

Informative, useful and helpful for further studies(P58)

Compatible environment with supervised session, useful and supportive training, learning a lot of new techniques and therapies (P157)

Training is very important part of clinical environment improve the session effective learning environment (P39)

I guess everything is best, we have learned a lot and got great exposure (P52)

It is very much helpful, I have learned a lot how to deal with client and to make case report, our environment is open and free with supervisor (P53)

It is an extremely good learning experience, helped me a lot in increasing my knowledge and skills regarding sessions (P66)

Interactive, supportive, cooperative (P15)

It has provided me with a good learning experience with a lot of knowledge, but it also had it is cons in maintaining a stress-free relationship (P124)

Learning environment was so good (P57)

It's interesting and valuable experience (P23)

The learning environment is comfortable; it is a great learning experience for me (P174)

My clinical training always proved to be a great deal of learning and experience as well as providing an atmosphere to open up and learn better ways to deal with the clients (P61)

It gives more knowledge and ways to tackle clients effectively, mind is open for learning things in new ways (P60)

I would say that its very good as we learn a lot in supervision session such as how to deal a difficult client, learning new techniques etc. (P112)

The training is very good, informative and helpful in enhancing my skills (P65)

My clinical supervision session is supportive, but not very knowledgeable but overall attitude is good (P55)

It is a good source of getting professional training as well as practical knowledge (P71)

That was conducive for learning new skills and sharpen the abilities (P121)

Best learning experience of my life, very comfortable environment (P76)

It is great opportunity for leaning and observing different kind of behavior (P163)

Clinical supervision sessions are helpful in understanding the different problems that facing with clients during session (P152)

Very much useful but it is tough until we pass it (P63)

Clinical supervision is helpful during sessions (P91)

Structure of the course

Supervisors and supervisees mutually shared the ideas, suggestions, recommendations and objections on current course of internship/ supervision. Improvement in course for better outcome and optimal learning were also noticed:

Success depends on supervisee's potential of learning and application of knowledge. It is like developmental process, near completion of training supervisees get more independent in applying techniques. (P1)

Weekly case presentation by each supervisee & viva voce examination (P40)

yes. If number of supervisees are reduced (P21)

our standard does meet with national level, but we cannot compare it with international level as per changes and variations in culture and environment. (P3)

I think there was cultural barrier western techniques to deal disorder, needs cultural modification (P9)

Due to less activities session understanding was not very much effective (P42)

Lack of expert and experience trainees using old techniques and supervisors never update their knowledge according to new techniques (P134)

The bookish or theoretical could not be applied on daily living. The techniques need to be tailor made. (P96)

Practical demonstration of the techniques learned (P67)

If the supervision session starts from the first day of year, it will work best (P47)

By giving extra time and start the supervision from beginning and giving the enough sketch that how you will deal with client's problem and how you will interpret tests applied on client and making its feedback (P141)

Yes, it is important to improve your level of learning but in Pakistan our training in clinical psychology is not met with international standards (P164)

Yes, to some extend but needs to be worked more (P43)

No, but we are doing good or at least putting effort toward making it in a good shape (P81)

To some extent, but we need to work hard (P118)

No, there still needs to be a lot of improvement (P153)

Yes, but not everywhere, only in few places (P173)

No, we don't need international standards rather we need culturally specific practices (P44)

No, they are very better (P117)

Somewhat, need to improve a lot (P172)

No, I don't agree with the preposition as the student supervisor relationship in our training program is entirely different from abroad. They do not face the problem of supervisors degrading and unconcerned attitude. (P82)

No, 1 credit hour don't meet their criteria, this is the case with every Pakistani university (P120)

Not really, we need to work on it (P131)

Not that much, cultural barriers mostly involved (P143)

No, (with due apology). Yes, some practices are good (training seminars) but lot of improvement is needed (P46)

It needs to improve much (P166)

Hope so, they do not have equal standards at each placement (P90)

No, it needs improvement (P48)

Yes, but by further improving or enhancing it may increase its success (P169)

To some extend but are still lagging behind (P50)

It should include more psychological tests and techniques should be practiced thoroughly to enhance effectiveness (P106)

I would like to say that clinical practice should meet the international standards and proper testing with therapies should be practiced getting exposure in practical field (P165)

Supervisors are way to success; they open our way to learning and competence by guiding us (P128)

Supervisors are the guide (P154)

Attitudes

A number of participants reported issues related to attitudes of different individuals involved in clinical internship process. However, a few participants mentioned positive and supportive attitudes on departmental and placement related individuals:

Effective session in teams of learning sharing experiences, knowledge and attitude in short duration where from specific internees moves to general. (P2)

The training was learning; my supervisor was supportive (P53)

Her style of learning is very interactive, her attitude towards her supervisee is calm, she always supports us in her best way I got chance to learn many things/technique problems (P128)

My supervisor tends to maintain a learning and conductive environment during clinical meeting and sessions, she also provided me with comfortable environment to clear my confusions. (P162)

The learning during supervised session is amazing, my supervisor is highly supportive of me, she only intervenes if I am doing something out of line (P88)

It's very helpful in learning process, and gives you practical exposure in an open environment, I have had a very supportive relationship with my supervisor so far (P122)

Learning environment and her attitude is very helping, and she is very supportive (P41)

My experience with my supervisor developed my clinical skills and confidence the attitude was friendly and helpful she had knowledge and knew how to deliver it practically (P82)

The training was very conducive to learning, the environment was friendly, the positive attitude of my supervisor helped me learn a lot (P157)

It is going well; my supervisor had taught me real life solutions and strategies to understand clients (P142)

Learning environment was very supportive, and attitude of trainer was very supportive and useful and training was very useful for personal training. (P106)

Environment was friendly, and I learned a lot from it, supervisor was understanding (P175)

She never discouraged, she always encouraged, I think she is blessing for me (P152)

In supervision I learnt a lot, supervisors' attitude was so cooperative and little bit taunting behavior she guided me very carefully related to my clients and I learnt more skills from her (P117)

Supportive attitude of supervisor and my interest in patient help to apply and learn skill (P75)

With practice it has become easier (P86)

Some sort of biased attitudes (P76)

No, barriers might be the other colleague's negative attitude towards the trainees, that may limit the supervision skills or openness (P161)

Attitude of supervisor is very helpful (P134)

Humble and polite attitude of supervisor in addition to this better guidance provided by supervisor can contribute (P111)

Skills and responsible behavior of supervisor (P154)

Cooperative attitude (P174)

My supervisor's way of delivering the practical knowledge is a basic factor (P44)

Dedication of my supervisor (P57)

Yes, her dedication, listening skills and understanding (P72)

Supervisor's competence makes us more energetic (P103)

Supervisor knowledge and cooperative calm personality (P125)

Sometimes, she doesn't give response to our questions (P42)

Excellent learning experience, my supervisor guides me about all important thing that are necessary for me to learn. (P81)

Level of learning, friendly attitude, learning a lot of skills (P52)

Physical

Physical environment, facilities, availability of clients, space, tools and others related issues were identified as a hurdle in learning and supervision process:

> Limitation with reference to availability of clinical material and tests etc. (P14)
>
> Obviously not, people lack in training and then are hesitant in sharing knowledge, taking permission to enter any institute is itself really tough. (P160)
>
> Management and environment. Most clinical settings lake supervision guidance specifically for trainees (P144)
>
> Environment, university resources/time management (P110)
>
> Lack of clients is a major barrier, additionally dropout rate and fee structure (P62)
>
> There was shortage of space in hospitals therefore it was difficult to take sessions properly (P56)
>
> Environmental barrier as space for conducting proper session is limited in hospital settings (P64)
>
> Stressful environment, trainee and placement barrier (P73)
>
> Not as such any barrier but yes, limited therapeutic rooms (P16)
>
> There are certain barriers at workplace, such as privacy, secrecy of information etc. that make it difficult (P109)

Yes, it is quite troublesome, due to unavailability of client and increased dropout rate, students are unable to complete their degree within the given tenure (P137)

Limitation and workplace (unavailability of clients for daily session etc.), lack of cooperation on behalf of clients (P159)

Distractions from the surroundings (P155)

No proper place for conduction sessions (P100)

It is difficult at workplace; people did not follow your command (P87)

Destruction and environmental factors create hindrances during sessions (P126)

Personality clashes (P129)

Environment factors such as sound lite temperature and sometimes personal health issues (P93)

Proper and uniformed management in settings like professional highly equipped lab and cabins (P107)

Session/classroom should have adequate space (P17)

Time and work overload

Work overload on supervisor and supervisee is resulting in time constraint which is leading to hurdles in optimal learning. Excessive numbers of supervisees associated with each supervisor is reducing the availability of time for proper guidance and supervision:

Yes, number of trainees with reference to time duration allotted to train them (P4)

Limited time, resources and permissions (P30)

yes. If number of supervisees are reduced (P134)

My training supervision sessions are not good so far, my supervisor does not give me enough time, she is not competent enough, even though the learning environment is favorable but there is no adequate supervision. (P160)

The experience is very enriching informative and useful, it can be more so, if given more time and less work (P156)

Time duration of sessions with client is a barrier (P158)

Sometimes, environmental factor or peer pressure (P127)

Time management and interest in client (P108)

Time is short for learning (P94)

I fell that time is not adequate (P138)

Time gape in practicing clinical skills (P49)

The time restraint as we have to work out a time when both the client and supervisor are available and that is causing problem with time management (P38)

Time and workload (P68)

Time management (P146)

Motivation and workload (P94)

Limited time of placement (P101)

Limitation of time and schedule (P133)

Time is a barrier here; it is limited time (P59)

Shortage of time for meeting with supervisor (P73)

My supervisor never takes sessions with me and doesn't give me her proper time (P51)

Short and occasionally meeting with supervisor (P130)

Yes, it happens sometimes due to time limit because in supervision one case is discussed in detail, due to which the other internee didn't get enough time to discuss his/her problem, but it is managed later. (P102)

Time constraints (P66)

The busy schedule of my supervisor (P97)

Yes, studies another subject demand sometime so, less time available so, time constraint limits the use of clinical skills (P74)

A lack of time so I could study and prepare my session as my supervisor do not have ample time to properly guide me. (P139)

Limited time duration (P158)

Yes, the number of trainees that are allotted to each supervisor should be reduced (P167)

Can be effective by reducing the burden (P18)

Preparation and time management (P146)

When the training not made burden for the students (P113)

She may give us more time and plan sessions with us (P136)

Proper time should be given to trainees (P11)

Time management required to meet the supervisor (P77)

Reduce her workload (P102)

Overburden, depress, irritable (P139)

It was a burden because of overload (P165)

Sometimes I feel a lot burdened than I should which can be reduced by management skills (P173)

If a student needs time to share any of issue it is to be given to him/her as it maybe disturbing of conflicting to him/her (P96)

Supervisor's attitude

Supervisor's negative attitude towards supervisees is reported as barrier in effective learning by few supervisees. On the other hand, a number of supervisees experienced positive and supportive attitude of supervisor:

My training supervision sessions are not good so far, my supervisor does not give me enough time, she is not competent enough, even though the learning environment is favorable but there is no adequate supervision. (P83)

I apply my personal previous learning skills to clients; my supervisor does not give me supervision (P104)

I feel difficulty in the application of knowledge and skills with the client as my supervisor does not provide any fruitful understanding of those skills (P147)

The duration does not apply on me, because I rarely if ever have a meeting with supervisor, there are no formal or prompted discussions about my cases (P79)

Evaluative attitude of supervisor during session is a barrier to trainees' effective learning (P80)

Health issues of my supervisor, however my supervisor always tried to guide me through emails, messages and phone calls (P84)

If my supervisor will give me her knowledge, I think I can enhance my skills (P85)

Yes, sometimes I think I can do much better if proper guidance/ instructions is given (P140)

There is lack of motivation on part of me as a supervisor is mostly unconcerned and does not provide the required support (P105)

There is a very little assistance on part of supervisor, therefore, sometimes I feel lost and demotivated at times also a sense of incompetence and failure but then I pull myself together and take assistance from books and tutorials. (P100)

My supervisor never takes sessions with me and doesn't give me her proper time (P116)

Sometime unavailability of supervisor and motivation (P138)

Yes, the limited and outdated knowledge of my supervisor, her unconcerned attitude and my lack of motivation to acquire skills by myself. (P70)

Maybe, busy routine of supervisor (P73)

The communication gap between supervisor and supervisee (P93)

Lack of motivation from supervisor and communication gap between supervisor and supervisee (P46)

The availability of my supervisor. She, being the HOD was unable to attend 70% of the meeting neither were these supervisions structures (P148)

My supervisor never discusses the cases with me which is a limitation for me as I don't get any management according to my client's case conceptualization (P114)

No, my supervisor is not teacbing any techniques (P156)

Supervisee's limitations

There are number of limitations on supervisees side which decrease the learning level during supervision process, having low motivation, procrastinating and limited theoretical knowledge are examples of supervisee's limitations:

Too much pressure of other tasks like assignments, quizzes etc. (P149)

Motivation should be high of students (P25)

Yes, my own confidence (P135)

Yes, sometimes your style is not as effective as your supervisor (P143)

If only I could get that clinical supervision skills (P115)

Yes, lack of experience is the only thing that will hinder in workplace (P13)

Lack of awareness, non-cooperative behavior (P67)

I do not think so, this all depends on seekers (P133)

If I don't learn any effective during my learning phase how can I even get good job opportunity or supervision (P107)

Reduced learned skills from supervisor makes it difficult (P71)

Yes, sometimes my lack of planning or striving for perfection (P170)

Our motivation (P126)

Personal problems lower down my self-esteem and it was later increased with the negative evaluation when done by my supervisor or lack of empathy of the stresses the I have given through (P49)

It would have been enough if learning environment was more focused and conductive and I would not have been torn between number of academic tasks (P64)

However, number of participants reported no limitations in learning during supervision (P134)

Yes, same tests are mandatory which limits my application of theoretical knowledge. (P99)

However, a few participants indicated that there were no barriers in learning:

I think there were no barriers or any other limits to stop my learning (P150)

No, there no such factors (P129)

No, there is not (P166)

No, nothing at all (P147)

NO, I don't think so (P102)

No, it does not limit our supervision skills (P68)

None (P62)

No (P136)

There is nothing which will limit my skills (P109)

Clinical supervision is always helpful, no barrier (P169)

No, I don't think that there is any barrier in learning (P159)

No, I think they have the best ways to train (P127)

No, I don't think so, because our supervisor gives us equal chances to discuss about the client (P43)

No, rather I think it enhances all my hidden flaws and made me able to do much better (P59)

No, I was free for learning and didn't face any barrier (P148)

No, it is not limited for me it enhances my skill (P172)

I think there is no barrier in my supervision that limit my supervision skills (P95)

Use of skills

Experiences related to use of skills were expressed by supervisees, a variety of positive and negative experiences are reported:

Supervisees try to make maximum benefits of their skills (P22)

Supervisees try to apply if and effectiveness in application seems to be more than 70% (P37)

Supervisees try to maximum to utilize what is taught to them (P7)

Openness to trainee perspective about client situation and provision of using their creative abilities for clients. (P19)

Training session is a place to acknowledge to polish skills (P24)

Yes, I feel confident in applying my theoretical knowledge in clinical session (P144)

Now I am trained to take independently and apply therapeutic treatment process (P97)

It is easy to apply intervention under supervision (P101)

I feel difficulty in the application of knowledge and skills with the client as my supervisor does not provide any fruitful understanding of those skills (P160)

Almost all techniques taught by my supervisor are effective and easily applicable and understandable by me (P91)

Training made me well equipped, so I can easily implement any knowledge for the wellbeing of people (P141)

It was easy to apply after internship (P112)

Most of time, I successfully apply the knowledge and skills but sometimes it becomes quite difficult (P79)

I am very successful in applying my skills (P77)

If supervisors taught anything it's interesting to apply and easy to use (P84)

I found easy to apply techniques under her supervision (P61)

The knowledge is easily applicable; the feedback helps me to improve (P58)

I have faced some difficulties in application, but the training is very important for proper guidance (P87)

I apply my personal previous learning skills to clients; my supervisor does not give me supervision (P85)

I am moderately successful, as I am still in the learning phase (P83)

The skills I have learned during my training helped me in workplaces as I tailor made the techniques and applied them. (P121)

No, there is nothing that makes it difficult to use the clinically supervision skills during sessions (P96)

No, all the skills covered during sessions could be applied successfully in workplace (P114)

I am not fully expert in applying skills (P140)

The techniques were effectively learned and easy to apply in practical setting. (P135)

I can apply the skills which I learned in supervision very effectively (P134)

Too much extent we apply them (P146)

I can apply the things quite easily (P149)

To some extend I would successful in applying skills (P96)

Experience with client

Applying skills and knowledge on clients is different experience done by supervisees, different positive and negative experience with clients were identified as a sub-theme:

Successful session with clients and rate of intake increased, more bilateral termination seems improved the success. (P155)

Client emotional outburst (Crying) (P153)

Very useful, these skills have helped not only me but my clients as well (P118)

It varies from client to client that how he/she will respond to any technique, good skills can be seen during sessions if learned and adopted properly (P115)

Skills and techniques discussed proved helpful with clients in sessions and provided an idea to have better treatment plans for them. (P116)

Client's never of understanding might cause hurdle in applying techniques sometimes (P145)

Nothing except the culturally violation of rules and morality, ethics etc. (P130)

When client starts crying or gets emotional or sad (P119)

Supervisor's support/ Support in course

Support in learning from supervisor is one of key factor for developing professional skills as mentioned by supervisees. Support in course and from organization/ department is helpful for better outcomes of supervision process:

Support from management and coordinator and motivation of internees (P26)

Giving listening ear to trainees (P8)

Give more confidence to students (P28)

My supervisor increases my motivation and I learned a lot (P90)

The supervision sessions are very supportive, and the environment is really good and comfortable (P104)

Her way of understanding, our problems and guide us how to deal with problems Open communication rather than stabbing each other (P105)

I tried to explain all perspective of my case to supervisor but the response or guideline I received in return is unsatisfactory (P124)

It helps a lot to do sessions more carefully and more reliably by the help of supervisor and I think it build trust in the trainees to treat the clients with much understanding and care. (P119)

Skills and techniques discussed proved helpful with clients in sessions and provided an idea to have better treatment plans for them. (P80)

Through supervision sessions you attain mastery in field of dealing with client in more ways (P55)

Management and environment. Most clinical settings lake supervision guidance specifically for trainees (P65)

Sometimes, it feels that your group member doesn't allow you to discuss thing properly with your head (P47)

The supervisor was very cooperative. Some of the collcagues were resistant (P48)

Yes, sometimes the trainee supervisor relationship blocks adequate communication (P60)

Colleagues support (P110)

Yes, our supervisor is very supportive and motivate us to deal with client in an effective manner (P42)

This training is helpful and supportive for me because my supervisor supports me in every problem (P172)

I do not discuss about my clinical session with my supervisor because in earlier time to period I discussed with him but could not find satisfactory reply even he didn't know about any technique of applying (P100)

As supervisor doesn't come up with new techniques, I apply some specific techniques which my supervisor taught me in good in effective way (P159)

I find it easy because she provides time to understand the problematic behavior (P137)

I guess the only barrier I faced was 'me' if you are motivated you can do it as madam was really supportive and she tries to manage classes for us but sometimes our lazy approaches create barrier (P74)

Supportive environment

Cooperative, positive, supportive and suitable environment for optimal learning is highly related to learn and apply clinical skills on clients:

Training is very interesting, there is a lot to learn in positive environment (P175)

The learning environment was good. It was a useful training experience. (P166)

Learning environment was good (P134)

Environment was friendly, and I learned a lot from it, supervisor was understanding (P93)

Clinical supervision session is helpful in sorting out any problem and ambiguity about the intervention or technique related to client + or any problem regarding session is discussed freely and in supporting environment (P53)

Interactive, supportive and cooperative, the learning environment was so good (P67)

Informative learning environment enhances communication skills (P61)

Many things, friendly environment (P51)

Cooperative and learning environment, getting a grasp on knowledge about how to deal with people (P127)

The environment is conducive and renders learning (P133)

Open to share our problem, cooperative and accepts our mistakes, comfortable environment (P94)

Training was in good learning environment, supportive work (P55)

The environment is related to learning and practicing. (P44)

In supervision session it's a learning environment where the internee can learn things from supervisor (P52)

During our supervision session the environment was good, and we learned a lot, supervisor polished my clinical skills (P64)

My clinical training always proved to be a great deal of learning and experience as well as providing an atmosphere to open up and learn better ways to deal with the clients (P169)

It provides an open environment to learn new skills and how to implement those skills effectively, it provides clear concept of the procedure of application of new things (P142)

Support, guidance, motivation, environment (P136)

Yes, the cooperative and positive environment (P87)

A friendly atmosphere and a direct communication between the trainee and supervisor (P46)

Discussing the client's problem and related intervention helps further (P50)

Supervisor should create sharing, tension and fear free atmosphere, the students should go confidently for the session (P161)

Emotions to trainee/ supervisor/ client

Trainees identified their emotions related to clients and supervisors during clinical internship supervision, supervisors expressed their feeling related to trainees in different circumstances:

Not specifically about trainee show excitement when they see that client problem is resolved (P6)

Positive where internees feel being guided, supervised and tracked if they are in need. (P27)

Trainee own emotional problem, (P35)

When you do not get cooperative doctors, counselors or management (P90)

When client starts crying or gets emotional or sad (P124)

When client narrates the story that resembles your life (P97)

Hopelessness (P163)

Lots of emotional events like, happiness sadness (P138)

Some private information of client made me shock (P99)

Once my USB got corrupted and my supervisor was very aggressive, it made me sad and helpless (P125)

Weeping, being highly sad. (P135)

Sometimes emotional event occurs during supervision is being ridiculed / sad when supervisor insults (P59)

Sense of achievement and happiness on making the supervisor happy (P62)

Unconcerned attitude of my supervisor (P66)

The kind of emotional events that occur frequently are fear shame, guilt in me as a result of my supervisor's aggressive attitude. (P71)

The way of communication of my supervisor during session inspires me a lot (P73)

Supervisors' attitude may affect supervisee's self-esteem intense demonstration sessions cause anxiety among supervisees (P165)

When the autistic child first time smiled by my efforts (P108)

While discussing the problems (P111)

They used to cry during session (P72)

Ignorance, unconcerned supervisor (P139)

When you cannot open up with your client (P115)

Clients usually starts crying in session (P140)

Insult by supervisor (P58)

Some time I feel fearful and not able to communicate with her properly (P56)

Burn out of therapist due to workload (P121)

Emotional and moral support of supervisor gives sense of achievement (P77)

She helped me when I needed it, (P102)

Sometimes clients start to cry during session (P107)

Supervisor used to communicate and expect a lot (P68)

Stress, panic (P144)

Supervisor insults (P149)

When the case of our class fellow shifted to another therapist due to incompetence. (P156)

When supervisor encourage us, we feel happy and tried to work better next time (P59)

Sometimes, disappointment sometimes worthy and competent (P70)

When supervisor appreciate my good ability and testing then I feel happy (P146)

When I held a case of my client (child abuse) (P110)

Stress, sometimes anxiety (P132)

Different emotional events occurred during sessions, some related to the client's problem and some related to the collcague/fellows (P157)

During the whole training session home sickness ill health biased attitude of people all prove to affect a bit emotionally (P43)

Personal problems lower down my self-esteem and it was later increased with the negative evaluation when done by my supervisor or lack of empathy of the stresses the I have given through (P112)

Emotion to supervision / learning

Feelings associated with learning and supervision processes were identified in supervisees, emotional reactions to the internship process and learning were expressed by internees:

The feeling that they are practically supervised (P131)

There is a very little assistance on part of supervisor, therefore, sometimes I feel lost and demotivated at times also a sense of incompetence and failure but then I pull myself together and take assistance from books and tutorials. (P141)

The discussion at the end of my case conference (P160)

Emotional events such as successfully collecting the data sample on time and meeting all the deadlines (P173)

Stress and burdened overwhelmed and due to this it became difficult to manage (P167)

The stress of academics' long journey through out studies (P104)

Low self-esteem, lack of energy, aggression (P53)

Tiredness exhausted mood sometimes (P76)

Sometimes emotional event occurs during supervision is being ridiculed / sad when supervisor insults (P79)

The completion of supervision session successfully (P147)

Ones that boost confidence and induce the emotions & develop state of relaxation during training sessions. (P143)

Discussion about personal hurdles during session (P170)

During the whole course of supervision, we come across different kind of emotion from happiness, contentment, to low self-esteem, inferiority complex which is part of training. (P163)

The training is quite vigorous, due to which emotional outburst occurs frequent therapy sessions should be conducted for therapists as well (P158)

Stressful, over exhaustion and constant pressure of completing the reports rather than learning and growing in the placement process (P96)

No emotional events

A small number of supervisees replied to question about their feelings related training/supervision or supervisor/client that they haven't expressed any emotions related to these, as this is a professional relationship and in professional relationships there is no space for personal emotions:

Nothing like this ever happened (P10)

No significant event (P163)

None (P137)

It's profession. Not emotional (P20) (P33)

No significant event (P108) (P56)

Nothing yet. (P113)

None, so far (P137)

Nothing like this ever happened (P63) (P74)

A

Additional Analysis

Table: 6

Correlation between sample of supervisee and supervisor

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	Attachment Anxiety Supervisor	-	.573**	-.041	-.043	-.034	.155	.118	.190	-.275	-.324*	-.013	.019	.129	-.018	.076
2	Attachment Avoidance Supervisor			.204	.171	-.221	.100	-.012	.070	-.377*	-.363*	-.142	-.052	.172	.056	.132
3	Perceived Attachment Anxiety Supervisor			-	.088	.080	.055	.053	-.008	-.084	-.067	-.035	.171	-.023	-.145	-.070
4	Perceived Attachment Avoidanee Supervisor				-	.123	.242	.216	.188	-.156	-.196	-.158	.031	.066	-.060	.020
5	Rapport Supervisor					-	.755**	.870**	.498**	.229	.047	-.060	-.067	-.129	-.154	-.142
6	Client Focus Supervisor						-	.946**	.658**	-.006	-.055	-.140	-.149	-.054	-.088	-.069
7	SWAI Supervisor							-	.788**	.059	-.014	-.072	-.042	-.107	-.159	-.130
8	Identification Supervisor								-	-.073	-.017	.057	.186	-.118	-.208	-.155
9	Attachment Anxiety Trainee									-	.542**	.572**	.366**	-.636**	-.596**	-.645**
10	Attachment Avoidanee Trainee										-	.416**	.559**	-.379**	-.374**	-.392**
11	Perceived Attachment Anxiety Trainee											-	.338**	-.374**	-.298**	-.359**
12	Pereeived Attachment Avoidance Trainee												-	-.282**	-.326**	-.310**
13	Rapport Supervisee													-	.843**	.978**
14	Client Focus Supervisee														-	.937**
15	SWAI Supervisee															-

**. Correlation is significant at the 0.01 level (2-tailed).

Table: 7

Descriptive statistics of facets of attachment.

	Mean	Std. Deviation	Skewness	Kurtosis	Range	Minimum	Maximum	Percentiles 25	50	75
Attachment Anxiety Supervisor	21.90	4.878	-.741	.577	22	8	30	19.50	23.00	25.00
Attachment Avoidance Supervisor	10.83	2.836	-1.200	.945	11	3	14	9.00	11.00	13.00
Perceived Attachment Anxiety Supervisor	28.24	7.506	-.333	-.120	30	12	42	24.00	29.00	33.00
Perceived Attachment Avoidance Supervisor	10.07	2.349	.029	-.728	9	5	14	8.00	10.00	12.00
Attachment Anxiety Trainee	18.76	6.957	.752	.716	34	6	40	13.75	19.00	22.00
Attachment Avoidance Trainee	8.08	4.173	.681	-.630	15	3	18	5.00	7.00	11.00
Perceived Attachment Anxiety Trainee	20.93	6.488	.047	.729	36	6	42	17.00	21.00	24.25
Perceived Attachment Avoidance Trainee	8.59	3.673	.489	-.436	15	3	18	6.00	8.00	12.00

Chapter IV

DISCUSSION

Table: 8

Table Decisions about hypotheses

Hypothesis. No.	Hypotheses	Results							
		Attachment Anxiety	Attachment Avoidance	Perceived Attachment Anxiety	Perceived Attachment Avoidance	Working Alliance			Decision
						Client focus	Rapport	Identification	
1	There will be negative relationship of working alliance with attachment anxiety and attachment avoidance	-.64**	-.39**				SWAI		A
2	Working alliance will be negatively related with perceived attachment anxiety and perceived attachment avoidance			-.36**	-.31**		SWAI		A
3	There will be positive correlation between client focus and rapport of supervisees' supervisory working alliance.					.84**			A
4	Supervisees with a secure attachment to their supervisors will rate higher working alliance with their supervisor.	-.64**	-.39**				SWAI		A

5	Supervisees' attachment avoidance with the supervisor will be positive correlated with supervisees' attachment anxiety.	54**					A
6	There will be positive relationship between Supervisees' perceptions of supervisors' attachment avoidance and their perceptions of supervisors' attachment anxiety.		.34**				A
7	There will be positive correlation between supervisors' self-rated attachment avoidance and their attachment anxiety with supervisees.	57**					A
8	There will be positive correlation between supervisors' perceptions of supervisees' attachment avoidance and anxiety with supervisors.		0.09				R
12	There will be positive correlation between client focus and identification of supervisors' supervisory working alliance.			95**	.87**	79**	A

Reference: Table 3, A= Hypothesis accepted, R= Hypothesis rejected.

Discussion table 9: Decision about Hypotheses

Hypothesis No.	Hypotheses	Decision	Reference
9	There will be significant difference of supervisors and supervisees on attachment anxiety and attachment avoidance.	Accepted	Table 4
10	There will be significant difference of supervisees' perception of supervisors and supervisors' perception of supervisees on attachment avoidance and attachment anxiety.	Accepted	Table 4
11	There will be significant difference of rapport, client focus and working alliance between supervisors and supervisees.	Accepted	Table 4

The current research was carried out to explore relationship of supervisees' and supervisors from the model of attachment theories and to study the factors which are facilitating or hindering the learning in this process. Supervision is beached on collaboration, and it is a process of agreement on the tasks and goals related to treatment of client and growth of supervisee. The subtleties which effect this relationship or learning of supervisee and health of client are desired to be premeditated by exploratory researches so that process of learning and clinical amenities may be enhanced. Clinical supervision is just not a teaching-learning collaboration, it is a process of transformation of supervisee, supervisor and client in formal-cum-informal milieu which impacts all of them, particularly they are vital in learning of supervisee and in formation of individualized treatment methodology which supervisees' will espouse for their entire career.

With extensive literature review a model was proposed that attachment styles of supervisees' and supervisors' and their perceptions regarding perception of others for their attachment style will have an impact on working alliance. In total twelve hypotheses were proposed in current research for the factors which are affecting a relationship of supervisees and supervisors. Eleven of them have been accepted (table 1 and 2 in discussion). Our results have built understanding regarding diverse factors which are contributing in this relationship.

Previous researches had mostly focused on supervisees' role in working alliance, in current research both supervisees and supervisors were studied so to spot contribution of perceptions and attachment styles of each member in the working alliance and to look how the attachments in themselves are related.

There is a negative relationship of working alliance with attachment anxiety and attachment avoidance (Hypothesis 1), working alliance is negatively related with perceived attachment anxiety and perceived attachment avoidance (hypothesis 2). The hypothesis one and two are

building theoretical orientation for relationship of supervisees attachment orientation with working alliance, and it was revealed that supervisees with a secure attachment to their supervisors have a higher working alliance with their supervisor (hypothesis 4).

Supervisees' attachment avoidance with the supervisor is positively correlated with supervisees' attachment anxiety (hypothesis 5), Likewise, there is a positive correlation between supervisors' self-rated attachment avoidance and their attachment anxiety with supervisees (Hypothesis 7), There is a positive relationship between Supervisees' perceptions of supervisors' attachment avoidance and their perceptions of supervisors' attachment anxiety (hypothesis 6), however, there is no significant correlation between supervisors' perceptions of supervisees' attachment avoidance and anxiety with supervisors (hypothesis 8).

Results of this research reveals that attachment styles in current relationship and perceptions of attachment from other figure are significantly related to working alliance for supervisee and not for supervisor. All the four factors of attachment viz attachment anxiety, attachment avoidance, perceived attachment anxiety and perceived attachment avoidance were not related with working alliance or any of its component (rapport, client focus and identification) for supervisor, revealing that attachment style of supervisors or their perceived attachment is not associated with their working alliance or the working alliance of supervisees (table 3). However, all facets of attachment of supervisees were significantly associated among each other and were significantly correlated with their perception of working alliance. Apparently, our data reflects that it is just supervisee, who is associated with perception of its own working alliance and supervisors have astoundingly minimum role in the formation of their supervisee's perception regarding supervisory relationship. But each of the component is needed to be explored for the explanation of a relationship.

Confirmation of hypothesis 9, 10, and 11 (table 2, discussion; table 4 in results) has grippingly portrayed an outlandish picture of scores. There is a significant difference of supervisors and supervisees on attachment anxiety and attachment avoidance (hypothesis 9). There is a significant difference of supervisees' perception of supervisors and supervisors' perception of supervisees on attachment avoidance and attachment anxiety (hypothesis 10) and there is a significant difference of rapport, client focus or working alliance between supervisors and supervisees (hypothesis (11).

Supervisors on all scales of attachment scored higher than supervisees and were significantly differed from them in their perceptions. Mean scores of supervisors were greater for attachment anxiety, attachment avoidance, perceived anxiety and perceived avoidance from supervisees. There are certain considerations which explains phenomenon. Firstly, there is a huge difference of sample size of supervisees (n= 134) and supervisors (n = 41). Increase in sample size increases diversity of scores and bring the results which are more trustworthy to be considered as actual representation of population. Nature of our research was that in which minimum sample of supervisors could be obtained. So, the matching across the sample of supervisors and supervisees is although statistically robust but conceptually it is not, as the higher mean difference of sample doesn't make the characteristics of each set of samples applicable for matching.

Ahead from statistical elucidation, the construct of ECR-RS scale explains the process. ECR-RS doesn't measure the global personality attachment of a person. It measures relationship specific attachment, which is bounded to current circumstances and may or may not be related with individual personality predisposition of attachment styles. The relationship specific attachment is influenced by number of factors including perception of other individual, experiences expended with them and prominently the schematic evaluation of purposefulness of tasks, goals and roles of current relationship. Authors of ECR-RS have validated its applicability in wide range of

relationships which included mother, father, friend and partner and has suggested its applicability of use for range of other relationships like with teachers, God and supervisors (Fraley, Heffernan, Vicary & Brumbaugh, 2011). But then again items of scales are naturally inclined to produce skewed mean in professional samples. Working alliance in professional relationship is a dyad in which one partner is leading and other is subservient, the former provides nurturance of knowledge and later seeks it.

Supervisees expect knowledge, guidance and training from supervisors in calm, supportive and energetic environment but they cannot deliver such facilities to supervisors. Supervisors in a professional relationship, due to boundedness by professionalism couldn't expect their subordinates to be available for them in tough and hard times. Items of scale measure following constructs of attachment: availability of person at times of need (item 1), self-disclosure (item 2), frank discussion (item 3), dependence (item 4), openness (item 5), self-disclosure of emotions (item 6), care (item 7), security (item 8), and reciprocity (item 9; Annexure). Each of the following construct seems to be misappropriate for professional who is delivering services in a relationship, and at the same time, they are relevant to the one who is seeking services in a relationship. In the dyad same roles and responsibilities cannot be expected from both for attachment. As both members of dyad have different social responsibilities, so they would invest differently in attachment. So, our results reveal that same expectations could not be made from supervisees and supervisors in a relationship which is based on professional goals. As supervise are expected to learn from supervisors and earn benefits from them, so ideally, they should score lower on ECR-RS and as supervisors are destined to deliver more and expect less, so they should score higher on ECR-RS. The opposite polarity of a scores of dyads will be representative of their working alliance. The higher scores of supervisors and lower scores of supervisee and significant difference

among each facet of ECR-RS) (table 3, results) thus doesn't mean they don't have secure relationship. But it means that their relationship is secure from perspective of professionalism (table 4, discussion). As it is seen in additional analysis, table 2, that 75% supervisors have showed anxiety and avoidance in last quartile of range, which is in fact projection of their emotional discountenance from professional relationship and engagement in supervisory relationship without consideration of personal benefits from the relationship. We have conceptualized that attachment in professional relationship is naturally different from traditional attachment which is presented in table 3 of discussion. In traditional attachments, the one who has a strong sense for oneself as well as others will be considered as having a secure sense of attachment. Based on our stance, for supervisors, who are professionals, disconnectedness from supervisee is not because of feeling of unlovability or unworthiness as shown in table 3, instead they are disconnected due to professionalism. As, ECR-RS doesn't measure global sense of self and sense of others, instead it measures sense of self and other in a current relationship. In a current relationship of professionalism thus higher scores of supervisors on avoidance thus means that they have a secure sense of self. (table 4, discussion). Our interpretation thus establishes that traditional interpretation of ECR-RS is not a suitable to measure supervisors' attachment in a supervisory relationship, instead of correlation the significant difference of scores is however representative of secure attachment.

Table 10: Conceptualization of attachment from traditional theory

Attachment	Sense for others	Sense for Self	Anxiety	Avoidance
Secure	Trust	Strong Sense	Low	Low
Preoccupied	Need of approval	Unworthiness-	High	Low
Fearful/ avoidant	Distrust	Unlovable	High	High
Dismissing	Focus on personal achievement	High sense of self reliance	Low	High

Table 11: Proposed model of secure attachment for supervisors

Attachment	Sense for others	Sense for Self	Anxiety	Avoidance
Secure	Trust	Strong Sense	High	High

Supervisors were also asked to rate the ECR-RS from the perspective of their supervisees, i.e. what they think that how their supervisees' will answer the same questions for them. It was termed perceived ECR-RS. The one sample t-test in additional analysis was conducted to look at scores of perceived ECR-RS in relevance to original response of supervisors for ECR-RS, which revealed significant difference among variables. This shows that supervisors pereeive that their supervisees think that they are more avoidant and less anxious from what they are. Effect size was greater for difference of avoidance as compared to anxiety, revealing that supervisors perceive that their supervisees consider them more avoidant and less anxious from what they are. Avoidance is reliant

on sense of others and anxiousness is related with sense of self (table 3, discussion). Supervisors perception that their supervisees consider them avoidant may means that they are sure that their supervisees are not getting any clue for favor. But in-congruency between their real avoidance and perceived avoidance (as significant difference among them) means that they want to be professionally more avoidant, or want their clients to consider them more avoidant, thus reflecting presence of room of professional development for supervisors, literature also reflects that with increase in professional knowledge and clinical experience, supervisors develop the greater complexity, density and profundity within the professional relationships (Baker et al., 2002; Efstation et al., 1990).

Story of supervisees is different from supervisors. Supervisees in our sample, although have less mean scores on ECR-RS which means that they are expecting more from their supervisors. The overall mean and percentiles reveal that 75% supervisees scored in middle quartile, revealing that they have average avoidance and anxiety for supervisors. As like supervisors, trainee's actual avoidance and anxiety was significantly lower than their perceived avoidance and anxiety. It means, they perceive that their supervisors think that they are more avoidant and anxious from what they are. We are moving with dual standards of interpretation, because of nature of responsibilities of dyad. For supervisors, higher scores on anxiety and avoidance meant secure relationship and discrepancy of scores for actual and perceived scores of ECR-RS was conceptualized as room for professional development, but for trainees, higher scores of anxiety and avoidance means insecure relationship. Discrepancy of actual and perceived ECR-RS scores, with significant difference among them (table 4, additional analysis) means that their alliance with supervisors is not well established- they think that their supervisors considers them more insecure from what they are. This would have an impact on their working alliance too:

There is a positive correlation between client focus and rapport of supervisees' supervisory working alliance (hypothesis 3) and there is a positive correlation between client focus and identification of supervisors' supervisory working alliance (hypothesis 12), which reflects uniformity of sub-components of constructs in relation to global construct of working alliance. So, taking overall scores of working alliances in consideration, results reveal that perception of working alliance differed for supervisees and supervisors. Supervisors had significantly higher mean (M = 131, S.D. = 8.65) for working alliance as compared to supervisees (M= 100, SD = 20.50). Reflecting that supervisors have more vigorous perception for their working alliance and in the same relationship, the supervisees have significantly different perception about a relationship. Working alliance is contingent upon relationship dynamics, the level of communication among dyad and the trust on each other. Qualitative analysis has opened dynamics of relationship among supervisors and supervisees and elucidated the factors contributing in relationship of them. Four major factors explain gap between supervisors and supervisees as perceived by later are: relationship aspects, emotions of trainee, attitude of others and attitude of supervisors. In addition to them other factors including, experience of learning, learning barriers and experience of applying explains overall process of learning and transfer being carried out in a relationship with exposition of factors that encumber and facilitate this process.

Qualitative analysis in current research discovered that among factors which are hindering supervisees performance the prominent and the first one is experience of learning which involves perception of participants regarding their ideal perception for objective of supervision and structure of course and their perception for current supervision regarding its objective and ideally how it can be managed.

Literature supports a stance that in a process of supervision the agreement of dyad on purposes of supervision (goals and tasks) is more significant factor which result in augmentation of working alliance which in turn results in increase in sense of competence and emotional bonding of supervisees. Individuals involved in supervision are aware about characteristics for learning and training. Participants in our study identified that purpose of their supervision is to polish clinical skills (P12, learning of therapeutic techniques (P31, P95, P125), to know about mistakes and errors and get motivation (P111), to get feedback about cultural diversity (P29) and develop conversational skill (P70, P161). Timing of supervision was also a significant factor as some reflected on its duration and said it should be on weekly basis (P5). Our participants had clear purpose and desired outcome of learning and training, which are related with purposefulness of training.

Second sub-theme which is termed, "Reaction to training" identifies the satisfaction of participants with objectives of supervision. Most of the participants considered the current supervision as appropriate for their clinical skills (P 53, P150, P65), it was helpful (P167, P58), informative (P58, P124), supportive (P15, P157), they learned new techniques (P157, P60, P61, P112) and it increased their exposure (P52). The statements of these two sub-themes so far picturize the tasks and reaction to these tasks, which reveals that participants in our sample were agreed with their supervisors on tasks of supervision.

The third sub-theme i.e. structure of course explains the other shade of picture. Factors related with structure of course which are possibly contributing in less mean scores for working alliance for the supervisees are: the overloaded students in a supervision group (P21), less number of interactions with supervisor (P42), conventional methods of supervisors and informal environment of supervision (P141). Some participants were dissatisfied due to their perception of low standard

for their institute as compared with international institutes (P3). However, others were dissatisfied with cultural non-relevance of clinical training (P9) and stressed it to be more culturally relevant (P82) and be more practical rather than theoretical (P96).

The structure of course has an impact on working alliance. Working alliance as defined by the authors was the relationship among supervisors and their supervisees which makes their agreement and consensus regarding the goals of relationship, clear considerate for the tasks of each other, and the development of bonds among each other which influences the partners of a dyad to endure the enterprise" (Bordin, 1983, p. 35). As reflected from qualitative analysis, the informal, unstructured environment and mismatching of system with either of cultural, international or professional setup results in dissatisfaction regarding purposes of alliance. Previous researches also explain notion that supervisees who doesn't establish congruence or agreement on the purposes (goals and tasks) of supervision may establish mistrust on relationship resulting in fostering of working alliance (Ramos-Sanchez et al., 2002; White & Queener, 2003).

. The other factors like preference of supervisory styles and complexity of conceptualization are less important for establishment of working alliance (Ladany, Ellis,& Friedlander, 1999.) They have also revealed that the preferences of supervisees for the styles of supervision are not related with the density of conceptualization and case formulation. (Ladany, Marotta, & Muse-Burke (2001a). In our sample "Supervisor's support/ Support in course" theme emerged which highlighted factors that are contributing in learning. Support from supervisors is, listening to trainees (P8), giving confidence and motivation to them (p28, P90), guidance on problems (P105), discussion on skills, techniques and treatment (P80, P55, P100). It revealed that support in learning from supervisor in these areas is one of key factor for developing professional skills as mentioned by supervisees. Support in course and from organization/ department is helpful for better outcomes

of supervision process, as some participants were dissatisfied due to incomplete guidance (P124, P100) and support from their supervisors. In addition to support and guidance another theme of, "Supportive environment" revealed that: cooperative, positive, supportive and suitable environment for optimal learning is highly related to learn and apply clinical skills on clients.

The relationship with supervisors, especially attitude of supervisor is somewhat valid in the explanation of low mean scores, and diverse standard score of working alliance for supervisees. The theme of attitude towards supervisors revealed that some participants were satisfied with attitudes of their supervisors, terming it supportive (P53, P75, P88, P122, P41, P106), friendly (P52, P157, P175), encouraging (P152), cooperative (P117, P174), interactive, calm (P128), and polite (P111). However, for some the taunting behavior of supervisors (117), their biased attitude (76), and non-professionalism, not giving time to supervisees (P42), perceived incompetency of supervisor, lack of motivation from supervisor (P46), and non-didactic attitude (not teaching techniques or skills, P156) was source of distress. Overall, participants had mixed response for satisfaction with their supervisor attitude. Developing a working alliance through clinical practice includes creation of an atmosphere of rapport which enables the individuals for openness and develops trust that endures their professional challenges which are engendered for both lay supervisee and experienced supervisors (Campbell, 2011.) In current research, mixed results regarding attitude of supervisors from participants on one hand has explained nature of issues students are facing, and on the same time they explain they diversity in standard scores for working alliance among supervisees (table 4). This also explains high perceived avoidance and anxiety which supervises were having regarding their supervisors, as compared to actual avoidance and anxiety as projected in table 4 of additional analysis.

Another sub theme of, "time and work overload" revealed that in our sample work overload on supervisor and supervisee is resulting in time constraint which is leading to hurdles in optimal learning. Excessive numbers of supervisees associated with each supervisor is reducing the availability of time for proper guidance and supervision for each supervisee, some supervisors are not giving time to their supervisees (P51, 97, 139, 167, 11, 165, 130 and many others). When supervisors are not giving enough time to their supervisees then development of working alliance is compromised. The proper and uncluttered communication was significant factor that was noted in several other studies, which impact supervisory relationship (Campbell, 2011; Trotter-Mathison, Skovholt, Koch, & Sanger, 2011). Thus, possibly in our sample the major diversity in standard scores of SWAI of supervisees (M = 100, SD = 20) is due to the attitude of supervisors, as some are providing space for support and others are unavailable to them for any such help.

There is also a connection among the ability to produce the durable working alliance/proficient bonds and the resilience which is seen in the field (Trotter-Mathison, M., et. al., 2011). As creation of alliance and its development can influence the strength of onset and ongoing of supervisory or professional relationships (Campbell, 2011; Trotter-Mathison, M., et. al., 2011); another dimension of development of a positive and secure relationship is ending of alliance which also effect perceptions of supervisee for future clinical practice (Dawson & Akhurst, 2015). Thus, previous researches had identified the positive impressions of the supervisory working alliance which creates bond among dyad and influence the supervisory work. Dawson and Akhurst (2015) had studied the factors which supervisors opt to end their relationship with their supervisees. They conducted qualitative analysis of self-constructed interviews which were semi-structured of the supervisees who had gone through the unintended ending to their professional/supervisory relationship, authors had identified seven related themes which were explaining the ending of the

relationships, all of which were explaining negative impact on their future clinical practice (Dawson & Akhurst, 2015). The results so far support the notion that supportive attitude of supervisor or positive perception regarding its attitude augment the perception of working alliance for supervisees, and they show that supervisees have an agreement on tasks of goals with supervisors but not on structure of course, and attitude of supervisors is problematic for some supervisees and it explains significant difference in scores of working alliances among two stakeholders. Moving ahead, factors, other than supervisor which are possibly contributing in lower working alliances are explored. They are physical barriers to learning, learning environment, factors pertinent to supervisees and their emotions.

Among physical barriers, Placement in hospital or facility (P160); management and environment of hospital (P144); time management (P110); lack of client and dropout rate (P62); shortage of space in hospital (P56, P100) which effects privacy of clients (P109), and causes distraction (P155, P126); temperature and weather conditions (P93), congested class rooms and unequipped labs from psychological tools (P107) were identified as a hurdle in learning and supervision process. Physical barriers are the source of stress which are then related with low performance of supervisees in learning process and effects their attachment in the supervision. A research conducted on seventy-one members counselling association of America (AMHCA) who took the supervision or in last 12-month period in their supervision process of post-master's degree. The results had statistically revealed that decreased stress and increased satisfaction is related with strong perception of supervisees regarding their working alliance (Sterner, 2009).

There are number of limitations on supervisees side which decrease the learning level during supervision process, as having low motivation (P25, P126) low confidence (P135); lack of previous experience (P13); low self-esteem (P49), procrastinating, lack of planning (P170), and

limited theoretical knowledge were factors pertaining to supervisees which they think are contributing in low transfer of training and learning. Some have completely external locus of control and think it doesn't depend on seekers (P133). "Proper use of skills," is another theme which effects this process too, experiences related to use of skills were expressed by supervisees, a variety of positive and negative experiences regarding use of skills were reported which are affecting their learning and their perception about learning and relationship.

Last mental health of supervisees and their emotional reaction to supervision process is also a key factor that contributes in low learning and working alliance. Qualitative analysis revealed feelings associated with learning and supervision processes of supervisees, emotional reactions to the internship process and learning. Most of them experienced negative emotions, like negative feeling of being supervised (P131), demotivation, sense of incompetence (P141), stress and overwhelming feelings (P167), low self-esteem, aggression (P53), tiredness, exhaustion (P76), sadness when supervisor insults (p79), pressure of deadlines were the salient negative emotions. Successful completion of case conference (P160), supervision (P147), meeting deadlines (P173), happiness, contentment (P163), were positive emotions for few participants. A small number of supervisees replied to question about their feelings related training/supervision or supervisor/client that they haven't expressed any emotions related to these, as this is a professional relationship and in professional relationships there is no space for personal emotions. Overall, it is portrayed that participants experience negative emotions during process of supervision which is integral component of their experience for process and effects their learning and perception about working alliance.

Summary and conclusion

The present study was conducted to know about dynamics of supervisory relationship from the perspective of attachment theory and to identify the factors that are contributing in a process of learning. Results of study reveals that the attachment anxiety and avoidance of supervisees is negatively related with their working alliance and is hindering process of their learning. Qualitative analysis identified themes which are hindering process of learning, they are: dissatisfaction from structure of course, negative attitude of supervisors, unavailability of supervisors due to time constraints, physical barriers and experience of negative emotions in a learning process. The mentioned factors are possibly aggravating negative attachment of supervisees and is affecting their working alliance. Supervisees have higher perceived avoidance and anxiety as compared to their actual avoidance and anxiety, which reflects the overall susceptibility of insecure attachment on the end of supervisees emerging due to the factors mentioned above. The story is completely opposite for supervisors, there is no relationship between attachment style of supervisors and their working alliance, and there is a significant difference between all facets of attachment among supervisors and supervisees, and supervisors have higher mean scores as compared to later. We have proposed a model that supervisory relationship is a professional relationship and it is conceptually different from traditional models of attachment. In it there are dual standards of responsibilities: supervisors cannot expect the same from supervisees as they do from them. Due to professional boundedness, supervisors must show high avoidance for personal connection and the same appeared in our results. It was proposed that significant difference on ECR-RS among supervisees and supervisors, with higher mean scores of supervisors will be indicative of secure attachment of supervisors. Relating with our proposition, the secure attachment of supervisors has

significantly related with working alliance. Low working alliance of supervisees was discussed and explained from themes which emerged from qualitative section.

Limitations

In the present study, the attachment was only measured through ECR-RS which is not the global measure of attachment styles and it measures the attachment in a current relationship. In future researches dynamics of global and relationship specific attachments can be measured simultaneously to explore dynamics of distinctive relationship. Besides, data was not matched for same supervisor and supervisee, instead mean scores of different supervisors and supervisees were analyzed. Case studies of same supervisor and their supervisees and the qualitative analysis of relationship dynamics and other possible attributing factors of supervisory relationship may develop more rigorous understanding regarding the dynamics of relationship. Low sample size of supervisors was another limitation, which was conceptually fading the understanding of matching with supervisees, so future studies may match characteristics on large sample size of supervisees. Furthermore, the current research was exploratory in nature, in which trainees who were at different position of training were studied at a time, longitudinal studies are recommended to explore dynamics of relationship across different stages of supervision and this will also help us to deduce the causal inferences regarding attributes effecting relationship. In addition, qualitative data derived from interviews of supervisees and supervisors was combinedly analyzed, it is recommended for future studies to analyze the data of supervisors and supervisees separately in order to have a better understanding of challenges during supervision on both ends. Lastly, quantitative data was analyzed separately for the supervisor and supervisee and dyadic analysis between supervisor and supervisee can be done in future using AMOS for better understanding.

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Annexure [A]

Screening Page

In order to participate in this survey, you must either be:

(a) A Clinical Psychology student who is currently completing a clinical internship and receives clinical supervision as a component of your education,

OR

(b) The clinical supervisor of an individual completing a clinical internship as part of a Clinical Psychology program.

Are you either a supervisor or supervisee as defined above?

Yes

No

Annexure [A1]

Informed Consent

Dear Participant,

My name is Shakir Iqbal, and I am a Ph.D. Scholar at International Islamic University Islamabad (IIUI). I am conducting research for my Ph.D. thesis, which explores the relationship between supervisee and supervisor attachment styles and their working alliance. Data collected will be used for my Ph.D. thesis, presentations and possible publication.

To participate, you must either be (A) currently completing a clinical internship or field placement as part of Clinical Psychology program, OR (B) the clinical supervisor of an individual completing a clinical internship or field placement as part of Clinical Psychology program. This study is only being conducted in English. Your participation in the study will take approximately (…) minutes depending on your pace. This study will be conducted through a quantitative questionnaire and semi-structured interview. You will be asked demographic questions (such as gender, age and racial identity). You will be asked answer two surveys and then will be interviewed. Participating in this study has the potential to cause mild discomfort as if may prompt you to consider your own attachment style and/or your experiences in supervision. You may find that participation in the study offers you a new perspective on your own attachment style and/or your positive experience in a supervision relationship. Your participation in this survey will be kept confidential. Identifying information will be separated from your data once data collection is completed (tentatively ….). Only my supervisor, a data analyst, and I will have access to data. My supervisor and the data analyst will only see your data after identifying information has been removed. In publications or presentations, data will be presented as a whole in order to protect individuals' identities. All data will be kept securely for a period of three years as required. If data are still needed after three years,

they will remain securely protected. Data will be destroyed when no longer needed. Participation in this study is voluntary. You may refuse to answer any question. if you have any concerns about your rights or about any aspect of the study, you can contact the researcher.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's Signature: _____

Date: _____

Annexure [A2]

Demographic Survey

Age: ____

Race/Ethnicity: _____

Gender: _____

Annexure [A3]

Role Survey

Please check one.

I am...

____ a **student of Clinical Psychology** who is currently completing a clinical internship for which I receive clinical supervision

____ the **clinical supervisor** of an individual completing a clinical internship as part of a **Clinical Psychology** program

Annexure [A4]

Demographic Survey Continued (Supervisees Only)

What clinical psychology program are you currently enrolled in? _____

How many years have you completed in Clinical Psychology program? ___

Annexure [A5]

Relationship Structures (ECR-RS) Questionnaire (Supervisee Version)

This questionnaire is designed to assess the way in which you mentally represent important people in your life. You'll be asked to answer questions about your clinical supervisor. You will then be asked to answer questions about how you think your supervisor would answer the same questions about you. Please indicate the extent to which you agree or disagree with each statement by circling a number for each item.

Please answer the following questions about your clinical supervisor

---

1. It helps to turn to this person in times of need.

strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I usually discuss my problems and concerns with this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

3. I talk things over with this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

4. I find it easy to depend on this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I don't feel comfortable opening up to this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

6. I prefer not to show this person how I feel deep down.

strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I often worry that this person doesn't really care for me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I'm afraid that this person may abandon me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I worry that this person won't care about me as much as I care about him or her.

strongly disagree 1 2 3 4 5 6 7 strongly agree

Please answer the following questions in the way you think your supervisor would answer about you.

---

1. It helps to turn to this person in times of need.

strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I usually discuss my problems and concerns with this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

3. I talk things over with this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

4. I find it easy to depend on this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I don't feel comfortable opening up to this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

6. I prefer not to show this person how I feel deep down.

strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I often worry that this person doesn't really care for me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I'm afraid that this person may abandon me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I worry that this person won't care about me as much as I care about him or her.

strongly disagree 1 2 3 4 5 6 7 strongly agree

Annexure [A6]

Relationship Structures (ECR-RS) Questionnaire (Supervisor Version)

This questionnaire is designed to assess the way in which you mentally represent important people in your life. You'll be asked to answer questions about your student supervisee. You will then be asked to answer questions about how you think your student supervisee would answer the same questions about you. Please indicate the extent to which you agree or disagree with each statement by circling a number for each item.

Please answer the following questions about your clinical supervisee.

---

1. It helps to turn to this person in times of need.

strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I usually discuss my problems and concerns with this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

3. I talk things over with this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

4. I find it easy to depend on this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I don't feel comfortable opening up to this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

6. I prefer not to show this person how I feel deep down.

strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I often worry that this person doesn't really care for me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I'm afraid that this person may abandon me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I worry that this person won't care about me as much as I care about him or her.

strongly disagree 1 2 3 4 5 6 7 strongly agree

Please answer the following questions in the way you think your supervisee would answer about you.

---

1. It helps to turn to this person in times of need.

strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I usually discuss my problems and concerns with this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

86

3. I talk things over with this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

4. I find it easy to depend on this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I don't feel comfortable opening up to this person.

strongly disagree 1 2 3 4 5 6 7 strongly agree

6. I prefer not to show this person how I feel deep down.

strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I often worry that this person doesn't really care for me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I'm afraid that this person may abandon me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I worry that this person won't care about me as much as I care about him or her.

strongly disagree 1 2 3 4 5 6 7 strongly agree

Annexure [A7]

Trainee's Version of the Supervisory Working Alliance Inventory

Please rate the following items on a scale of *almost never* (1) to *almost always* (7).

1. I feel comfortable working with my supervisor.

2. My supervisor welcomes my explanations about the client's behavior.

3. My supervisor makes the effort to understand me.

4. My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.

5. My supervisor is tactful when commenting about my performance.

6. My supervisor encourages me to formulate my own interventions with the client.

7. My supervisor helps me talk freely in our sessions.

8. My supervisor stays in tune with me during supervision.

9. I understand client behavior and treatment technique similar to the way my supervisor does.

10. I feel free to mention to my supervisor any troublesome feelings I might have about him/her.

11. My supervisor treats me like a colleague in our supervisory sessions.

12. In supervision, I am more curious than anxious when discussing my difficulties with clients.

13. In supervision, my supervisor places a high priority on our understanding the client's perspective.

14. My supervisor encourages me to take time to understand what the client is saying and doing.

15. My supervisor's style is to carefully and systematically consider the material I bring to supervision.

16. When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client.

17. My supervisor helps me work within a specific treatment plan with my clients.

18. My supervisor helps me stay on track during our meetings.

19. I work with my supervisor on specific goals in the supervisory session.

Annexure [A8]

Supervisor's Version of the Supervisory Working Alliance Inventory

Please rate the following items on a scale of *almost never* (1) to *almost always* (7).

1. I help my trainee work within a specific treatment plan with his/her trainee.

2. I help my trainee stay on track during our meetings.

3. My style is to carefully and systematically consider the material that my trainee brings to supervision.

4. My trainee works with me on specific goals in the supervisory session.

5. In supervision, I expect my trainee to think about or reflect on my comments to him/her.

6. I teach my trainee through direct suggestion.

7. In supervision, I place a high priority on our understanding the client's perspective.

8. I encourage my trainee to take time to understand what the client is saying and doing.

9. When correcting my trainee's errors with a client, I offer alternative ways of intervening with that client.

10. I encourage my trainee to formulate his/her own interventions with his/her clients.

11.I encourage my trainee to talk about the work in ways that are comfortable for him/her.

12. I welcome my trainee's explanations about his/ her client's behavior.

13. During supervision, my trainee talks more than I do.

14. I make an effort to understand my trainee.

15. I am tactful when commenting about my trainee's performance.

16. I facilitate my trainee's talking in our sessions.

17. In supervision, my trainee is more curious than anxious when discussing his/her difficulties with clients.

18. My trainee appears to be comfortable working with me.

19. My trainee understands client behavior and treatment technique similar to the way I do.

20. During supervision, my trainee seems able to stand back and reflect on what I am saying to him/her.

21.I stay in tune with my trainee during supervision.

22. My trainee identifies with me in the way he/she thinks and talks about his/her clients.

23. My trainee consistently implements suggestions made in supervision.

Annexure [9]

Interview (Supervisor)

The aim of this part of research is to establish whether emotions are an important factor in the learning process and in the applying of that knowledge to the workplace. Your responses will be totally confidential, and the interview should last no longer than thirty minutes. If there is anything you do not understand or have any questions, please do not hesitate to ask. If you would like to receive feedback about this research, please ask and we will be happy to let you know. You are free to stop the interview at any time you wish. Thank you for your time.

1. How would you describe the training/clinical supervision session? i.e. If someone else asked you to describe the training, what would you say about it? (E.g. learning environment; attitudes to ICP, support, usefulness of the training etc.)

2. How successful do you think your supervisees are in applying skills discussed during clinical supervision to workplace?

3. Do you think? Is there something in the training programme /clinical supervision session that limit your supervision skills? (e.g. barriers- management/colleague support, environment, motivation, trainees etc.)

4. Is there anything that makes it difficult to use the skills with your supervisees during the clinical supervision session? (e.g. management/colleague support, work environment, motivation etc.)

5. Is there anything in the training/clinical supervision session that improves the effectiveness of supervision?

6. What do you think improved the success of the ICP training in the workplace?

7. What would you say about barriers and boosters during the process of clinical supervision?

8. Which kind of emotional events occur during the training/clinical supervision session?

9. Of the events that occur during the training/clinical supervision session, which ones do you feel are the most significant emotionally? (Positive or negative)

10. What do you think? Which is the most significant emotional event (positive or negative) that occurs during the training/supervision session?

11. Would you like to add any other comments before we finish the interview? In particular, is there anything else you would like to say about the emotional aspect of the ICP training/use in the workplace?

12. Are you satisfied with current duration of clinical supervision, in term of year or months?

13. Do you think that placement of clinical supervision in different units e.g. Child, adolescent and adult related health, learning disability and old age psychiatry is essential?
14. Do you think that our training/supervision in clinical psychology is in link with international standards and best practices?

Annexure [A10]

Interview (Supervisees)

The aim of this part of research is to establish whether emotions are an important factor in the learning process and in the applying of that knowledge to the workplace. Your responses will be totally confidential, and the interview should last no longer than thirty minutes. If there is anything you do not understand or have any questions, please do not hesitate to ask. If you would like to receive feedback about this research, please ask and we will be happy to let you know. You are free to stop the interview at any time you wish. Thank you for your time.

1. How would you describe the training/clinical supervision session? i.e. If someone else asked you to describe the training, what would you say about it? (E.g. learning environment; attitudes to, support, usefulness of the training etc.)

2. How successful do you think you are in applying skills discussed during clinical supervision sessions with your supervisor to workplace? (e.g. case of application, usefulness of the training at work etc.)

3. Do you think? Is there something in the training programme /clinical supervision session that limit your supervision skills? (e.g. barriers- management/colleague support, environment, motivation, trainer etc.)

4. Is there anything that makes it difficult to use the clinical supervision skills covered during the session to your workplace?

5. Is there anything in the training/clinical supervision session that improves the effectiveness of supervision?
6. Considering, what you have said about barriers and boosters, to what extent have you felt able to:(a) Learn (b) Transfer
7. Which kind of emotional events occur during the training/clinical supervision session?
8. Of the events that occur during the training/clinical supervision session, which ones do you feel are the most significant emotionally?
9. Are you satisfied with current duration of clinical supervision in term of year or months?
10. Do you think that placement of clinical supervision in different units e.g. Child, adolescent and adult related health, learning disability and old age psychiatry are essential?
11. Do you think that our training in clinical psychology are in link with international standards and best practices?
12. Would you like to add any other comments before we finish the interview? In particular is there anything else you would like to say about the emotional aspeet of ICP training/clinical supervision session and the experience of sharing skills with your supervisor?