EXPLORING GROUP PROCESSES IN PEER SUPERVISORY PRACTICE WHEN SYSTEMIC PRACTITIONERS DISPLAY VULNERABILITY

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ABSTRACT

This systemic doctoral project addresses the research gap concerning what is made from clinical peer group supervision and the impact of group supervisory processes. The study is centred around the research question: "*What happens when systemic practitioners talk about their difficulties in peer group supervision within the Norwegian Family Welfare Service?*" The aim is to provide insight into peer group supervisory processes originating from supervision requests where systemic practitioners display vulnerability. The project is designed as a small-scale ethnography integrating components from conversation analysis and action research to make sense of relational processes. The research findings indicate that relational, emotional, organisational, and cultural elements intra-act in constraining group processes in peer supervision. There is a sense of vulnerability and insecurity connected with revealing and addressing therapist difficulties in supervision, leading to a frequent move from inviting to intimacy to keeping a distance in the supervision conversations. The research participants associate this shift with feeling unsupported or unaided in peer group supervision.

Key recommendations made from the results of this study:

- Establish an institutional peer group supervision mandate to hold and direct the supervision practice within the Norwegian Family Welfare Service.
- Apply an overall caretaking supervision frame that supports systemic learning and increases safety in peer group supervision.
- Challenge the cultural value of equality as sameness to embrace the systemic idea of learning through difference and the production of multiple perspectives.
- Attend to bodily responses, affect, and emotions as an essential mode of knowing in supervision practice.

A reflexive commentary on my motivation for carrying out the research is included towards the end of the thesis.

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CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

The following extract is a concluding remark from a longitudinal study about the professional development of psychotherapists and the status of clinical supervision:

> "It is our understanding that the ability and willingness to continually reflect upon professional experiences in general and difficulties and challenges in particular, are prerequisites for optimal development." (Rønnestad and Skovholt, 2003, p.38)

I have chosen clinical peer group supervision as the topic of my doctoral project. In this first chapter, I introduce my interest in the research topic, research aim, research questions and my position as a systemic practitioner-researcher. Then, I describe the Norwegian research context, make some notes about the translated data material and finally, provide a guide to the structure of this doctoral thesis.

1.2 MY INTEREST IN THE RESEARCH TOPIC

Over the last 20 years, I have practised as a family therapist in different sections of the Norwegian welfare system. My line of work has ranged from substance abuse care, child protection services, mental health care and family welfare services. Across workplaces, I have regularly participated in clinical group supervision with colleagues to reflect on challenges experienced in the practice field. In this thesis, I refer to all types of clinical group supervision with colleagues as "peer group supervision", aware that some would prefer to make distinctions between counselling groups, supervision groups, and so forth. Congruent with my professional experiences, clinical supervision has taken a pivotal role across helping professions over the last 30 years (Bernard and Goodyear, 2014; Campbell and Mason, 2018; Hanetz Gamliel et al., 2020) with widespread use of peer group supervision in more recent years (Borders, 2012). I view peer group supervision as a valuable resource in the workplace with immense potential. In developing my professional identity, feedback from colleagues has proven crucial. However, I have also experienced peer group supervision to be irrelevant and insignificant. The seemingly random nature of this supervision practice, along with a perception that it is taken for granted and inadequately managed, has

increasingly become a point of annoyance for me. I have come to realise that during my professional life, I have never been invited to a formal evaluation of what is made from clinical supervision with colleagues. My impression is that there is an inherent lack of curiosity about what happens in peer group supervision, resulting in a supervision practice assumed to be important without asking *how* it is important. My interest in the research topic is also rooted in personal life experiences and values concerning speaking openly about difficulties and vulnerabilities. There is a strong connection between my private story and my professional doctorate project. I have included a reflexive commentary about this connection towards the end of the thesis.

In the supervision literature, clinical supervision is commonly seen as having two primary purposes: to promote professional development and to ensure client welfare (Bernard and Goodyear, 2014, p.13). Regardless of the therapist's level of experience, reflection on the complexities of therapeutic work to better understand oneself and others is deemed essential for optimal learning and professional development in clinical supervision (Rønnestad and Skovholt, 2003). There is much at stake, as the opposite of professional development is professional stagnation associated with experiences such as feeling incompetent, impaired, disillusioned, and burned out. A longitudinal study by Orlinsky and Rønnestad (2005) illustrates the manner in which thousands of psychotherapists across professions, genders and countries describe clinical supervision as the second most important learning arena after directly engaging with clients. The peer group supervision literature underscores the importance of professional growth through learning from each other and preventing therapist isolation and burnout (Knight, 2017; Bernard and Goodyear, 2014; Zahm, Veach and LeRoy, 2008). Nevertheless, there seems to be a research gap with regard to group processes in supervision (Campbell and Mason, 2018; Hanetz Gamliel et al., 2020) and a lack of a framework to support valuable ways of learning in groups (Orlinsky and Rønnestad, 2005; Knight, 2017; Flåm, 2016). This gap is concerning, given that the effectiveness of peer group supervision heavily relies on group dynamics, peers staying on task, and constructive feedback (Borders, 2001). The lack of evidence base for peer group supervision contrasts with the reliance on the supervision practice within the therapeutic field (Borders, 2012).

In this research project, I wish to develop more insights into what happens in peer group supervision within the Norwegian Family Welfare Service, where I currently work. My professional experiences of clinical peer supervision and the research gap about group supervisory processes have ignited my curiosity about what is made from communication and interaction processes in supervision. I am unaware of other research projects that have explored peer group supervision processes within my organisation, rendering this study a unique contribution to the practice field.

1.3 RESEARCH AIM AND QUESTIONS

The research aim of the project is to offer detailed insights into peer group supervisory processes originating from supervision requests where systemic practitioners display vulnerability. Utilising the supervision setting to reflect on difficulties encountered in therapeutic practice is seen as crucial for therapists` professional development. However, openly discussing difficulties in peer group supervision also entails exposing vulnerability in front of peers. In this study, I am interested in understanding how the therapists` difficulties travel within supervision groups and how communication and interaction processes contribute to the ongoing learning and support of systemic practitioners. The overall objective is to generate ideas about strengthening peer group supervision practice within the Norwegian Family Welfare Service.

The study is centred around the main research question: ***"What happens when systemic practitioners talk about their difficulties in peer group supervision within the Norwegian Family Welfare Service?"***

The research question is broadly formulated to accommodate different perspectives of what might happen in peer group supervision practice. The following sub-questions are used to explore the research question and provide direction for the data analysis:

1. How are stories about therapist difficulties performed in peer supervision?
2. What are the communication patterns connected to stories about difficulties?
3. What conditions seem to affect the communication and interaction processes?

1.3.1 Clarification of terms

The term *"systemic practitioners"* applies to all psychotherapists working within the Norwegian Family Welfare Service, as the organisation promotes a systemic clinical practice (NOU 2019:20). Most therapists are qualified systemic family therapists. However, some hold a degree in psychology while working systemically. Throughout this thesis, I alternate in referring to the practitioners at the Family Welfare Service as *"systemic practitioners", "psychotherapists"*, and *"therapists"*. I use the terms *"family therapist"* or *"systemic psychotherapist"* when specifically referring to systemic family therapists holding a systemic degree.

"Therapist difficulties" denotes the range of challenges systemic practitioners might experience from interacting with their clients. The term is employed to distinguish between experiencing difficulties as a therapist as opposed to focusing on the clients` difficulties. The emphasis on therapist difficulties represents a cut in the research design to pursue a selected research focus (Barad, 2007).

I apply the term *"performances of stories"* to underline my understanding of storytelling as a contextual, dialogical phenomenon (Rober, 2005) used to display preferred identities (Goffman, 1959). The term is used to emphasise how stories are often incomplete and contradictory because they are told with an audience in mind as a response to something said or done before. Drawing on Butler's idea of performativity, speech acts and embodied practices identified in this study are seen as both maintaining and constructing the identity of social actors (Butler, 2006; Jackson and Mazzei, 2023). The term *"interaction"* refers to shared communicative and embodied performances between the practitioners engaging in peer supervision.

My understanding of *"communication"* includes utterances, inner voices, bodily responses, movements, gestures, tone of voice, and other forms of communication that go beyond the spoken (Shotter, 2004; Seikkula, 2008, Krause, 2012). Dialogical practice is incorporated in this understanding of communication. However, I sometimes apply the term *"dialogues"* to emphasise the interactive perspective of communication and how moments of responsiveness determine the direction of communication processes (Shotter, 2004).

1.4 SYSTEMIC PRACTITIONER RESEARCH

I have undertaken this research from the position of a systemic practitioner-researcher. Simon (2018) describes systemic practitioner research as being "conducted from within the doing of relationally reflexive professional practice" (p.41). I have conducted research from within my professional practice field, having insider knowledge of the researched phenomenon. In the capacity of a practitioner-researcher, I cannot be extricated from the research material produced. During the research process, I have tried to be responsive to my prior knowledge by inquiring into both my and the research participants` knowing and meaning-making processes. Responsiveness is demonstrated through reflexive thinking and writing in this thesis.

Utilising participant observations as the primary method for collecting data, the study is designed as a small-scale ethnography. Being a participant observer is an ethnographic position that fits well with systemic practitioner research (Simon, 2018), situating the researcher as a part of the researched system to create relational knowledge through interaction with others. I experimented with the observations by adding elements from conversation analysis and collaborative action research. The need for different methods evolved as a response to studying the complex, unfolding relational processes in peer group supervision from different angles.

The knowledge production in this project belongs to a post-positivist research paradigm (Lincoln, Lynham and Guba, 2018). In systemic practitioner research, there is a preference for approaches to research that prioritise constructing realities rather than merely representing them (Simon, 2018). I have explored various descriptions and perspectives of what happens when systemic practitioners talk about their difficulties in peer supervision. As a researcher, I have been more concerned with what things *do* or *make* than what they *are*. I have viewed peer group supervision as a relational process, underscoring what the systemic practitioners do together and what their "doing" makes. Insider-led research projects are often relatively concrete, aiming at making improvements, sharing ideas, or suggesting something new to benefit the practice field (Costley, Elliot and Gibbs, 2010). My research objective was to strengthen clinical peer group supervision practice in the Family Welfare Service.

1.5 THE NORWEGIAN RESEARCH CONTEXT

As a Norwegian researcher conducting research within a Norwegian context, any insight from this study stems from a Norwegian cultural perspective. Awareness of the Norwegian research context is essential to understanding the findings regarding relational group processes in peer supervision. In the following, I outline the Norwegian Family Welfare Service and provide ethnographic data indicating typical characteristics of Norwegian interaction.

1.5.1 The Norwegian Family Welfare Service

The Norwegian Family Welfare Service is a state-run organisation providing therapy, counselling, and mediation on a low-threshold level to families experiencing relational problems, crises, and conflicts (Familievernkontorloven, 1997, § 1). Family therapists and psychologists assist families with minor children free of charge within Family Welfare Clinics across the country. Clients can directly schedule appointments as no referral is necessary to access the services. The inception of the first two Family Welfare Clinics in Norway dates back to 1959 and 1960, and primarily aimed at providing maternal sexual counselling and preventing family problems from occurring (Kummen, 2016). Presently, there are 42 clinics nationwide specialising in systemic practice and couples therapy (NOU 2019:20). The focus has shifted from preventing family problems from occurring to preventing them from escalating.

The Family Welfare Service embodies the principal investment of the Norwegian Government in the family policy area (Barne-og likestillingsdepartementet, 2016) and operates under the administration of the Norwegian Directorate for Children, Youth, and Family Affairs. Services offered at the Family Welfare Clinics are rooted in Norwegian welfare policies, reflecting the egalitarian idea of equality that has become characteristic of the Scandinavian countries (Sørensen and Stråth, 1997; Bruun, Jakobsen and Krøijer, 2011; Bendixsen, Bringslid and Vike, 2018a). It is often contended that the welfare systems in Scandinavia have institutionalised egalitarian values expressing their citizens' equal worth, rights, and status (Bruun, Jakobsen and Krøijer, 2011; Bendixsen, Bringslid and Vike, 2018b).

1.5.2 Characteristics of Norwegian interaction

Equality is also dominant in Scandinavian everyday life and interaction, although it is commonly referred to as *likhet* within this context (Bruun, Jakobsen and Krøijer, 2018; Gullestad, 2002; Gullestad, 2010). The Norwegian notion of *likhet* translates to sameness, emphasising being and doing the same. In an ethnographic study of social relations and everyday life in Norway, Gullestad (2010) found that Norwegians adopted an interaction style emphasising sameness while under-communicating differences (p.104). In social interaction, sameness foregrounded what people had in common. In a similar vein, a withdrawal from relationships was often seen if differences were too significant. This pattern corresponded with another important Norwegian value, “Peace and quiet”, referring to a preferable emotional state (Gullestad, 2010, p.141). As other people could threaten personal boundaries and values, there were times when Norwegians limited their social interaction to maintain peace and quiet. Distancing was perceived by Gullestad as a required mode of interaction, used as a “symbolic fence” to safeguard the social identity of sameness. Such fences have made it difficult for the indigenous Sami population and foreign immigrants to integrate into everyday Norwegian life (Gullestad, 2002; Gullestad, 2010, p.105). Although equality as sameness seemed to provide a sense of protection and solidarity for most Norwegians, it isolated people who did not fit into the category of sameness in terms of lifestyle and social class.

Based on the notion of sameness as an ideal and condition of social interaction, equality is frequently viewed as both a part and outcome of Scandinavian social life (Bruun, Jakobsen and Krøijer, 2011). This mode of interacting contrasts with, for example, the USA, where equality primarily revolves around equal opportunities seen as a foundation for achieving success and distinction in life. In Scandinavian culture, modesty is highly valued (Gullestad, 2010). To be accepted into social circles, individuals should refrain from seeking prestige, boasting, or openly expressing distinctiveness. The Norwegian/Danish author Aksel Sandemose formulated *The Laws of Jante* (1933) as a code of conduct warning people about what would happen if they stood out of the group. This code is still used on a frequent basis to describe equality as sameness in Scandinavian social life. However, Bruun, Jakobsen and Krøijer (2011) critique the powerful positioning of equality as sameness used in social anthropological literature to describe Scandinavian interaction because it hinders identifying complexities and differences. They suggest describing social life through a

hierarchy of values to include other valued forms of social interaction. As a case in point, in Denmark, the notion of *hygge* has emerged from an idealised version of equality (Abram, 2018, p.103). *Hygge* offers a retreat from social disharmony by emphasising an emotional atmosphere of cosiness, security and warmth and is commonly used to describe Danish social life and lifestyle (Bruun, Jakobsen and Krøijer, 2011; Jenkins, 2016).

1.6 NOTES ON TRANSLATED DATA MATERIAL

I have collected the data material in Norwegian and translated data excerpts used in the analysis into English. When translating data, it is crucial to be sensitive to details and nuances in the original language (Hepburn and Bolden, 2017). Recognising that language can sometimes lose some of its meaning in the translation process, I relied on my Norwegian supervisor as a consultant when translating Norwegian data into English. A few words that did not easily translate were displayed in Norwegian and explained to contain the richness and difference in language translation. An example is "*hygge"*, which was used in the previous sub-section to describe a valued form of interaction in Danish social life. Since this word did not translate without providing a fuller description, it was implemented in its original format.

As I utilised conversation analysis as one of the methods to analyse data, I employed a verbatim transcription style, transcribing the supervision conversations word-for-word. Nevertheless, at times I needed to adjust the word positioning in the translated text to convey meaning accurately. Owing to the transcription style, some of the data excerpts may have a Norwegian sound to them and include words and stutters more typical of Norwegian than the English language. An example is the widespread use of the word "*then"*, typically used by the end of a sentence in Norwegian speech to refer to a prior point made.

1.7 GUIDE TO THE THESIS

The thesis is structured into five chapters. This is the conclusion of the first chapter, introducing the research project. Chapter 2 delves into a literature review on clinical systemic supervision and group processes. Chapter 3 outlines the methodology and

methods employed in the research project. Chapter 4 presents the findings derived from the analysed data material. Finally, Chapter 5 discusses the findings and their implications for practice, concluding with final remarks.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This literature review aims “to set the scene for the project” (Aveyard, 2014, p.42). My research project focuses on processes of communication and interaction in peer group supervision when systemic practitioners talk about their difficulties. The objective is to explore how group processes might contribute to strengthening the professional development and support of systemic practitioners. In this chapter, I seek to provide an overview of systemic literature concerning central topics in the research project by asking:

1. What is clinical systemic supervision?
2. How do group processes impact clinical group supervision?

In the following review, I summarise and critique academic papers on clinical systemic supervision and group processes in supervision. I distinguish between theoretical literature from academic handbooks, research literature and conceptual literature. By research literature, I mean academic papers describing a systematic study undertaken by a scientific method and a certain level of research rigour (Aveyard, 2014). Conceptual literature refers to academic papers pertaining to relevant ideas, theories, concepts or practices without providing research evidence or rigour. To ensure the review was consistent across papers, I quality assessed the literature by using a framework for critiquing qualitative research articles developed by Holland and Rees (2010). This implies reviewing the research focus, background, study aims, research methodology, methods, sample size, ethical considerations, findings, conclusions, overall strengths and limitations, and application to practice.

2.2 SEARCH STRATEGY

I approached the literature review systematically to identify the most relevant literature concerning my literature review questions. For a literature review to be systematic, the search strategy must exhibit comprehensiveness and reproducibility (Harper and Thompson, 2012). I conducted a broad literature search using the

Discovery database, encompassing all databases accessible within the academic library`s repository. In addition, I applied the *Journal Finder* database to search for literature in the following journals: *Journal of Family Therapy*, *Australian and New Zealand Journal of Family Therapy*, *Family Process*, and *Journal of Marital and Family Therapy*. All searches were run in November and December 2023 and were limited to academic journals in English from 2003 to 2023. Given that my research project concerned the supervision of systemic practitioners, I narrowed my search to literature about the supervision of practitioners, excluding academic papers about the supervision of clients or the supervision of students lacking clinical experience. I also excluded papers advocating for a specific supervision method or concept, looking for broader descriptions of systemic supervision and group processes. Primarily, I looked for research papers, but because of a lack of literature, I included conceptual papers about the nature of systemic supervision. When searching for research papers addressing group processes in supervision, I included two categories of papers: i) group supervision of systemic practitioners and ii) practitioners receiving systemic group supervision. Eventually, four papers about systemic supervision and six papers about group processes were included in the review.

Finding the most successful search terms and combination of terms for the literature search was an interactive process. Initially, search terms on *Discovery* included “peer group supervision”, “systemic supervision”, “systemic group supervision”, “systemic psychotherapists”, “group processes”, “group dynamics”, and “group work”. The terms were used alone or in different combinations using Boolean operators. Most searches gave vast search results. To illustrate, searching for “Systemic group supervision” yielded 227 740 results. Adding “group processes” reduced the number to 172 292, while adding “group dynamics” increased the results to 5 672 336. Searching for “systemic group supervision” AND “systemic psychotherapists” AND “group processes” was more successful, providing merely 5019 results. I reviewed abstracts from the initial 350 papers resulting from this search to gain a comprehensive understanding of the literature landscape. It emerged that a significant portion of the papers focused on aspects such as client supervision, therapeutic techniques, treatment efficacy, and self-care practices. Nonetheless, I identified eight papers of initial interest and incorporated four of these into the comprehensive literature review. In another *Discovery* search, the terms “journal of

family therapy" AND "systemic supervision" gave 74 952 results. During the course of reviewing abstracts from the first 350 papers, I found that most of the literature concerned supervision practice with clients, supervision used in training to become practitioners or different supervision methods. Still, I identified ten papers of potential interest and included two in the review. Moving on to undertake searches on the *Journal Finder,* I used the search term "systemic supervision" across all the identified journals. These searches yielded a total of 731 papers following the removal of duplicates. After filtering the papers based on their titles and abstracts, a subset of 23 papers emerged that were of initial interest, with four ultimately included into the literature review. Additionally, two relevant papers were previously identified through Discovery searches. However, the extensive literature on supervision uncovered during this investigation underscored a notable dearth in the literature concerning clinical systemic supervision and the impact of group processes.

2.3 PRESENTATION OF RELEVANT LITERATURE: Systemic supervision

In this section, I present the papers from the literature review about clinical systemic supervision and some definitions selected from academic handbooks about systemic supervision. The table below illustrates the main themes identified from the reviewed literature concerning systemic supervision. These themes will be further explained.

Table 1: Themes from the reviewed literature: Systemic supervision

Learning systemic ideas and practice:	**Critical thinking on systemic practice:**	**Professional gatekeeping:**
Butler et al. (2021) Senediak (2014) Shaw (2014) Simon (2010) Bertrando and Gilli (2018)* Bownas and Fredman (2017)* Storm and Todd (2014)* Sheehan (2017)* Ulleberg and Jensen (2017)*	Shaw (2014) Senediak (2014) Simon (2010)	Shaw (2014) Bownas and Fredman (2017)* Storm and Todd (2014)*

*

* References to academic handbooks about systemic supervision

2.3.1 Definitions of systemic supervision

The systemic supervision literature can be critiqued for providing poor descriptions of the specific aspects of systemic supervision (Butler et al., 2021), thus making it challenging to define systemic supervision. Although there is consensus about the importance of clinical supervision, what the term supervision means within a systemic context seems unclear. In *Mirror and Reflections*, Bertrando and Gilli (2018, p.5) connect supervision practice with clinical practice, suggesting that systemic supervision should be isomorphic to systemic practice. Within this perspective, the focus is more oriented towards the supervision form than the supervision content. The linking of therapeutic processes with supervisory processes is what Bateson (2000) describes as “patterns that connect”. In *Working with Embodiment in Supervision*, Bownas and Fredman (2017, p.3) refer to systemic supervision as both monitoring therapeutic practice and enriching it through engagement in reflective processes. Thus, the aim of supervision is not merely to promote professional development but also to uphold professional standards. In *The Complete Systemic Supervisor*, Storm and Todd (2014, p.347) understand systemic supervision as an arena where practitioners are helped to grasp systemic, relational ideas and the manner in which they apply to practice. The function of the systemic supervisor is to help practitioners become systemic while also engaging in the evaluation of practice, mentoring, and gatekeeping. In *Supervision of Family Therapy and Systemic Practice*, Sheehan (2017, p.4) describes systemic supervision as a learning arena with potential for personal and professional development. He posits that the aim of supervision aligns with the aim of family therapy training, which is assisting practitioners in attaining self-supervision skills and fostering independent systemic practice. In *Systemisk Veiledning i Profesjonell Praksis*, Ulleberg and Jensen (2017, p.36) use the term systemic supervision on any clinical supervision embracing a dialogical, relational, contextual frame of learning and development of systemic practitioners.

2.3.2 Learning systemic ideas and practice

Although emphasising various aspects of supervision, all the academic papers identified in the literature review postulate that systemic supervision is as an arena for learning systemic ideas and practice (Butler et al., 2021; Senediak, 2014; Shaw,

2014; Simon, 2010). This overall view aligns with the various definitions of systemic supervision stemming from academic handbooks (Bertrando and Gilli, 2018; Brownas and Fredman, 2017; Storm and Todd, 2014; Sheehan, 2017; Ulleberg and Jensen, 2017). Nevertheless, the alleged agreement on the attributes of supervision faces challenges when considering the definition of systemic practice. Certain academic papers in this review imply consensus regarding these matters, merely citing systemic techniques such as reflective processes and reflexivity. However, assumptions about systemic concepts are not universal as they can be perceived differently by different practitioners (Simon, 2010).

Butler et al. (2021) developed a scale to measure the processes occurring in systemic supervision from a robust literature review of the distinct practice of systemic supervision for psychotherapists. Their literature search revealed that very few papers specified the systemic aspects of supervision, resulting in a lack of competency framework describing systemic supervision. However, the researchers managed to identify three overarching themes that were applied to build a systemic supervisor scale: i) supervision is moderated by the context in which it occurs, ii) interrelations between the supervisor and the supervisee need to be understood within a systemic framework, and ii) multiple perspectives and reflexivity should be privileged in the supervision conversations. There was a notable absence of further elaboration on the systemic themes identified, implying a presumption that everyone had the same ideas about the systemic ideas. Utilising five focus groups, the researchers assessed the utility of the systemic scale by administering it to students and supervisors enrolled in a UK systemic supervision course. Ethical approval for the research was obtained from the University of Bath and the University of Exeter. Information gathered encompassed participants` initial impressions of the scale and their experiences utilising it. The data analysis was conducted through inductive thematic analysis. Despite the robustness of the research design, I was puzzled by the limited descriptions of findings from the focus groups. Nevertheless, the researchers asserted that participants perceived the scale as beneficial in enhancing supervision skills, leading to no alternations being made to the scale.

In a conceptual paper, Senediak (2014) discuss systemic supervision as a reflective, collaborative practice where family therapists can develop professional skills and self-

awareness through reflections and reflexivity. There are different views of reflexivity (Givropoulou and Tseliou, 2020) and the author can be criticised for not explaining her use of the term. However, she does provide a description of reflective practice and the needed quality of reflections. Senediak understands the aim of systemic supervision as attending to interactions in the therapeutic context in order to develop alternative interpretations. Reflective processes are seen as essential to increase empathy and provide different perspectives on feelings, senses, and theories related to relationships the family therapist engages in. She stresses that supervision reflections must be deep enough to explore the different layers of a case and assist family therapists in thinking beyond what is already known. She also suggests practicing reflectivity as preparation for supervision, emphasising the complexity of reflective practice.

Shaw (2014) discusses systemic supervision on a continuum ranging from surveillance on the one side to support on the other. She opines that systemic supervision is in alignment with ethical professional practice. Simon (2010) inhabits a slightly different position, reflecting on supervision as a transgressive practice. She views systemic supervision as a practice where systemic therapists are engaged in becoming systemic. Through supervision, the systemic therapist is helped with challenging preconceptions, looking out for what is different, and being prepared to alter the manner in which they engage in different relationships. In line with other views of systemic supervision in this review, Simon finds that supervision is undertaken in accordance with systemic theory. She refers to the systemic element in supervision by stressing the importance of entering into a relaxed, ethics-led relationship, connecting with the experiences of others, and avoiding pathologising and individualising discourses. Notably, Simon does not explore the interpretation of these references, which could elicit criticism for providing limited descriptions of systemic theory. Nonetheless, her argument revolves around the notion that systemic therapists will have different understandings of systemic theory determined by their culture, life experiences and distinct ways of thinking. Consequently, the various understandings of systemic theory need to be addressed in supervision. Practice and theory are interdependent, and utilising supervision to develop systemic accounts of practice can extend the boundaries of what counts as systemic practice.

2.3.3 Critical thinking on systemic practice

Although everyone seems to share the view of systemic supervision as an arena for learning systemic ideas and practice, some also emphasise critical thinking on systemic practice as essential in supervision (Senediak, 2014; Shaw, 2014; Simon, 2010). In the paper related to reflective practice in systemic supervision, Senediak (2014) describes supervision as a process of inquiry where therapeutic work is investigated through critical considerations. Shaw (2014) stresses that since support and comfort in supervision do not contribute to the professional development of therapists on their own, critical thinking about practice is important. She perceives the tension arising from feeling challenged in supervision as valuable for learning, as it bears the potential to reveal the therapist`s blind spots. Thus, a supervisor must be willing to take risks within the supervisory relationship and acknowledge the critical role alongside the more comfortable, affirmative functions. Simon (2010) elaborates on this concept in her paper about supervision as transgression. She illustrates how systemic practitioners cultivate critical thinking skills in supervision by being encouraged to question their relationships and dominant norms within their thinking. She sees this learning process as transgressive teaching, where the supervision outcome lies in the hands of the practitioners. Through inquiry and critical thinking in supervision, systemic practitioners are enabled to use systemic ideas in new and different ways, keeping systemic practice on the move.

It might be contradictory to search for a fixed definition of systemic supervision within a perspective of systemic practice as flexible and evolving. If the field of practice is perceived as continually evolving, a rigid, narrow definition of systemic supervision may constrain supervisory practice. This might explain why both Senediak (2014) and Simon (2010) broadly characterise systemic supervision as an arena of difference where practitioners learn to be responsive, critical thinkers of how they engage in various relationships. Indeed, this might explain why all descriptions of systemic supervision referred to in this review appear somewhat vague. There seems to be a need for sufficient space for exploring different understandings of systemic theory and practice in systemic supervision. Simon adds to this point by emphasising how the cultivation of critical thinking skills in supervision contributes to the evolving construction of systemic practice. Within a collaborative supervisory setting, new ideas may emerge, potentially changing the very nature of systemic practice. In this

regard, systemic supervision plays a pivotal role not only in the development of systemic practitioners but also in shaping the broader systemic practice field.

Compared with the definitions of systemic supervision in the academic handbooks, none explicitly highlighted critical thinking as a pivotal aspect of supervision. A perspective possibly aligning with this perspective is articulated by Sheehan (2017), who perceives systemic supervision as a space for learning that nurtures practitioners towards self-supervision and autonomous practice. It could be argued that learning the skill of critical thinking is encompassed within the process of becoming an autonomous practitioner engaging in self-supervision. Further, Bertrando and Gilli's (2018) definition of supervision as learning the form of systemic practice might encompass engaging in critical, relational thinking. This definition is premised on an isomorphic perspective of supervision consistent with Simon's (2010) way of emphasising the parallel supervisory and clinical practice processes.

2.3.4 Professional gatekeeping

From the academic handbooks on supervision, both Bownas and Fredman (2017) and Storm and Todd (2014) mention professional gatekeeping as an essential aspect in their definition of systemic supervision. This expands the view of systemic supervision as an arena for promoting professional development and learning skills through the inclusion of quality assessment, evaluation, and practice monitoring. The aim is to ensure systemic practice is conducted within the profession's norms (Bownas and Fredman, 2017; Storm and Todd, 2014). Nevertheless, gatekeeping in supervision might stand in contrast to the view of systemic practice as flexible and constantly evolving (Simon, 2010). From the perspective of talking systemic practice into being, the definition of assessment criteria could be problematised.

In a paper about the importance of balancing mentoring and monitoring in supervision, Shaw (2014) addresses professional gatekeeping in systemic supervision in a different manner. Her contention is that most systemic practitioners prefer merely focusing on learning and developing in supervision, associating monitoring with a modernist and normative practice that does not fit systemic theory and practice. However, she views both monitoring and mentoring as necessary for the professional development of systemic practitioners. Evaluating and challenging

systemic practice is understood as creating a productive tension in supervision, which, in turn, is valuable for learning. According to Shaw, the challenge is not gatekeeping but conducting a gatekeeping practice in line with ethical professional practice. For example, holding authority as a supervisor without becoming authoritarian. In the realm of supervision, exploring vulnerability and ethical dilemmas in supervision depends on the quality of the supervisory relationship. Shaw finds that a predictable, transparent, and ethical supervision practice enables the systemic supervisor to enter into a hierarchical supervisory relationship, accepting that power difference exists yet being mindful of it.

2.3.5 Summary reflections on systemic supervision

In the literature search for academic papers about clinical, systemic supervision, I was struck by the lack of literature and the failure to identify newly released papers. This discovery prompted me to question whether clinical supervision is being overlooked or has lost relevance within the systemic field. The revelation was particularly striking given the review`s demonstration of varied definitions and interpretations of systemic supervision. There was unanimous agreement regarding the pivotal role of systemic supervision in facilitating the learning of systemic ideas and practice, but systemic concepts like reflective processes, reflexivity and providing different perspectives were often referred to without further description (Simon, 2010; Shaw, 2014; Butler et al., 2021). One explanation might be a conception of systemic practice as flexible and evolving (Simon, 2010), where rigid definitions could stymie critical thinking and innovative systemic practice. Although this argument makes a good point, the broad definitions of systemic supervision could convey an oversimplified view of systemic practice. Merely alluding to systemic ideas and techniques may undermine the recognition that practitioners possess different interpretations of systemic theory, not to mention the intricate nature of systemic theory and practice. Furthermore, it might make the boundaries of systemic supervision unclear and confusing. This is problematic as supervision practice does not merely exist in language. There is also a “doing” of supervision that needs to have a form.

Within the different views of systemic supervision, a distinction seemed to be made between supervision as a way of learning by doing systemic practice (Bertrando and

Gilli, 2018; Simon, 2010) and supervision as reflecting on systemic practice (Bownas and Fredman, 2017; Storm and Todd, 2014; Senediak, 2014). Further, some emphasised the importance of critical thinking regarding engagement in relationships (Senediak, 2014; Simon, 2010; Shaw, 2014) and professional gatekeeping (Bownas and Fredman, 2017; Storm and Todd, 2014; Simon, 2010; Shaw, 2014) in their descriptions of clinical, systemic supervision. Conversely, others primarily focused on supervision as a means for the professional development of systemic practitioners (Bertrando and Gilli, 2018; Sheehan, 2017; Ulleberg and Jensen, 2017). The latter group could be criticised for overlooking monitoring in supervision as a salient aspect of learning and developing systemic practice (Shaw, 2014).

2.4 PRESENTATION OF RELEVANT LITERATURE: Group processes in supervision

In this section, I review research papers about group processes in supervision. The literature search revealed a lack of systemic research papers about communication and interaction processes in clinical group supervision, leaving the impression that this was an overlooked theme in systemic supervision literature. Nevertheless, six research papers met the inclusion criteria and were included in the literature review. The table below illustrates the main themes identified from the research papers and will be further explained in the following literature presentation.

Table 2: Themes from the reviewed literature: Group processes in supervision

Case discussions:	Reichelt and Skjerve (2013) Bingle and Middleton (2019)
Relational and emotional experiences:	Clarke and Rowan (2009) Reichelt and Skjerve (2013) Smith (2022) Zvelc and Zvelc (2021)
Reflexive practice:	Reichelt and Skjerve (2013) Bingle and Middleton (2019) Givropoulou and Tseliou (2020) Smith (2022)
Leadership styles:	Reichelt and Skjerve (2013) Smith (2022)

	Zvelc and Zvelc (2021) Givropoulou and Tseliou (2020)
Professional development:	Clarke and Rowan (2009) Reichelt and Skjerve (2013) Bingle and Middleton (2019) Smith (2022) Zvelc and Zvelc (2021) Givropoulou and Tseliou (2020)

2.4.1 Case discussions

Two out of six research papers pertained to communication processes in group supervision, labelled as case discussions. Bingle and Middleton (2019) studied the impact of introducing a systemic approach in child protection practice by observing a single session of group reflective supervision at a local authority in London. The group comprised five social workers and one unit manager, and most group members had received basic training in systemic practice. The University of Bedfordshire granted ethical approval to undertake the research. UK child protection services are increasingly adopting systemic interventions to improve practice, giving relevance to the study. However, the sample size is small, even for qualitative research. In this study, communication and interaction processes progressed through different stages: First, a case was presented with a formulated dilemma, following which clarifying questions were asked, and eventually, the social worker requesting supervision was placed in a listening position whilst the group members generated ideas about the presented case. By describing a dilemma, the social worker seeking supervision became a participant in the case in line with the postmodern, systemic idea of being a part of the observed system. The group would then present ideas through hypotheses about relationships and interactions between the people described in the case. Data was analysed by using thematic coding and field notes from the observation. Findings revealed that although hypotheses could bring forth formulations of systemic principles, many were also classified as “linear assumptions” characterised by certainty and deterministic language. The linear statements suggested the social workers engaged in a pathologising discourse. Group reflections concerned “the others” and did not include the self of the social worker. The authors of this paper see this lack of reflexivity in child protection supervision as

failing to grasp the second-order position in systemic practice. They call for a more explicit systemic supervision model to ensure the social worker and her feelings are included in the supervision reflection.

The study of Reichelt and Skjerve (2013) expands the understanding of case discussions in supervision. In a relatively robust qualitative study, they explored how the original reflecting team format was practised in supervision groups of Norwegian postgraduate psychologists specialising in family psychology and systemic practice. The study was prompted by a concern that the Reflecting Team method, when applied in supervision, was being used in varied ways without clarity on whether modifications were beneficial. Ten supervision groups participated in the study, each comprising one experienced supervisor and four psychologists with a minimum of two years of work experience. Each group`s supervision session was filmed, and the film was subsequently viewed separately to each group member to elicit their descriptions and evaluations of what happened, aiming to assess the participants` satisfaction with the supervisory process. The data analysis followed the principles of consensual qualitative research. The study demonstrated transparency regarding descriptions of the research design and sample size. However, there was no mention of ethical approval, informed consent, or confidentiality, raising questions about the study`s ethical rigor. The findings revealed that most supervisors deviated from the original reflecting team approach, focusing on the case rather than the dilemmas and concerns of the therapist. In eight out of ten supervision groups, the supervisee was encouraged to discuss the case when presenting the supervision request. There appeared to be a close correlation between the approach to a supervision request and the subsequent reflection from the team, with nine out of ten supervision groups predominantly focusing on different aspects of the case.

Compared with the findings of Bingle and Middleton (2019), Reichelt and Skjerve's (2013) study managed to identify the group participants' reactions to the case discussions. Most therapists seeking supervision from the Norwegian study felt that the case discussions were irrelevant to their needs. They missed a more significant focus on their concerns and challenges from clinical work. Nevertheless, half of the reflecting team members reported that the information about the case did help them develop ideas and make interpretations during the reflection. The other half missed

hearing more about the therapist's challenges. This indicated that both the therapist receiving supervision and members of the reflecting team experienced case discussions in supervision failing to include the therapist as dissatisfying. The study resembled with the study of Bingle and Middleton (2019) in how there seemed to be a lack of reflexivity in supervision conversations taking the form of case discussions.

2.4.2 Relational and emotional experiences

Four out of six research papers about group processes in supervision addressed relational and emotional experiences in the group as impacting communication and interaction. In a review of systemic literature on group processes, Clarke and Rowan (2009) find a lack of literature about group processes and their impact on supervision. The background of the review is the extensive use of group supervision within the practice field and the many potential benefits described for this type of supervision practice. Clarke and Rowan accord relevance to the review by comparing how problems related to group processes are mentioned in the supervision literature without accompanying theoretical models attending to such problems. Most of the supervision literature predominantly focuses on the relationship between the supervisor and the supervisee, thus neglecting the relationship between the supervisor and the group or between group members. While the review presents a compelling argument for its subject matter, it may be criticised for lacking the methodological rigour of a systematic literature review and for being outdated. There is no mention of a search strategy or inclusion/exclusion criteria, thus raising questions about the study`s rigour. Nevertheless, the review offers a valuable perspective by examining how the team functioning has been handled in the supervision literature over the years. Traditional supervision literature relied heavily on systemic supervisors and systemic techniques to reduce potential difficulties between group members. However, in postmodern literature on team functioning, the focus has shifted towards collaboration within supervision groups and embracing the productive aspects of differences between group members. The authors argue that both approaches to group processes suggest an idealised view of team functioning in systemic group supervision, overlooking the relational and emotional experiences within the group. They critique systemic supervision literature for failing to recognise the supervision group as a socially constructed entity influenced by the discourses operating within it that impact its members. To address this literature gap, they

propose applying psychoanalytic theories about group dynamics to enrich systemic theories and deepen the understanding of group processes and team functioning in systemic supervision.

In a study employing non-participant observation, Smith (2022) investigated events and emotional atmospheres within six group supervision sessions in the UK`s children's services. Employing a methodology informed by psychoanalysis and an interpretative approach to thematic analysis, Smith utilised NVIVO software to produce numerical data and codes. Ethical consent for the study was granted both by the Tavistock Research and Ethics Committee and local authorities, ensuring the research adherent to ethical standards. The supervision sessions followed the Unit Meeting model of systemic social work supervision, implemented in the *Reclaim Social work* project to improve child protection services across the UK. The aim of the Unit Meeting model was understood as fore-fronting reflective practice, providing multiple perspectives and a space to rehearse conversations with clients. Although there appeared to be consensus regarding the role of systemic supervision in enhancing UK social work practice, Smith identified a gap regarding what happened in the Unit Meetings that gave relevance to the study. Existing knowledge about supervisory practices primarily relied on self-reports, neglecting the examination of group processes. To address this gap, Smith employed a research methodology informed by psychoanalytic principles to investigate the influence of both conscious and unconscious processes in systemic group supervision across two different local authorities. The research design appeared innovative and robust, with a relatively large sample size. Findings indicated the presence of varying degree of anxiety within all supervision groups, which appeared to be linked with different leadership styles. Further elaboration on this relationship will be provided in the sub-section “Leadership styles”.

In the study of Reichelt and Skjerve (2013), the majority of supervisees found case discussions to be irrelevant to their needs and were dissatisfied with the supervision. They frequently experienced that the group lost sight of the supervision request, becoming occupied with their own conversation. Group discussions instead of reflections could impede the listening-speaking process described in the original reflecting team format. A significant amount of advice was given, but few comments

were made about therapists experiencing difficulties. Some of the reflecting team members noticed this pattern. They echoed the discontent of the supervisees by describing the team's reflection as too general, similar, lacking curiosity, becoming stuck, and losing sight of the supervision request. Other team members described the reflection as interesting. Although the study fails to describe how the negative experiences of group members impact communication and interaction processes, it is reasonable to assume that such experiences likely impact what happens in supervision and the sense of belonging to the group. Interestingly, the supervisors mainly considered the team reflections to be of high quality, suggesting that dissatisfaction was not openly expressed in the supervision groups.

In a mixed methods study, Zvelc and Zvelc (2021) examined processes of non-disclosure in psychotherapy supervision across psychotherapeutic orientations, including the systemic orientation. Their endeavour was to explore the frequency, content, and reasons for non-disclosure in clinical supervision. Ethical consent was granted by the Ethics Committee of the Faculty of Arts at the University of Ljubljana. Fifty supervisees from Slovenia participated in the study, engaging in both individual and group supervision sessions. Following each supervision session, participants were asked to complete a questionnaire regarding significant aspects of the supervision. Ninety completed questionnaires were returned. Additionally, ten qualitative interviews were conducted to explore the impact of supervision on subsequent therapeutic work. The study demonstrated rigour through detailed descriptions of research methods, procedures, and findings, as well as through the utilisation of both qualitative and quantitative methodologies. Findings revealed that supervisees withheld relevant information essential for the supervision process in 21% of the sessions. The most common type of withheld information included dissatisfaction with the supervisor, the supervision group, and personal information related to the ongoing therapeutic work. Various reasons were cited for withholding information, such as feeling unsafe in the supervision relationship or the supervision group, fearing negative consequences, aiming to please the supervisor, finding the information too personal, feeling shame, and upholding client confidentiality.

2.4.3 Reflexive practice

Reflexive practice was considered essential for communication processes in systemic group supervision in four out of six research papers. Although reflexivity is used across disciplines with different meanings, the papers reviewed forefronted a systemic perspective on reflexivity. Givropoulou and Tseliou (2020) delineated therapist reflexivity as essential in postmodern, systemic practice where the therapist is positioned as a part of the observed system. They described reflexive practice as reflections about how the therapist engages in client relationships, influences the context, and contributes to processes of change. Bingle and Middleton (2019) shared a similar understanding of reflexivity, employing the term self-reflexivity to denote a stance wherein social workers become cognisant of their role in shaping meaning during client interactions. Within the realm of supervision, reflexive practice was deemed vital for acknowledging the myriad constructions possible for social workers and for nurturing curiosity in social work practice. According to the above definitions of reflexivity, the study of Reichelt and Skjerve (2012) addressed reflexivity in supervision by referencing the lack of reflections about the therapist's role in the system. They did not, however, use the term reflexivity, possibly indicative of the contested definitions of reflective practice within supervision literature. In his paper about systemic social work supervision, Smith (2022) outlined five different categories of reflective practice. He distinguished between reflective and reflexive practice, underscoring that such differentiation was not consistently observed in the literature. He regarded both practices as reflecting the practitioners` impact on their client work but construed reflexive practice as emphasising the practitioners` emotional experiences.

In a qualitative study, Givropoulou and Tseliou (2020) examined the experiences of reflexivity through group processes in reflecting teams. Their search for existing literature revealed a research gap on the topic, as no other studies addressed the development of reflexivity through group processes seen from the participants' perspective. The authors underscored the significance of reflexive development for the personal and professional growth of systemic psychotherapists, conceptualising reflexivity as the cultivation of self-awareness regarding one's contribution to therapeutic endeavours. The study involved interviews with ten mental health professionals from the third year of a four-year systemic training program in Greece. These participants engaged in reflective teams guided by a supervisor as part of their

training on reflexivity. Approval for the study was obtained from the Institute's scientific committee, and all participants provided informed consent. Each supervision session commenced with the team observing one member of the group conducting family therapy through a one-way mirror. Subsequently, the therapist joined the group to reflect on the use of self in the therapy. An interpretative phenomenological research method was employed to analyse interview data. A thorough description of methodology and positioning suggested that the study could easily be repeated. The findings uncovered three primary themes encapsulating the participants' encounters with learning reflexivity within group settings. The first theme was called *Developing Reflexivity Through Challenges and Rewards* and referred to the process of learning the skill of reflexivity. Reflexivity felt unfamiliar to the participants, who were initially uncomfortable sharing reflections with the group. However, they learned that the reflexive processes assisted with emotional coping and provided increased professional confidence. The second theme was called *A Conditional Reflexive Space Within the Training Group*. This theme addresses the importance of safe relationships and support. Reflexivity was associated with exposing vulnerability vis-á-vis peers. The participants experienced that an inclusive, non-judgemental group setting where reflections covered different points of view facilitated reflexive group discussions. The third theme was called *Encountering the Dynamics of Identity via Reflexive Group Processes*. This theme addressed how group members were helped to view themselves more clearly and evaluate their actions in therapy by working reflexively with the team. Relational, reflective processes enabled group members to develop new understandings and identities.

The study of Givropoulou and Tseliou (2020) poignantly demonstrated the complexity of engaging in processes of reflexivity in group supervision. In addition, the findings included negative experiences such as being unfamiliar with reflexivity, feeling uncomfortable with sharing personal reflections, and a sense of vulnerability vis-á-vis peers. The lack of reflexivity in the studies about systemic group supervision of social workers (Bingle and Middleton, 2019; Smith, 2022) and postgraduate psychologists specialising in family psychology and systemic practice (Reichelt and Skjerve, 2013) might be ascribed to these factors. If reflexive development is essential for systemic psychotherapists' personal and professional development, it seems problematic that case discussions trump reflexivity in systemic supervision. Congruent with the study

of Zvelc and Zvelc (2021) about non-disclosure in psychotherapy supervision, it could be argued that not feeling sufficiently safe in the group setting complicates sharing reflexive considerations. The study of Givropoulou and Tseliou (2020) also addressed this matter; in their study, the participants found an inclusive, non-judgemental group setting to prompt reflexive group discussions. Similarly, Smith (2022) experienced how defence mechanisms in group supervision denied processes of reflexivity and emotionality in the supervision conversations.

2.4.4 Leadership styles

Four out of six research papers addressed leadership styles in group supervision as exerting a significant impact on communication and interaction processes. Conducting a study on the Unit Meeting model of systemic social work supervision, Smith (2022) discovered significant differences in the supervision practice between two local authorities even though the same model was followed. The style of supervision appeared to correlate with the leadership approach adopted within the supervision groups. In one local authority, supervision sessions were marked by a direct leadership style akin to dyadic supervision in a group format. These sessions typically revolved around case discussions aimed at providing definitive answers, with vague references to systemic practice. In such groups, anxiety levels were notably high, accompanied by defence mechanisms employed to avoid emotional engagement with the case under discussion. Additionally, communication processes often featured passive group members who seldom challenged the supervisee. Conversely, supervision sessions were characterised by non-directive leadership style in the other local authority, fostering collaborative idea generation, reflexivity, systemic approaches, and a willingness to challenge one another in supervision. Consequently, anxiety levels within these supervision groups were considerably lower. These findings imply that leadership styles are essential to prompt impactful communication and interaction processes in supervision.

Interestingly, Smith's (2022) findings about leadership styles in group supervision apply to the findings from two other research papers in this review. In Greece, Givropoulou and Tseliou (2020) found that an inclusive, non-judgemental group setting where reflections covered different points of view facilitated reflexive group discussions. However, supervisors who took substantial charge of the group

discussion could impede reflexivity. On the other hand, a supervisor who supported the group to take responsibility for the discussed case promoted reflexivity. This was understood as taking a collaborative approach to the leadership of supervision groups. The study of non-disclosure in clinical group supervision by Zvelc and Zvelc (2021) yielded a similar result. In this study, the data analysis suggested that disclosing a sensitive topic in supervision was more likely if the supervisor was perceived as open and accepting. The quality of the supervision alliance seemed to predict whether difficulties stemming from clinical practice, or the supervisory relationship, could be openly shared in supervision. Thus, the supervisor's ability to create trusting relationships in supervision greatly impacted group processes in supervision. Although not clear-cut, the findings also indicated that non-disclosure could negatively impact therapeutic work with clients (Zvelc and Zvelc, 2021).

Reichelt and Skjerve's (2013) study revealed very different findings concerning leadership styles in supervision. Here, the fact that that the supervisor actively participated in the reflective supervision conversation was appreciated. Although the supervisors often pursued their own agenda instead of giving the supervisees space to respond and expand on the reflections from the group, the majority of supervisees described the supervision engagement as informative. They appreciated the direct feedback and lecturing from the supervisor. Some even experienced the supervisor's feedback as more impactful than the reflecting team. The assumption from the original Reflecting Team Model about reflective processes as sufficient for case management and therapist development was thus challenged.

Zvelc and Zvelc (2021) propose that tackling the issue of non-disclosure in supervision can be achieved by establishing effective working alliances. These alliances should be defined by a sense of safety, mutually agreed-upon goals and methods, transparent communication regarding supervisory relationships, and a focus on acknowledging and addressing the supervisee's emotional responses to the clients. Findings across the reviewed literature about group processes in supervision suggest that such an approach would benefit most supervision groups.

2.4.5 Professional development

The reviewed papers collectively highlight the significance of systemic group supervision in nurturing the professional development of systemic practitioners. However, despite its widespread use and potential advantages, there is a noticeable dearth of literature addressing group processes and their impact on learning in group supervision. Clarke and Rowan (2009) emphasise the need for further exploration into how group interactions shape therapist development. Similarly, Reichelt and Skjerve (2013) underscore the necessity for more research elucidating the role of case discussions in supervision in fostering therapist development. Bingle and Middleton (2019) advocate for additional studies examining the impact of systemic group supervision specifically in the context of UK child protection practice. Furthermore, Zvelc and Zvelc (2021) call attention to the importance of investigating how instances of non-disclosure during supervision may affect therapist development and subsequent client work. Givropoulou and Tseliou (2020) similarly emphasise the need for more research into the experiences of reflexivity within group settings and the processes through which reflexivity evolves.

In summary, these findings collectively reflect a gap in systemic literature concerning group processes in supervision. While the benefits of group supervision are widely acknowledged, how to create impactful processes of communication and interaction appears to be unexplored.

2.4.6 Summary reflections on group processes in supervision

The literature search undertaken for this review revealed a lack of research papers on group processes in clinical supervision. Most papers addressed the challenges of group communication and interaction in supervision and suggested the need for more research to understand how group processes impact learning in group supervision (Clarke and Rowan, 2019; Reichelt and Skjerve, 2013; Bingle and Middleton, 2019; Zvelc and Zvelc, 2019; Givropoulou and Tseliou, 2020). A significant finding concerned the complexity of engaging in reflexive processes in group supervision. Some of the research papers identified an absence of reflexivity in systemic group supervision (Smith, 2022; Reichelt and Skjerve, 2013; Bingle and Middleton, 2019). These findings suggested that the systemic element of group supervision was missing, as supervision conversations mainly focused on the case and failed to include the therapist. The study about learning reflexivity in groups shed

light on the complexity of engaging in reflexive processes in group supervision (Givropoulou and Tseliou, 2020). A similar finding was revealed by the study concerning non-disclosure in group supervision of psychotherapists (Zvelc and Zvelc, 2021). This study broadened the understanding of reflexivity within the context of group supervision, highlighting the pivotal role of leadership in shaping impactful group processes in supervision practice. A supervisor perceived as open and accepting increased the quality of supervision. A related finding was reported by Smith (2022) in his observation of systemic social work supervision; the anxiety level in groups was reduced by a non-directive leadership style, resulting in increased collaboration and reflexive practice.

2.5 SUMMARY OF THE LITERATURE REVIEW

This literature review illustrates how the territory of clinical, systemic supervision lacks clear boundaries. Findings reveal that although everyone agrees on systemic supervision as an arena for learning systemic ideas and practice (Butler et al., 2021; Senediak, 2014; Shaw, 2014; Simon, 2010; Bertrando and Gilli, 2018; Bownas and Fredman, 2017; Storm and Todd, 2014; Sheehan, 2017; Ulleberg and Jensen, 2017), understandings of how learning in supervision happens vary. Even though the one does not necessarily exclude the other, four different views are evident: i) learning-by-doing systemic practice (Bertrando and Gilli, 2018; Simon, 2010), ii) learning by reflecting on systemic practice (Bownas and Fredman, 2017; Storm and Todd, 2014; Senediak, 2014), iii) learning by critical thinking on how to engage in relationships (Senediak, 2014; Simon, 2010; Shaw, 2014) and iiii) learning by professional gatekeeping of systemic practice (Bownas and Fredman, 2017; Storm and Todd, 2014; Simon, 2010; Shaw, 2014). An additional challenge discovered in the reviewed literature concerning systemic supervision is the lack of explanation following systemic terminology like “reflecting processes” and “reflexivity”. Failing to provide explanations could result in unclear boundaries of systemic supervisory practice. Simon (2010) makes a good point of providing sufficient space for definitions of systemic practice to be talked into being in new and innovative ways in supervision. However, it could be argued that such an endeavour is challenging if the boundaries are blurry. Supervision is not merely linguistic, the social action of doing supervision has a form that needs to be addressed.

In systemic supervision practice, processes of reflective practice and reflexivity are frequently cited as essential (Butler et al., 2021; Senediak, 2014; Reichelt and Skjerve, 2013; Bingle and Middleton, 2019; Smith, 2022; Givropoulou and Tseliou, 2020) but engaging in reflexive processes appears to be difficult (Reichelt and Skjerve, 2013; Bingle and Middleton, 2019; Smith, 2022; Givropoulou and Tseliou, 2020). A safe and collaborative environment, in conjunction with engaged group members attending to reflexivity, seems to positively impact group processes in supervision (Reichelt and Skjerve, 2013; Givropoulou and Tseliou, 2020; Smith, 2022; Zvelc and Zvelc, 2021). Failure to do so can lead to discussions about the case that exclude the practitioner, dissatisfaction with the quality of group supervision, heightened anxiety, and defence behaviours within the group, withholding information, and failing to promote professional development and improve clinical practice (Reichelt and Skjerve, 2013; Smith, 2022; Zvelc and Zvelc, 2021; Bingle and Middleton, 2019).

CHAPTER 3: METHODOLOGY AND METHODS

3.1 INTRODUCTION

A research methodology describes the general research strategy of an inquiry, providing an overall orientation about how the research is conducted (Howell, 2013). Research methods refer to specific strategies or techniques employed for collecting and analysing data. In this chapter, I present the methodology and methods used in this research project and explain the research design.

3.2 RESEARCH METHODOLOGY

Research methodology can be quantitative, qualitative, or mixed (Creswell and Creswell, 2018). Various methodologies have distinct strengths and aims. Quantitative research designs are utilised to test hypotheses, establish causal explanations, and generalise across large samples (Sprenkle and Piercy, 2005). Conversely, qualitative research endeavours to attain profound insight into meanings and lived experiences from a more limited selection of research participants (Willig, 2013). Employing a mixed-method approach entails collecting both quantitative and qualitative data, integrating the two methodologies to acquire information that cannot be captured by one approach alone (Creswell and Creswell, 2018). For this research project, I opted for a qualitative research methodology aligned with my aim of gaining in-depth insight into peer group supervisory processes. However, if the project were on a larger scale, I would have supplemented the qualitative design with a questionnaire distributed to all practitioners at the Norwegian Family Welfare Service to establish general experiences and preferences in peer supervision across a larger sample size. Adding this quantitative method to the research design would have provided a more robust foundation to the study and its implications.

3.2.1 Systemic, qualitative research

I have included a systemic element in the qualitative research design to stress my relational research focus and a form of inquiry where learning happens from within the system and through the workings of relational processes (Simon, 2014). I understand relational processes as communication beyond the spoken, including

inner dialogues and bodily responses (Shotter, 2004; Seikkula, 2008; Krause, 2012). I am inspired by Shotter's notion of “withness”-thinking as an alternative to thinking “about”, suggesting how social practices can be understood from our responsiveness within the doing of them (Shotter, 2011, p.41). Shotter (2011) refers to withness-thinking as an unfolding relational way of being in the world through “imaginatively thinking from within a moment of acting, with the voice of another or with a detailed concrete circumstance in mind” (p.2). As a systemic researcher, I have endeavoured to be responsive to the unfolding moment-to-moment of interaction and knowledge as constructed through relational processes.

Krause (2012) describes the systemic element in relational practice as attending to “systems of relationships between relationships, and an emphasis on the meaning for those who participate” (p.225). To develop an awareness of what they do in clinical practice and how it might affect the clients, systemic psychotherapists commonly use reflexivity (Simon, 2013). Reflexivity entails becoming self-aware by taking a turn into yourself and utilising the insight to understand your effect on others (Hedges, 2010, p.10). Becoming self-aware includes inquiring into inner dialogues and bodily responses (Rober, 2005). In qualitative research, reflexivity is often called personal or epistemological reflexivity (Harper, 2012). Personal reflexivity involves inquiring into how the research is influenced by the researcher's experiences, feelings, values, culture, etc. (Creswell and Creswell, 2018) and how the research process has affected the researcher (Willig, 2013). Epistemological reflexivity serves to illustrate the researcher's philosophical assumptions, methodological choices, and subsequent implications for research. The relational aspect is evident across the different uses of reflexivity. In this study, I employed reflexivity as methodological tool to demonstrate my unfolding relationship with the researched and fostering mindful research (Pillow, 2003). I considered myself part of the observed system from where knowledge was produced, and emerging knowledge cannot be understood separately from me as a researcher. My lived life and belonging to a wider social and cultural context will have affected my way of looking and relating to the observed.

3.2.2 The new materialist perspective

My research approach draws on elements from the new materialist perspective, as I have studied both human and non-human agents to comprehend the social practice

of peer group supervision. A central idea within new materialism is that social reality cannot be understood in terms of language and interaction between human beings alone. The world is perceived as produced by different material forces (Fox and Alldred, 2018). Materiality describes anything that produces material effects, and can encompass everything from human bodies, organisms, and things to spaces and environments. The idea is that reality will differ when different materials are used in making it. This way of looking at the world is often referred to as the post-human turn in social sciences, where subjectivity is no longer restricted to the individual (Braidotti, 2019). Subjectivity also addresses the complexity of actions across and between different elements, thereby suggesting a new ontological framework of becoming humans. The idea links with Ingold (2013), who describes the condition of being in the world as “unfolding through a bundle of intertwined relationships” (p.9). Ingold posits that humans are constantly involved in multiple processes of becoming humans. Similarly, Deleuze and Guattari describe the present by pointing to two phenomena happening simultaneously: the awareness of what we are trying to be and the process of becoming (Deleuze and Guattari, 1996; Braidotti, 2019). In this study, I embraced the idea of reality as unfolding through different relationships and processes of becoming.

3.2.3 A diffractive research approach

Barad (2007) emphasises how humans, non-humans and materials are entangled in a constantly shifting social world in her exposition of a diffractive research methodology. Originating from the field of physics, diffraction refers to the movement of overlapping waves and the spreading of waves when they encounter an obstacle (Taguchi, 2012). In this regard, diffraction signifies the effects of interferences of waves. Barad uses the term as a metaphor to describe a research approach in the social sciences where insight from different areas is read through one another while attending to details, differences, and constantly shifting patterns (Barad, 2007). To stress how different bodies and materials are constantly affecting and being affected by each other, the expression interaction is replaced with intra-action. The objective of diffractive research is to produce unpredictable data readings where new perspectives can emerge (Barad, 2007). Research is understood as an assemblage of connections from plugging into different bodies and materials (Jackson and Mazzei, 2023). Deleuze initially introduced the concept of “plugging in” to elucidate

how the literary machine needs to be plugged into another machine to operate (Deleuze, 1997; Mazzei, 2014). The literary machine serves as a metaphor for theories, ideas and perspectives derived from literary sources. The term assemblage, in turn, refers to something that is temporarily interconnected (Nichterlein and Morrs, 2017), suggesting that a perspective produced in research is merely a temporary reading that will transform when something else is plugged into it. Barad (2007) underscores the importance of diffractively plugging texts from diverse traditions, personal experiences, and other data sources into each other to generate novel research perspectives. However, it is crucial to maintain clarity regarding what is included and excluded. Plugging into the literary machine also entails making research decisions about cuts. Barad refers to such cuts as agential to describe that the researcher makes boundaries that are not natural or pre-existing and will influence what is being made from research (Warfield, 2016).

I joined theories and methods in line with Barad's idea of diffraction to study what happened in peer group supervision. I understood a diffractive research approach as having a conversation with different perspectives, seeing the connections and disconnections, and investigating the outcomes. My aim was to study the data in creative ways to invite the emergence of newness. I added reflexivity to this perspective. Pillow (2003) bridges reflexivity and diffraction through a reflexive practice that includes exploring the unfamiliar and uncomfortable aspects of the relationship between the researcher and the researched as a means to facilitate new readings of the data material.

3.2.4 The idea of rhizomatic learning

Diffractive methodology corresponds well with the idea of rhizomatic research. In a world perceived as unpredictable and becoming, Deleuze and Guattari view qualitative data analysis as a rhizome (Deleuze and Guattari 2013; St. Pierre and Jackson, 2014). As opposed to the lineal form of a tree, the rhizome grows horizontally and is connectable in all dimensions. A rhizome may be broken but will start again on any other line. The lines always tie back to each other, which makes it impossible to posit dual connections. Within this picture, the analysis is seen as a process starting in the middle of things with no final beginning or end. The rhizomatic form keeps the analysis and knowledge production on the move, and rhizomatic

knowledge grows in unpredictable and complex ways (Mazzei, 2014). Rhizomatic learning thus becomes a process of making connections by using different paths to provide a perspective (Nichterlein and Morrs, 2017). I conceptualised the knowledge production in this study as starting a conversation to provide different perspectives of what happens when systemic practitioners talk about their difficulties in peer group supervision. The responses to this conversation might generate other conversations and new unanticipated perspectives taking multiple and unpredictable directions.

3.3 PHILOSOPHICAL STANCE

A qualitative research project is informed by ontological and epistemological assumptions regarding the social world and what can be known, establishing the researcher's philosophical stance (Willig, 2013, p.20). Epistemology can be described as the philosophy of knowledge concerning what it is possible to know (Harper, 2012). Hereby encompassing ideas about the nature of knowledge and claims related to validity and reliability. Ontology is a branch of philosophy concerned with the nature of reality. Hereunder lies ideas of what exists in the world and to what extent qualitative data are seen as mirroring reality, often denoted as the researcher's position on the realism-relativism continuum (Harper, 2012, p.87). Epistemological and ontological assumptions vary across different philosophical traditions.

3.3.1 Epistemological and ontological positioning

Willig (2013) maps out three overall types of qualitative knowledge production, referred to as realist, phenomenological, and social constructionist approaches (p.15). *A realist approach* to knowledge production ranges from naïve assumptions about an uncomplicated relationship between what the researcher can discover and what is really happening, to critical realist assumptions acknowledging the complicated nature of understanding social and psychological reality (Willig, 2013). *A phenomenological approach* is concerned with understanding the experiences of research participants as opposed to discovering what happens. *A social constructionist approach* emphasises that the world and what happens in it is constructed through language and discourse, producing multiple realities. As opposed to exploring the nature of a phenomenon or the quality of experiences, the emphasis here is placed on how people talk about the world and their experiences.

I adopted a critical realist position to observe what happened in peer group supervision when systemic practitioners talked about their difficulties. Critical realism occupies the intermediate ground between positivism on one side and absolute relativism on the other. It suggests that social or psychological phenomena exist independently of human awareness but cannot be mirrored directly because they are perceived through the lenses of the researcher (Harper, 2012, p.88). I found that critical realism could hold a diffractive, rhizomatic approach to research through Deleuze's ontological assumption that both virtual intensities and actual existences are real, existing together “on the same plane of immanence” (Deleuze and Guattari, 1996; St. Pierre, 2016). The plane metaphor exemplifies how the conditions of what is real will change through movements, forces, materials, and unfolding intensities on the move (St. Pierre, 2016, p.119). This suggests an ontology of difference, where the real *does* exist, but its conditions are ever-changing and lay the ground for something new (real) to arise. The critical realist stance requires the researcher to be continually reflexive without being blind to the existence of the real beyond relational processes (Davies, 2008, p.23). The relationship between the researcher and the Other is entangled and the researcher`s perception of the world is influenced by personal experiences, values, feelings, and cultural expectations. Krause (2007) stresses the importance of being mindful of one's own Otherness to understand the Other, for instance, by considering how culture could have influenced the researcher's gaze. Kitzinger and Wilkinson (1996) suggest pursuing questions of Othering in research practice by developing opportunities for dialogue between “us” and Others through participative research.

Although a critical realist position is in the domain of the Real, I see some social constructionism in it by the way one cannot directly access what is real. Hacking (1999) advocates the possibility of a localised use of social constructions while maintaining that the researched phenomenon is real (p.6). I concur with his argument that something can be both real and a social construction. I view the real as entangled with the constructed as both discourses, social constructions, and bodies, are involved in the process of making reality (Barad, 2007). While viewing supervision conversations as socially constructed, I consider therapist difficulties, affect, feelings and bodily sensations unfolding from participating in supervision as

real, in line with Deleuze's view of the real as both actual and virtual (St. Pierre, 2016). The moments of reality are likely to change following the way human beings are constantly involved in processes of becoming (Ingold, 2013; Fox and Alldred, 2018). Barad (2007) refers to these philosophical assumptions as onto-epistemology, emphasising that what is in the world and how we know it is intertwined. While agreeing with Barad's point, I find embracing an ontology of difference adequate to suggest that something can be real despite not being permanent.

3.3.2 Positioning within research paradigms

Lincoln, Lynham and Guba (2018) differentiate between five competing paradigms: Positivism, Post-positivism, Critical Theory, Constructivism, and Participatory (p.111). In this overview, the constructivism paradigm does not distinguish between constructivism and social constructionism. Nevertheless, within the field of systemic psychotherapy, an essential distinction is made between the two. Constructivism points to how reality is perceived through the eyes of an observer and the complex relational processes of constructing reality (Harper, 2012). Social constructionism sees reality as socially constructed through language and forefronts how different realities can be created and maintained through social interaction (Anderson, 2003, p.72). From this distinction, my critical realist approach to knowledge production belongs to the research paradigm Lincoln, Lynham and Guba (2018) refer to as a post-positivist paradigm. However, I also add methodology from the constructivist and participatory paradigms.

My shifting positioning between paradigms reflects my approach to the study rather than ideas about how reality should be perceived within one specific research methodology. I have relied on Willig (2013), who emphasises it is possible to combine qualitative methodologies despite subscribing to different epistemological positions (p.19). She describes such an approach as “pluralism in qualitative research”, in which one can ask different questions of the same data to interpret the data in a new manner. I collected data about peer group supervision through participant observations. From a critical realist stance, I strived to look openly at the research phenomenon to get the bigger picture of what happened (Tubbs and Burton, 2005, p.139). I observed interaction, bodies, things and affect, considering reality as a combination of social, psychological, and material devices (Fox and Alldred, 2018). I

included myself in the data material, reading data from my body as a researcher. Furthermore, I employed CA methodology to the same data set to examine how the therapists co-constructed the supervision conversation in more detail. Through the examination of video recordings and verbatim transcripts from the observed supervision sessions, I aimed to grasp the structure of the supervision conversations and how social activities were initiated and progressed in talk (Lester and O'Reilly, 2019, p.156). Eventually, I took the initial analysis back to each supervision group to reflect and learn together with the research participants. My approach to knowledge production thus involved a participatory element and the co-creating of findings (Lincoln, Lynham and Guba, 2018, p.111).

3.4 RESEARCH DESIGN

I viewed my research project as a small-scale ethnography that included conversation analysis and action research elements to make sense of relational group processes in supervision. As a researcher, I was more concerned with what things did than what they were or what they meant. Rather than seeking hard facts, I looked for different descriptions and perspectives of what happened when systemic practitioners talked about their difficulties in peer supervision.

3.4.1 Arriving at the research design

From the very start of planning this project, my intention was to utilise observations as a primary method of data collection. I was more interested in exploring unfolding processes of communication and interaction than in descriptions of peer supervision. The interest stemmed from readings about the dominance of interviews in qualitative research and the associated criticism of interview data being interpreted in a referential manner while overlooking the social aspects of data collection (Hammersley, 2017; Silverman, 2017). Initially, I planned to video-record supervision sessions, observe the recordings, and apply conversation analysis to attend to the unfolding talk-in-interaction (Gale, 2011). Subsequently, I would engage the supervision groups in dialogues to take part in the process of reading the data. Ensuring a participatory element in the research design always felt essential, in line with postmodern systemic theory about being a part of the researched system (Anderson, 2003). However, as I studied conversation analysis in more depth, I

realised the method was not sufficient to capture the different elements of what happened in peer group supervision. Most research methods have limitations, and I felt that CA was limited by its significant emphasis on the linguistic aspect and a lack of focus on the broader supervision context. It reminded me of a common critique towards the field of systemic psychotherapy concerning the emphasis on language to understand social phenomena without taking culture and emotions into consideration (Krause, 2007). To get a broader view of what happened in supervision, I decided to use participant observations for data collection alongside video recordings and CA analysis. From being present during supervision sessions, I could observe the broader context, get the feel of the atmosphere in the supervision room, and capture emotions and embodiment in addition to the interactional aspect of language.

3.5 RESEARCH ETHICS

In this section, I describe different aspects of ethics concerning my research project. Research ethics addresses questions about morality and moral behaviour in research contexts and are primarily concerned with issues of consent and avoidance of risk to research participants (Wiles, 2013, p.9). In the domain of qualitative research, a distinction is made between procedural ethics and ethics in practice (Wiles, 2013). While procedural ethics involves seeking approval from a relevant ethics committee before undertaking social research, ethics in practice addresses the ethical conduct of research (Guillemin and Gillam, 2004). Always relational and ongoing, ethics in practice pertains to what happens between the researcher and the researched.

3.5.1 Ethical approval

On an institutional level, the Tavistock and Portman NHS Foundation Trust is responsible for promoting research that preserves the dignity, rights, safety, and well-being of research participants. Hence, obtaining formal ethical approval from the Tavistock and Portman Trust Research Ethics Committee (TREC) is imperative for research involving human subjects. I was granted my TREC approval (see Appendix J) in December 2021, based on considerations related to the research design, methodology, participant confidentiality and anonymity, risk assessment, risk management, and data storage. Additionally, to conduct research within the

Norwegian Family Welfare Service, I secured organisational consent from the Norwegian Directorate for Children, Youth and Family Affairs (see Appendix K).

3.5.2 Informed consent

Informed consent is essential in ethical research practice (Wiles, 2013). All participants in this project were thoroughly informed about my research project before they gave their consent to participate (see Appendix I and Q). I recruited supervision groups through the leaders of local Family Clinics to make sure that consent to engage in the research project was provided at a local level as well. This approach created a distance between me as a practitioner-researcher and the practitioners working in the same organisation as me. Establishing distance at this research stage seemed crucial to ensure that participants did not feel obligated to take part.

Prior to the observations, I conducted online meetings with each supervision group. The objective was to ensure that the consent to participate in the study was sufficiently informed, lower barriers to asking questions, and prepare for the observation. During these meetings, I introduced myself and elaborated on my interest in the research topic, the study`s objectives, the rationale behind using participant observations for collecting data, my role as a curious learner, and how the supervision group would eventually be invited to reflect on my reflections from the observation. I emphasised that the therapists should proceed with their usual peer group supervision activities, despite being observed. While no significant risks were identified in the research, I highlighted the possibility of discomfort arising during the observations due to being self-critical. Additionally, I reminded them about the freedom to withdraw from the study at any point and without providing explanation. However, the group participants appeared unconcerned about potential risks associated with participation in the research project. Across online meetings, they expressed motivation and excitement about being included in the study. They were enthused about participating in the study and satisfied with the focus on group processes rather than methods, as they could find the processes challenging. They described spending much time on peer group supervision and hoped to develop their practice further by participating in the research project. The high level of engagement displayed by the supervision groups was highly motivating for me as a researcher and instilled confidence in the research`s potential to benefit the Family Welfare

Service. Following the initial online meetings, I was more at ease about the upcoming observations. I felt that we were mindfully getting to know each other, establishing a relationship from which we could research together.

The written consent forms (see Appendix Q) were collected on the day of the participant observation before undertaking the observation, thus giving group participants time to consider their participation. As it turned out, everyone had signed the consent forms when I arrived at the clinics and were on board throughout the research process.

3.5.3 Ethics in practice

My position as a critical realist suggests that it is an ethical position to build a relationship with research participants and remain transparent about constructions. There are constraints to understanding the Other because the world is perceived through an observer's feelings and presuppositions (Bateson, 2002). As opposed to truly understanding, you can only guess (Bateson, 2000, p.150). Thus, the quality of the connection between the researcher and the research participants determines what can be understood, and there is always a question mark as to whether you are connected. Because of my prior experiences with the researched phenomenon, it felt essential to remain curious and maintain an open mind. I addresses this dilemma by being transparent about my self-reflections and how I utilised them during the research process. Hence, reflexivity became part of my ethical practice.

I stressed my stance as a curious learner and the co-production of findings when I met with the supervision groups in online meetings, to avoid conveying a position resembling an expert position. However, I was cognisant of the fact that I would be unable to control their perception of me and always ended participant observations by asking the group how my presence had affected them, assuming it had an impact. To avoid the objectifying feeling of being assessed, I chose to write down my field notes *after* each observation as taking notes as a shared activity with the group felt impossible. Further, it was an ethical choice to engage in dialogues with each group to create a reflexive space where I could balance my perspective with theirs and we could develop ideas together. I recruited participants who worked in areas distinct from my own, to do research without being too influenced by pre-existing work

relationships and prevent mixing of roles. In order to uphold confidentiality and anonymity, research participants were assigned pseudonyms. Any further details that could reveal the identity of supervision groups and clinics were removed or changed.

3.6 RESEARCH PARTICIPANTS

In the following, I explain the procedure of recruiting supervision groups and provide details of the groups participating in the research project.

3.6.1 Recruiting supervision groups

I recruited supervision groups from middle-sized to large clinics in the south of Norway, where most Family Welfare Clinics are situated. I sent an email containing a recruitment advertisement (see Appendix H) and the participant information sheet (see Appendix I) to the leaders of six different clinics. Then, the supervision groups contacted me directly to register their interest in participating in the study. The first four supervision groups who replied with an interest were included in the research project. The following two groups were placed on a waiting list. As the observations yielded much information, no more than four supervision groups were included in the study. The groups came from three different Family Welfare Clinics.

I aimed to observe the naturally occurring event of peer supervision and requested that the groups conducted an ordinary supervision session at the usual time and place. Since the observations relied on naturally occurring events, there were few inclusion and exclusion criteria for participation. Characteristics such as group size, composition, and supervision structures were determined by the clinic where the observation took place, and not by me as a researcher. The inclusion criteria were simply supervision groups engaging in peer group supervision that had been established for a minimum of two months at the time of my observation and agreed to convene for a dialogue to provide reflections on my initial analysis. I sought for the supervision groups to possess some experience from working together prior to the observation to avoid processes of getting to know each other from obscuring data about how therapist difficulties travelled in the supervision conversations.

3.6.2 Details of the supervision groups

Each supervision group was considered unique due to its specific group members, group context and moment-to-moment interaction. Nevertheless, I aligned with Cooper (2009), who claims that it is still a valid research object to study "family resemblances" across cases. In this study, I looked at both similarities and differences among supervision groups in order to understand group supervisory processes deriving from therapists displaying vulnerability.

The table below is based on information collected from a demographic questionnaire developed for this study (see Appendix P) to illustrate variables across supervision groups. The group size constituted the peer groups on the day of the observation and did not necessarily represent the full-size group.

Table 3: Overview of group compositions

	GROUP 1	**GROUP 2**	**GROUP 3**	**GROUP 4**
Group size	5	5	3	4
Females	3: "Liz", "Ann", "Julia"	4: "Sarah", "Britt", "Lisa", "Isabel"	2: "Emma", "Leah"	4: "Grace", "Mia", "Pamela", "Emily"
Men	2: "Carl", "John"	1: "Steven"	1: "Liam"	0
Systemic psychotherapists	4	3	3	2
Psychologists	1	2	0	2
Range of age	4: 50-60 yrs. 1: 25-39 yrs.	3: 50-60 yrs. 1: 40-49 yrs. 1: 25-39 yrs.	1: 60+ yrs. 2: 40-49 yrs.	1: 60+ yrs. 2: 50-60 yrs. 1: 40-49 yrs.
Frequency of group meetings	90 minutes once a week	90 minutes once a week	180 minutes once a week	90 minutes once a week
Duration of peer group participation	2: 3 yrs. 2: 1 yr. 1: 6 months	1: 8 yrs. 2: 1 yr. 2: 6 months	3: 3 yrs.	4: 9 months
Peer supervision experience from the Family Welfare Service	2: 10-20 yrs. 2: 1-4 yrs. 1: less than 1 yr.	1: 10-20 yrs. 2: 5-9 yrs. 1: 1-4 yrs. 1: less than 1 yr.	2: 5-9 yrs. 1: 1-4 yrs.	1: 10-20 yrs. 2: 5-9 yrs. 1: 1-4 yrs.
Work experience from Family Welfare Service	2: 10-20 yrs. 2: 1-4 yrs. 1: less than 1 yr.	1: 10-20 yrs. 2: 5-9 yrs. 1: 1-4 yrs. 1: less than 1 yr.	2: 5-9 yrs. 1: 1-4 yrs.	1: 10-20 yrs. 2: 5-9 yrs. 1: 1-4 yrs.

Work experience as therapists	5: 10-20 yrs.	1: 20+ yrs. 1: 10-20 yrs. 2: 5-9 yrs. 1: 1-4 yrs.	1: 20+ yrs. 1: 10-20 yrs. 1: 5-9 yrs.	3: 20+ yrs. 1: 10-20 yrs.

3.7 DATA GENERATION

In this section, I describe how the data about peer group supervision was generated. Data collection methods included participant observations, video observations and dialogues with research participants. The combination of methods provided a unique perspective of what happened when systemic practitioners talked about their difficulties in peer group supervision.

I adopted different observer positions in the process of generating data. I undertook participant observations of peer group supervision while video-recording the supervision sessions for subsequent digital observations. As I observed others, I also observed myself observing, constantly moving between my own experiences and the others` as I saw them. I included my own experiences, thoughts, and feelings in the data material. Eventually, I shared my observations and reflections with each supervision group in dialogues to incorporate the participants` perspectives in the data generation. By combining different data collection methods and observing peer group supervision from different positions, I sought to provide multiple perspectives and deep insight into the processes of communication and interaction in supervision.

3.7.1 Participant observations of supervision

I conducted participant observations to acquire rich information about local supervision contexts and social interactions (Davies, 2008). Participant observations allow for the capture of outer dialogues, postures, gestures, embodiment, and contextual details connected to the researched phenomenon (Ingold, 2000). In this study, I undertook 6 hours and 16 minutes of participant observations of supervision. The observations took place where the research participants worked and usually had their supervision to collect data in and about their natural environment. I observed four groups having a supervision session that lasted between 81 and 123 minutes. A total of 11 supervision cases were discussed across the groups.

Being a participant observer is an ethnographic position where observations are made through bodily participation and by using ourselves actively (Krause, 2003). My participant observations provided an insight into the local supervision contexts that included supervision atmospheres, the feel of being in the room together with the research participants and embodied responses. Such nuanced data could not have been fully captured through the lenses of a camera alone. I align with Madden (2017), who claims that participant observation is “a whole of body experience” that includes all senses, not solely eyes and ears (p.19). The researcher's body is used as a recording device to collect data, and the researcher needs to be aware of her emotions, state, and bodily responses. While participant observations provide an insider experience of an environment, the extent of participation in the activities observed may vary (Genzuk, 2003). In this study, I observed peer group supervision practice without taking part in the supervision conversation, striving not to impact the naturalistic setting more than I already did with my presence. However, I participated with my body, engaging in what happened through my inner dialogues, feelings, and bodily responses. My position thus involved an active role, not simply observing what the others did. I was affected by sitting in the supervision rooms observing what the groups were doing. In line with the view of communication as relational and responsive, I believed my presence also impacted the group members being observed. This point does not compromise the research data but emphasises knowledge production as relational (Simon, 2013; Krause, 2003; Madden, 2017). The following excerpt is taken from my field notes from Group 2, to illustrate the material generated through participant observations:

> “The female therapist has looked my way a couple of times. On one occasion I met her gaze and smiled gently. Now I'm starting to wonder if she feels limited by me being in the room. She did not present a supervision case when they took the preliminary round, and she has participated little in the group dialogue. I've also wondered if her hand is slightly shaking. I noticed it on an occasion when she put her hair behind one ear. I am possibly wrong, but if that is the case, I am curious what the trembling is about. Is she experiencing the unfolding group conversation as uncomfortable? Is it hard for her to be observed? I remember that in the Teams conversation she said that she was

> looking forward to the observation, and that she thought they as a group were lucky to get an outside view of themselves."

During the supervision sessions, the therapists would typically sit in a circle. To avoid interfering too much with the unfolding supervision conversation, I positioned myself slightly outside the circle. However, I remained close enough to access the ambience of the supervision context, the outlook of communication and interaction, and my own experience from being in the room together with the research participants. The positioning afforded me an insider's view of peer group supervision, allowing me to witness what happened and feel what it was like to be part of the group. At the end of each supervision session, I joined the circle of therapists to inquire about their experiences of being observed. Throughout, I remained cognisant of my dual role as both a participant and a learner, echoing the notion of the ethnographer as simultaneously an insider and an outsider (Genzuk, 2003; Madden, 2017). In this sense I was an insider in the supervision groups but, at the same time, an outsider seeking to learn something new about peer group supervision.

I was interested in observing group communication and interaction processes, but I did not prepare to direct my gaze at anything specific in advance of the observations. I intended to observe with an open mind, pursuing curiosity, thinking every detail might be important. In practice, my unfolding experiences of being in the room with the supervision groups guided my gaze. I agree with Ingold (2014), who views participant observation as a responsive practice where you attend to what others say and do, follow their lead, and see where it takes you. Directly after each observation, I wrote a detailed description of the supervision context, the conversations, the group dynamics, my perceptions of the supervision room, and my subjective experiences and reflections from attending the supervision. These field notes (see Appendix E) provided me with a valuable record for analysis.

3.7.2 Video recordings of supervision

Adding video recording as a data collection method in addition to the participant observations, provided a digital record of the supervision sessions. I align with Pink et al. (2015), who claim that using digital tools to analyse data is insufficient to understand the complexity of relationships (p.10), which is why I similarly collected

data through participant observations. However, the digital records of the supervision conversations complemented the participant observations by giving access to reviewing what happened and attending to details I did not capture in my retrospective field notes. The recordings enabled me to explore micro-moments of interaction and identify interactional patterns (Hedges, 2010) in the supervision.

I produced verbatim transcripts from each video recording to establish a written record for analysing the supervision conversations (see Appendix F). Laughter, vocal sounds, and gestures deemed significant for understanding the conversations were encapsulated within parenthesis. Pauses were denoted with dots, with one dot representing one second. Crafting these transcripts allowed me to become familiar with and reflect further on the data generated from the supervision conversations.

The verbatim transcripts provided a foundation for applying conversation analysis (CA) as one of my many lenses on data, exploring the sequential organisation of talk and talk as social action (Ten Have, 2007). For this purpose, I determined that a standard orthographic transcript sufficed. Although a Jeffersonian transcription style would have offered greater linguistic details (Hepburn and Bolden, 2017) this was not needed in my use of CA. I included multiple lenses in the analysis process to also study factors beyond language. The following excerpt is taken from the beginning of the supervision session in Group 1, and illustrates the transcription style adopted:

> **Ann:** Does anyone have anything for supervision today?
> **Carl:** I haven't thought about supervision today, to put it bluntly. I've been thinking about that meeting.
> **John:** I have a completely new case, which I fumble a little bit with the approach to, that I could possibly take.
> **Ann:** Mhm.. Do you have anything for today? (looks at Julia)
> **Julia:** No, not actually. I'm so filled with it.. the course we have. And then we had a group gathering yesterday, and.. so like that.. process guidance right now.. I don`t have anything. If so, it would have to be about that.
> **Ann:** Mhm..

3.7.2 Dialogues: Sharing thoughts and ideas

Collecting data included having dialogues with each supervision group about my initial analysis report (see Appendix O). The dialogues were used as a forum for sharing my thoughts and ideas deriving from the initial analysis and being responsive to the research participants' responses and ways of thinking and understanding. Bertrando claims that one must put their ideas into play with the ideas of others for a genuine dialogue to happen (Krause, 2012, p.15). I always felt slightly nervous when presenting the initial analysis, being aware of the possibility of offending someone with my ideas and realising there might be different ideas about what happened. In retrospect, I think my emotional state helped me stay mindful in the group dialogues while still sharing my ideas honestly.

I participated in 8 hours and 22 minutes of group dialogue about the initial analysis. Each dialogue lasted from 116 minutes to 148 minutes. All the dialogues were recorded and transcribed the same way as the recordings from the supervision sessions (see Appendix G). Nevertheless, I left out some of my descriptions of the initial analysis, as the aim of these transcripts was to capture the participants` perspectives and the movement of perception.

In the dialogues, I took the role of a participant facilitator of a dialogical process, encouraging research participants to offer their feedback, express reflections, and engage in dialogue. To mitigate potential anxiety in the group, I always initiated the dialogue by reminding them of my research design, emphasising the value of different ideas and granting permission to express disagreement with my viewpoints. Subsequently, I outlined the different themes for us to discuss and in which order:

1. Questions about the institutional task of peer group supervision
2. My view of the structuring of each supervision conversation
3. My experiences of the supervision atmosphere, bodies and flow of affect
4. My analysis of performances of therapist difficulties, the clarifying of difficulties, and group responses to difficulties

I asked every group about the institutional task and framing of peer supervision. Then, I handed out and presented a structured overview of the group's supervision session and the case(s) included in the analysis. To introduce the theme of supervision atmospheres, bodies and flow of affect, I presented my observations,

sensations and embodied experiences from being in the supervision room together with the participants. Performances of therapist difficulties were introduced by sharing the video recording of the analysed sequence in each case and explain my view of what happened. I used the same strategy to introduce the theme of clarifying difficulties. I handed out an overview of response acts across groups and shared my opinions about the patterns, to introduce the theme of responding to difficulties.

Engaging in dialogues with the research participants proved instrumental in enriching my research data. I discovered things I had not seen before and was able to modify taken-for-granted constructions. It also felt ethical imperative to ensure that the participants resonated with the findings, underscoring the significance of their involvement in the process. These dialogues facilitated my active participation alongside the therapists in dissecting the nuances of the supervision conversations. I was curious about how the therapists would see my way of seeing and if my way of seeing differed from theirs. By adding the aspect of observing the observer observe, second-order observations were included in the study. I regard second-order observations as observations of observations, making it possible to take up blind spots established by the first-order observations (Rabinow, 2008, p.65). Responses from the therapists affected me and my view of what happened in supervision. I also affected the therapists and our dialogue by sharing my thoughts and ideas from the initial analysis. Below is an excerpt from a dialogue about reflective practice in Group 2, illustrative of how I presented initial findings in my dialogical approach to meaning-making:

> **Britt:** I almost seem to hear that we don't provide space for the reflection, when you (looks at the researcher) refer to how we're constantly addressing the one who seeks supervision. That we're kind of on the surface and don't get beyond the surface in a way. We don't reflect if I need to check in with Steven all the time.
> **Researcher:** It becomes a kind of reflection between the two of you, I think.
> **Sarah:** Yes.
> **Britt:** Yes, it does.
> **Researcher:** The reflection is very direct towards Steven. It's not that the group necessarily reflects so much among themselves, but more so that you

respond to the answers Steven gives. That's how we tend to do it in a conversation and that's how this supervision conversation is created, I think.
Steven: Yes, because you reflect on my demand more than Britt having an intrinsic value in reflecting on my theme. So, she's always going to sort of satisfy me in a way.
Britt: Mhm.

Engaging research participants in the data analysis process provided a collaborative element to the research design. Nonetheless, inherent power imbalance persisted between myself as the researcher and the research participants. While adapting the idea about participation from action research, my research participants were not included as collaborators at every stage of the research process as required in action research methodology to flatten hierarchical differences (Mendenhall and Doherty, 2005, p.103). In action research, the democratic process of doing research together in itself can bring about positive change and novel insight (Bell and Morse, 2010). My research project involved a sense of shared ownership by the way in which different perspectives from both myself and the participants were valued. However, ultimate decisions regarding methodological approaches and the use of data were made by me alone. I presented my view of something as I saw it and invited the participants to respond and share their views. However, I hoped these dialogues would trigger a continuing dialogical process within the groups aligning with their initial aspirations to develop their supervision practice.

3.8 DATA ANALYSIS

In this section, I explain the process of analysing data and methods used for analysis. To address the complexity of social interaction and group processes, I applied a diffractive approach to the analysis. I aimed to get a rich picture of what happened when systemic practitioners talked about their difficulties in peer supervision and open up to unpredictable readings of data material. I sought to converse with different perspectives and address various aspects of the research question by plugging different analysis methods into the data. In the process of analysing data, I read ethnographic data through the lenses of conversation analysis theory, theory from the new materialism perspective, and action research theory.

I leaned on Madden (2017), who regards descriptions from ethnographic work as “the beginning of fattening up the story” (p.149) before coding and interpretations. My detailed field notes from participant observations served as a background to the data analysis. The following excerpt is from my field notes in Group 4, and is illustrative of the details that could be captured through participant observations:

> “From where I sit, I notice that the door to the hallway is also in the dark turquoise colour, and it strikes me that the room is decorated with attention to details. Everything is in the same style, and the furniture matches the interior. I find that this gives the room both a modern and harmonious expression. I become observant of the fact that there is a giant television screen against the wall behind the therapist sitting at the end of the table. I didn't notice this before, because I turned my attention to the windows and the therapists sitting on the other end of the table eating lunch. Now, I think it's kind of amazing that I didn't see it. I also see a poster hanging behind the door with the Bufetat logo, in pink and green colours that fit the interior of the room. I seem to remember that it states the name of the family welfare clinic. Between the poster and the big TV hangs the wall clock. I register that the clock actually breaks a bit in the style of the other interior of the room. It is round with a yellowed wooden frame and appears unfashionable. On the other side of the TV, facing the window, is a tall conference table with a round, white top and grey aluminium foot. On top of it is a jumble of wires. I think it's a little bit messy. Right behind where I'm sitting, I've noticed a whiteboard on a black undercarriage with wheels. The floor appears to be a slightly yellowed, three-stave oak parquet.”

From verbatim transcripts of the supervision conversations, I could read data through the lenses of conversation analysis. The approach helped me attend to details and micro-moments of interaction in the conversations that otherwise would have gone unnoticed (Lester and O'Reilly, 2019). I did three rounds of “mapping” in this analysis, producing i) overall maps of the supervision sessions, ii) overall maps of supervision conversations about a case, and iii) expanded maps of supervision conversations

about a case. Samples of the different types of mapping will follow under the headline “Mapping conversational structures”.

Reading the field notes and repeatedly watching the video recordings of peer group supervision gave access to the analysis of supervision atmospheres (see Appendix L). To identify the entanglement of materials and affect in the supervision rooms, I read data through Böhme's (2014) characteristics of the spatial aspect of atmospheres. The following excerpt is a description of my experience of the interplay of senses in Group 4, and is illustrative of the material produced by studying atmospheres within the supervision space:

> “The dynamic interplay of senses was characterized by a “smooth” flow of the conversation with few interruptions, a comfortable pace and an equal amount of talk time, suggesting they were all engaged in the supervision task. I noticed Mia was chewing gum, and I could hear when she popped one out of the chewing gum tray. I think I could also smell it; it smelled fresh. There were no other smells in the room that I noticed. There was laughter on many occasions, especially when Mia pretended to knock on the imagined glass wall to give her feedback. The laughter always seemed friendly, and everyone would engage in the happening. Some laughed out loud, others smiled. It seemed like they mirrored each other both when laughing, but also when they were being serious. Most of the time, their facial expressions were being severe and attentive to what was said. But always with a friendly face. This interplay of senses seemed to be synchronized in the way the participants would follow and match each other.”

Eventually, I shared my initial analysis (see Appendix O) with the research participants to provide a space for sharing ideas, reflecting, and learning together. This approach secured a participatory aspect of the research project (Mendenhall and Doherty, 2005), provided the voice of the Others, and broadened my view. The excerpt below provides a sample from a dialogue about consensus practice in Group 3, and illustrates how the participants were invited to engage in the meaning-making process:

Researcher: The dynamic movement is most of all the agreement, consensus, and support that exists in that space. I don't notice any controversy, I don't notice any disagreements, I don't notice much differences. I don't know what you're thinking?
Leah: No.. It might be something nice, but also something limiting. Why is it like that? Is it because it's unsafe, or is it because in this particular group, it simply turned out that way? Right? That we joined it like that, in a way. Why don't we come up with something a little more controversial, or illuminate it in a completely different way? Because it's clear that would have expanded it as well. So that's kind of interesting then.
Emma: Yes.
Leah: Now Emma and I have worked together a lot. We've worked together for 10 years before we started here. That might explain something then.
Emma: Yes.

In the following, I will further elaborate upon how I applied conversation analysis and my approach to analysing supervision atmospheres.

3.8.1 Applied conversation analysis (CA)

Conversation analysis is a qualitative method used to study sequentially organised talk in social interaction and what people do with their talk, often referred to as “talk-in-interaction” (Hutchby and Wooffitt, 2008, p.12). There is a performative aspect to talk-in-interaction, by the way in which social acts are performed through language. CA seeks to comprehend how social actors make sense of and respond to each other in conversational turns (Lester and O'Reilly, 2019, p.4). For an interaction to succeed, participants must understand the social action being performed and respond to it appropriately.

The field of CA originated in the late 1960s with the works of Sacks, Schegloff and Jefferson (Stivers and Sidnell, 2014). They examined naturally occurring data from naturalistic settings to explore how social action and order were progressed through conversations (Liddicoat, 2022, p.18). By sequencing conversational turns, they captured how participants arranged for each other to talk about specific issues in specific ways through adjacency pairs (Lester and O'Reilly, 2019, p.27). Adjacency

pairs are paired utterances consisting of two interrelated turns, like question-answer. From this research, conversational rules and theories about talk-in-interaction were developed (Ten Have, 2007, p.196). Over time, a distinction has emerged between the original CA approach and “applied CA”. Applied CA is broadly described as the approach that investigates institutional talk-in-interaction (Lester and O'Reilly, 2019). Conversational rules and theories about conversation structures are applied to specific settings to examine how they operate. While the centre of attention is still talk-in-interaction, there is an emphasis on social action and difference (Ten Have, 2007). Words are regarded as tools used to negotiate social activities such as requests, questions, proposals, and suggestions, and there might be tension between local speech practices and any larger structure they are part of. Applied CA aims to uncover novel insights into the organisation of social activities, generating ideas about how things may be done differently (Ten Have, 2007, p.196).

I applied conversation analysis on peer group supervision conversations to study conversational structures and social activities progressed in talk-in-interaction. I chose this approach to understand better the conditions for flowing supervision conversations about difficulties and the significance of specific response activities.

3.8.1.1 Approaching the CA analysis

Within applied CA, the term *naturally occurring activities* is used instead of *naturally occurring data* to recognise that social activities converted into data by a researcher will not be purely natural (Lester and O'Reilly, 2019, p.100). Further, the common perception of *unmotivated looking* as an entry point in the CA analysis is challenged. Liddicoat (2022) describe unmotivated looking as “Repeated listening to the same data in order to discover what is happening” (p.73). The aim is to notice what is done in a particular interaction without being obscured by a theorising starting point (Ten Have, 2007, p.120). Nevertheless, unmotivated looking can be critiqued for suggesting a research position that is impossible to achieve (Liddicoat, 2022, p.73). I agree with Ten Have (2007), who contends that the researcher never approaches the data from a completely neutral position and will always have a particular understanding of the nature of the data. I also adapted to his solution to the problem: looking at the data with an open mind as to what is of possible interest while recognising that your gaze will not be completely unmotivated.

I initiated the CA process with an open mind to what the data might present, examining the video recordings and transcripts repeatedly in search of social actions. This proved to be a formidable task, as I grappled with determining where to focus my attention and which aspects to observe closely. Over the course of several months, I endeavoured to identify the social actions being performed in the supervision conversations. However, I encountered challenges in pinpointing these actions and understanding the dynamics at play. Ultimately, I abandoned the loose idea of noticing action being performed and adopted Heritage's approach to data analysis. This involved constructing overall “maps” of conversations to study the structural organisation of talk-in-interaction (Ten Have, 2007, p.180). By mapping interaction in terms of different elements, each section could be explored to see how apparent a task orientation was, if the social actors seemed to agree on the task, and the evolving conversational structure social actors oriented to in their talk.

3.8.1.2 Mapping conversational structures

Initially, I generated overall maps of the peer group supervision sessions (see Appendix A). These maps delineated the different elements of a supervision session, detailing the duration of each element, its characteristics, and the supervision cases included in the CA analysis. My research focus was what happened when systemic practitioners requested supervision because of difficulties experienced within themselves from conducting the role of a therapist. Consequently, I excluded cases where therapists sought supervision solely to understand the clients` difficulties. In the overall maps of peer group supervision sessions, all supervision cases were named after the difficulty presented and marked with group and case numbers. Conversational structures and details were captured by examining video recordings of the supervision. Below is an exemplar of the overall map illustrating the supervision session in Group 1:

SUPERVISION ELEMENTS	TIME SLOT	CHARACTERISTICS	RESEARCH CUT
A round to check who needs supervision today and which cases to prioritise	2 min.	An appointed therapist leads the round, pays attention to the use of time, and joins the round	
G1, C1: “I feel insecure talking with the couple about sex”	30 min.	The supervisee presents a challenge concerning himself	

G1, C2: "I have trouble feeling empathy towards the woman in the couple"	37 min.	The supervisee presents a challenge concerning herself	
G1, C3: "I am not sure if the mother gives enough love and warmth to her children"	15 min.	The supervisee presents a concern about a mother's capacity to give care	X
A final round to check the group's experiences with being filmed and observed	1 min.	The researcher joins the group by asking questions	

Total duration = 85 min.

Then, I did another round of "mapping". By zooming in on the cases concerning therapist difficulties included in the further analysis, I produced maps that outlined the overall structure of the supervision conversations following each case discussed (see Appendix B). These maps provided a comprehensive visual representation of overall supervision activities in a case discussion, detailing the time spent on each activity, how the activities were performed, and the turn organisation operating within activities. Overall structures of the supervision conversations were captured through examining video recordings of the supervision sessions. The following sample illustrates the overall map of the supervision conversation pertaining to Case 1:

	SUPERVISION ACTIVITIES	**TIME SLOT**	**PERFORMANCES**	**TURN ORGANISATION**
1	Presentation of case and therapist difficulties	6 min., 40 sec.	A story is told to the group	The supervisee is given a lengthy turn to speak, only interrupted by group members self-selecting a turn on two occasions
2	Clarifying questions from the group	6 min., 55 sec.	A round of questions, the turn to ask is given by where you sit	The supervisee is selected to speak by adjacency pairs of question-answer
3	Group responses to provide help and support	13 min., 35 sec.	A round of responses, the turn to respond is self-selected	Self-selection of turns to speak within the slot of a group member The supervisee takes part in the turn organisation operating around responses
4	Ending the supervision	3 min., 5 sec.	Final speech acts in the group, self-selected	The supervisee self-selects a turn to end the supervision and then responds to some group members who continue to provide help and support

Total duration = 30 min., 15 sec.

Eventually, I expanded the maps of the supervision conversations about a case to include sequences of talk and social activities performed in the talk-in-interaction (see Appendix C). Lester and O'Reilly (2019, p.156) explain that a sequence of talk "starts when one speaker initiates an action or a topic that is responded to by others and ends when speakers no longer explicitly respond to the initial action or topic". I watched video recordings from the supervision numerous times in addition to successive readings of transcripts to determine social actions and the beginning and end of a sequence. Sequences of talk were then identified and marked within time slots. Through the expanded maps of the supervision conversations, I was able to study sequences of talk and social activities allocated in talk-in-interaction more profoundly. The sample below demonstrates the mapping of the question round in the expanded map of the supervision conversation regarding Case 1 and is illustrative of the way I mapped talk-in-interaction:

SUPERVISION ACTIVITIES	**TIME SLOT**	**PERFORMANCES**	**TURN ORGANISATION**
2. Clarifying questions from the group	**6 min., 55 sec.**	**A round of questions, the turn to speak is given by where you sit**	**The supervisee is selected to speak by adjacency pairs of question-answer**
Clarifying question about the case	00:08:40 – 00:11:06	*A question round is opened without explanation, but everyone seems to know what to do* A group member asks about the duration of the couple's problem and how they explain the problem	The supervisee answers the questions Another group member, who knows the family, takes a turn to talk about the foster child in the family and how challenging he must have been for the couple
Clarifying question about the case	00:11.06 – 00:12:20	A group member asks if the couple understands each other's needs	The supervisee answers the question; the couple talks about their needs
Clarifying question about the case	00:12:20 – 00:13:30	A group member asks if the couple has a language to talk about sensuality The group member says he can share how he works with sexual issues	The supervisee answers the question; confirms The supervisee welcomes the suggestion

		in therapy after the question round	
Clarifying question about the therapist`s difficulties	00:13:30 – 00:15:35	A group member asks the supervisee to repeat what he wants the group to help him with The group member continues to ask how the group can talk about the supervisee's difficulties in a helpful way	The supervisee answers the question by repeating his difficulties The supervisee answers the second question; wants the group to share their practice knowledge

3.8.1.3 Analysing social activities in talk

To analyse talk-in-interaction in more detail, I applied CA theory about sequential organisation of talk and activity allocation. I found this analysis approach to fit my research design and questions well. In the CA analysis, I was primarily guided by the research questions about performances of therapist difficulties and patterns of communication when the groups responded to stories about therapist difficulties. I relied heavily on both transcripts and video recordings, zooming in on the part of supervision conversations that addressed therapist difficulties.

The analysis process at this stage was as follows:

A. I studied sequences of talk about therapist difficulties identified within key supervision activities across groups: requesting supervision, questioning supervision requests, and responding to supervision requests.

B. From the supervision requests, I explored the sequence of each request where the fullest version of therapist difficulties was presented (see Appendix M). The selected sequence represented a story section attached to a supervision request. I applied conversation analysis in order to suggest how the therapists wanted their stories about therapist difficulties to be heard (Pridham, 2001), aiming to catch the performative aspect of presenting difficulties. The analysis of supervision requests will be thoroughly illustrated in the Findings chapter.

C. From the questioning of supervision requests, I explored sequences of talk where the therapist`s experiences of difficulties were questioned (see Appendix N). Selected sequences comprised adjacency pairs of question-answer, from which I analysed language use and performances connected to difficulties. I applied conversation analysis to suggest how the therapists wanted to be heard and catch the unfolding nature of talk-in-interaction between the therapists (Pridham, 2001). An illustration of the analysis of questioning therapist difficulties will be provided in the Findings chapter.

D. I studied sequences of talk and counted social activities allocated by the group in responding to a request to analyse responses to supervision requests (see Appendix D). The following sample is from the expanded map of the supervision conversation regarding Case 6, and illustrates sequences of talk and various response activities identified through mapping the talk-in-interaction:

SUPERVISION ACTIVITIES	TIME SLOT	PERFORMANCES	TURN ORGANISATION
3.Group responses to provide help and support	**25 min., 13 sec.**	**A round of responses, the turn to respond is firstly given by where you sit and then self-selected**	**Each group member reflects without being interrupted, only rarely experiencing minor comments from the group in their turn** **The supervisee self-selects turns on three occasions to give feedback to the group reflection**
Suggesting what to do **Suggesting what to do**	00:54:53-00:56:15	A group member asks rhetorically if it isn`t very respectful to meet the couple individually, regardless of whether supervisee uses the Gottman method or not? Checks with the group if the supervisee has already met the couple individually? Continues to state that the clinical offer could be understanding what each of them needs. Suggests that this could be much clearer after	A group member answers; she has met each of them individually

Understanding the client		further individual sessions. Thinks the woman wants to leave him but says she could be wrong. The woman might actually want to stay in the relationship, then that is what you work with.	
Suggesting what to do **Understanding the client**	00:56:15-00:57:05	A group member says that she feels the condition for offering couple`s therapy is absent, and that clarifying that fact might be helpful.  She continues by sharing a concern about the woman; if the supervisee offers a series of couple`s sessions, she will go along. This might be against its purpose and not something we should be doing of now	
Suggesting what to do	00:57:05-00:57:30	A group member wonders what the woman would have said if she was asked if it felt like having three children? Explains that therapist neutrality, etc is not always sufficient. Sometimes we need to give clients what they need by validating experiences and offer some words they do not find themselves.	The previous speaker says “yes”

From identifying and counting the social activities performed in language when responding to supervision requests, I discovered a pattern across cases. Response activities were differentiated, counted, and illustrated in a table (see Table 6). Following is a sample showing the social activities allocated through responses across cases and a counting of the activities in Cases 1, 2 and 3:

	Understanding the clients	Exploring therapist positions	Suggesting what to do in therapy	Providing verbal recognition and empathy
Case 1	5	0	8	2
Case 2	15	5	11	5
Case 3	11	0	11	5

3.8.2 Analysing supervision atmospheres

In an applied CA study, the view of context is usually limited to what happens in the talk-in-interaction. I, therefore, included the notion of space as an essential part of the supervision context to explore the dimension of atmospheres. I found this necessary as social interaction is not merely linguistic. Atmospheres represent an embodied mode of communication that goes beyond words. I refer to the supervision space in order to express the intra-active dynamics of things and bodies within a supervision context (Barad, 2007, p.246). I did not view the supervision context as fixed but as a space of emerging constructs and possibilities. I sought to broaden my view of what happened when systemic practitioners talked about their difficulties in peer group supervision by capturing the atmospheres of supervision rooms.

For this part of the analysis, I drew upon the ideas of philosopher Gernot Böhme, who emphasises the spatial dimension of atmospheres as integral to the qualities of a social context (Thibaud, 2017). Böhme highlights the flow of affective intensities between bodies within a space and how this force impacts an atmosphere. He explains how affective flows are subjectively experienced as emotions and how these emotions, in turn, flow back into space as affect. Affect can be understood in different ways. One perspective is the view of affect as an emotional state stemming from the field of psychology (Brian, 2017), while another is the philosophical view of affect as an intensive force operating in and between bodies. In this latter view, affect is seen as a distinct, non-linguistic mode of knowing that occurs at a bodily level, separate from conscious emotions. Deleuze is among the philosophers who has embraced affect as a preconscious and bodily force. Böhme bridges these perspectives of affect by offering a framework that considers affect both as an emotional state and as an intensive force in his theory of atmospheres.

3.8.2.1 Böhme's characteristics of atmospheres

Gernot Böhme (2014) uses five characteristics to identify spatial atmospheres:

1. Atmospheres are feelings “suspended in the air” that express a general mood or tenor within a space.
2. There is a dynamic interplay of senses within a space, and different states can be produced from different sensory qualities in an environment. For example, the interior of a room may evoke a sense of pleasure or discomfort.

3. There is a disposition towards movement within a space, from narrow to expansive and open.
4. Atmospheres arise between bodies even before a conversation begins. Thus, the space both influences and is influenced by the bodies present.
5. The space carries cultural meanings and values generated by conventional characteristics of bodies, objects and symbols that are culturally conditioned.

Guided by the above framework delineating the features of spatial atmospheres, I composed a description of the atmosphere in each supervision group (Appendix L). This record articulates my subjective experiences and feelings from being in the supervision room together with the supervision groups as a participant observer. Subsequently, I presented my descriptions of these atmospheres to the supervision groups, allowing them to contribute their own perspectives. The excerpt below encapsulates my experience of the disposition towards movement in Group 1, and is illustrative of the material generated from studying supervision atmospheres:

> “There is not much bodily movement in the group. I notice that the therapists follow the one that speaks with their eyes, some occasionally nod, and they all use hand gestures when they speak. Some take notes. Everyone sits with crossed legs. From my observation, Liz is the group member with the most bodily movement. She sometimes moves her upper body back and forth. She also turns her head in a significant manner to look at the one giving her a response. It seems she is trying to come closer to the one she is currently interacting with. When Carl speaks, he moves his upper body forward and makes big hand gestures. He sometimes changes which leg is crossed over which. Julia seems to be fickling with her hands, moving the pencil back and forth between her fingers when not taking notes. Ann sometimes holds her chin with one of her hands. John pats his head from time to time and occasionally takes notes. However, there also seems to be a movement in the supervision conversation from John speaking openly about his vulnerability as a therapist to the group keeping some distance from it. The group emphasise the part of the supervision request where John asks how to proceed in the therapy over his feeling of incompetency. It feels like a move from intimacy to a distance that makes me uncertain if the supervision was of help to John.”

You must be exposed to an atmosphere to register moods and senses. I was exposed to the supervision atmospheres through the participant observations. I used my body to capture information about other bodies, moods, senses, movements, and affect flows within the supervision space. I heavily relied on my field notes in this part of the analysis, supported by video recordings, to help my selected memory. The videos helped me study the details of bodies and interactions.

The essential part of Böhme's theory about atmospheres is that they are produced (Böhme, 2014). It is thus possible to identify generators of atmospheres to set the stage differently. I found this to be a good fit with the goal of applied CA, which is discovering something new about the organisation of social activities to see how things may be done differently (Ten Have 2007).

3.9 SUMMARY OF METHODOLOGY AND METHODS

This research project adopted a systemic, qualitative research design, akin to a small-scale ethnography incorporating elements of conversation analysis and action research. By combining different methods for collecting data, I welcomed a variety of perspectives about what happened when systemic practitioners talked about their difficulties. Adhering to a diffractive research approach, I read data through analysis methods from different traditions to have a conversation with different ideas and theories and see what emerged. The objective was to add more depth to the study. I embraced the new material perspective to look beyond language, including the spacial aspect of atmospheres, bodies, and flow of affect. My philosophical stance as a researcher aligned with critical realism. I acknowledged that social or psychological phenomena existed independently of my awareness yet recognised that they could not be directly mirrored when read through my lenses and were constantly changing. I viewed knowledge production as an ongoing process of connecting and providing different perspectives of the researched. I included reflexivity and participation in the research design for a mindful approach to the Others and Otherness.

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

In this chapter, I describe the findings that emerged from collecting and analysing data from participant observations, video observations and dialogues with the research participants. My research focus is what happens when systemic practitioners talk about their difficulties in peer group supervision. The findings encapsulate both my own perspectives and those of the participants, recognising that how we see things are subject to change over time as human beings are engaged in a constant process of learning and evolving. Embracing this ontological stance, I view research as always ongoing and incomplete. While the research journey documented in this thesis marks a distinct beginning and an end, I acknowledge the potential for further exploration and new discoveries.

4.2 THE INSTITUTIONAL STRUCTURING OF PEER SUPERVISION

In the following, I present findings from dialogues with research participants concerning the institutional structuring of peer group supervision. In the capacity of an observer, I viewed peer supervision as an institutional activity within the Family Welfare Service. Institutional conversations are characterised by being task-oriented in ways relevant to the specific institution, and institutional interaction will often demonstrate this orientation (Heritage, 1995). I conceptualised the institutional task of peer supervision as ensuring the delivery of high-quality services to help-seeking clients, aligning with the overarching objective characteristic of most clinical supervision (Helps, 2021, p.209). From my perspective, the fulfilment of the institutional task was contingent upon the provision of a space within the Family Welfare Clinics wherein peers could engage in reflections on clinical practice during peer group supervision sessions. However, my idea of supervision as an institutional activity was challenged during dialogues with the research participants as they demonstrated a lack of awareness regarding any overarching institutional framework informing their supervision practice.

4.2.1 An absent institutional supervision mandate

As an observer, I found it challenging to understand how the groups understood and oriented to the task of peer group supervision within the Family Welfare Service. However, through dialogues with the supervision groups, I learned that the institution did not enforce a specific mandate for the supervision practice. Instead, the impetus to engage in peer supervision appeared to stem from the requirements of the therapists. Despite lacking a formal mandate, peer group supervision was perceived as an ingrained practice within the Family Welfare Clinics. Participants seemed to regard peer supervision as institutionalised by the therapists themselves. **Sarah**, a member from Group 2, drew a distinction between the institutional needs and the needs of the therapists:

> I do not feel there are strong instructions from above about the supervision. I find that it is, to a much greater extent, characterised by the therapists. That it is we who, in a way, want it and that our needs are highlighted.

In Group 1, peer supervision was described as an unquestionable practice within the Family Welfare Service that the director might be unaware of. The therapists were not acquainted with any guidelines regarding the supervision practice provided by the Family Welfare Service authorities. **Carl** perceived peer group supervision as an internal institutional culture that had evolved into a customary practice:

> I think it is a custom. I do not think anyone has sat down to think this is important for the Family Welfare Service. It is not stated in a disposal letter or any similar document that there is a directive about it.

Similarly, in Group 3, peer group supervision was described as a taken-for-granted activity stemming from the practice field. **Emma** viewed the practice of peer group supervision as being institutionalised by the therapists:

> There is no basic document I can find that says we should do it, so I also think, for my part, that it is a continuation of practice and, as a professional, certainly something you have expectations of. So, I think it is a bit like this; on the other hand, you would have reacted strongly to it if it wasn't there when you came to this service. So, in that sense, the practice is institutionalised in a way.

4.2.2 A compensating professional mandate

Despite the lack of an institutional supervision mandate, there was a relatively clear, compensating professional mandate established in the practice field. When

discussing the supervision task with the supervision groups, they all agreed on peer group supervision targeting two main issues: i) providing emotional support for therapists in need, and ii) providing quality in clinical practice.

In Group 2, **Sarah** explained the purpose of peer group supervision in this manner:

> One must be able to air what is difficult and be allowed to have a place or an arena to talk about what is difficult. And then you have the second, which is more of a quality assurance of what we do here in a way, being about how we work in these cases.

Leah, from Group 3, gave a similar understanding of the supervision task:

> And I have thought that our service should have it (supervision) both to ensure the quality of what we do, and to look after ourselves in the work we do. To share experiences, not standing alone in cases, to know that we have a place once a week where we can get supervision on cases that are demanding.

In some groups, the therapists articulated strategies for enhancing the quality of clinical practice through peer supervision, one of which involved exposing the therapist seeking supervision to diverse perspectives. **Emma**, a member of Group 3, elucidated how the richness from multiple voices in peer supervision provided an opportunity for therapists to expand their understanding of ongoing clinical work. She drew a parallel between clinical supervision and therapy, highlighting a fundamental tenet of systemic psychotherapy positing that diverse perspectives foster richness:

> It is something we have together, built on a cornerstone that our field has a belief that more voices contribute to wealth, which almost feels like a prerequisite or a bedrock in the theories even. Otherwise, it feels as if life and teaching are not completely connected. So I think a bit for the client's part as well, that we get the opportunity not to lock ourselves completely in one track but expand our understanding. That you do not sit alone with your understanding of what you work with. If we get other views of what it might be about, I can provide a better offer to the clients as well.

Some groups also identified a connection between peer group supervision and an institutional goal about providing equal services across Family Welfare Clinics. Norwegian families should receive the same offer within the Family Welfare Service despite the location of the Family Welfare Clinic. In Group 1, **John** saw peer

supervision as a means of ensuring that clients received the same level of care, in addition to providing care for therapists:

> It is a goal from above to provide the most equal service offer possible, in a way. So, a quality assurance around that. And then I think it also has a lot to do with therapeutic care.

4.2.3 The lack of an institutional supervision frame

While I observed a structure across all supervision conversations, I remained uncertain whether therapists adhered to an overall institutional frame for structuring these conversations. Eventually, I discovered a dearth of an institutionally structured supervision frame. Groups responded to this absence in various ways. Some embraced an unplanned, unfolding supervision structure, allowing for flexibility in addressing therapist difficulties. Others relied on an implicit supervision structure drawn from a written description of peer group supervision provided by the local clinic. Still, others had established their supervision framework within the group`s initial formation. Despite these adaptions, all groups acknowledged challenges stemming from the lack of an institutional supervision frame. Feedback from the research participants suggested that the absence of a clear structure constrained supervision conversations concerning the therapists` difficulties.

In Group 2, **Steven** pointed out how the lack of an institutional supervision frame could make him anxious about presenting his clinical work in peer group supervision:

> Let's say you watch a film from therapy or present a case, and then you must take the round in the group. I mean, you can sort of get anxious instead of feeling that it's nice to be so open. This is the exact opposite of how it was intended. And that is because there are no guidelines. No one has any structure to it.

Within Group 3, the discussion revolved around the ambiguity surrounding what they were set to do in peer group supervision and the unclear delineation of their roles. **Liam** described the lack of a clear supervision structure as confusing:

> I have probably felt unsure of who is the supervisor and the supervisee. I mean, what is this in the group? I notice, I have been in an external supervision process as well, and there it became so clear that we were invited into a group supervision.

In Group 1, they talked about how a supervision structure described in a former internal document was currently embedded in the clinic's supervision practice. This structure provided a frame for the supervision conversations that made a positive difference. **Carl** said that they used to experience challenges in peer group supervision that no longer existed due to the established supervision frame:

> Before, people could sit and talk endlessly. Like 20-30 minutes. And then we had to tighten it up because we never finished.

In Group 4, considerable effort was dedicated to establishing a supervision structure that could accommodate the diverse needs of its members during its inception. Alongside defining the supervision structure, they also pledged to adhere to the framework and acknowledge the various roles held by the therapists during a supervision session. **Emily** recounted the group`s struggle prior to collectively determining the structure:

> Yes, because we talked a lot about that (the supervision structure) at the start. Because we struggled a bit with it at the start, but when you get to do a few laps like that, it becomes easier.

The local supervision groups assumed significant responsibility for structuring their peer group supervision practice. It felt like they were navigating without a map or having to make the map to find a direction, which had a negative impact on group interactions. Their destination was not predetermined as the institution did not define a supervision task. It seemed the groups could travel in whatever direction they found most fit. Nevertheless, they all landed at the same destination: aiming to provide quality to clinical practice and emotional support to therapists in need.

4.3 THE ORGANISATION OF SUPERVISION SESSIONS

In this section, I offer reflections derived from my participant observations of peer group supervision. The observations and reflections presented here serve as an initial glimpse into my emerging ideas about the organisation of supervision sessions. I will continue to provide reflections from participant observations throughout this chapter.

4.3.1 Reflections from participant observations

Through participant observations, I noticed differences in the supervisory practice across groups. However, the similarities in the overall organisation of the supervision sessions struck me the most (see Appendix A). One therapist was always tasked with commencing the supervision session by initiating a round in the group to find out who needed supervision. The group would subsequently co-operate in prioritising 2-3 cases for the ongoing supervision session and provide supervision. Around half of the prioritised cases dealt with the therapist`s difficulties. The other half addressed the clients` difficulties, often associated with a child's care situation. The following excerpt is drawn from my **field notes** pertaining to Group 1, and illustrates the beginning of a supervision session:

> "I notice that the older female therapist directs the supervision process. I think she has a pleasant appearance. She seems safe and calm. She has a friendly face, short flowing hair, and eyes that smile behind glasses. She is wearing a thin knitted jumper, denim trousers and trainers. I think she must have knitted the sweater herself. She rolls back on the green chair as if putting herself slightly outside the rest of the group. There is no more small talk in the group. She gets straight to the point and checks who has cases they want to bring up in the supervision. She begins with the therapist sitting on her left. He says he has a case he would like to discuss. She notes down on her pad. The therapist who went to the toilet says she has a case she might discuss. She has talked about it in the group before. The elderly male therapist says he is still filled up with the professional meeting and cannot think of cases today. The younger female therapist says she has a case she would like to discuss, a couple's therapy she is struggling with."

I perceived a sense of care emanating from the therapist who led the initial round in Group 1. At the same time, there was a discernible element of efficiency in the way in which the round was conducted, making me feel I was participating in a formal meeting. This characteristic was consistent across all groups. The leading therapist initiated the meeting and made sure that each participant had the opportunity to present relevant cases. She spoke with one therapist at a time without interruptions from the rest of the group. Conversations with each therapist were succinct and focused. All cases were written down. The limited amount of time in the supervision session, made it necessary to prioritise which cases to discuss. I was struck by how smoothly the therapists seemed to co-operate in prioritising cases. There was never any fuzz or feeling of disagreement around it. Some therapists were always willing to

withdraw their case to provide the space for someone else. The decision-making appeared to be informed by an assessment of the urgency or severity of each case. The following excerpt from my **field notes** of Group 3, exemplifies how the groups collaboratively prioritised cases to discuss in supervision:

> "All the therapists have cases they wish to discuss in the supervision session. They jointly decide which two cases to prioritise. It becomes the case of the male therapist and one of the female therapists` case. The other female therapist has informed the group that she can wait with her case. She does not need to bring it up today. They agree that the male therapist can start, as he needs help with a complicated case. I feel that whoever has the most challenging case gets to start first."

However, I found myself contemplating whether there might also be an element of avoidance inherent in the process of prioritising of cases. The idea derived from a sense I had when observing the joint practice of prioritising cases. The seamless nature of this process, wherein therapists readily yielded the spotlight to their peers, prompted me to consider the underlying dynamics at play. This sense of curiosity is reflected in my **field notes** pertaining to Group 4:

> "The therapist at the end of the table says she has a case of violence, which can wait. The therapist beside me says that she, too, has a case that can wait. I'm starting to wonder if they don't want to discuss their cases. Do they find it demanding to raise cases in supervision?"

I never noticed any time constraints imposed on the duration of each case discussed. Consequently, the first case introduced seemed to enjoy a degree of assured attention compared to subsequent cases. Of particular interest was the prominence of the cases related to therapist difficulties, which comprised approximately half of the prioritised cases for supervision. These cases consistently received preferential treatment, being included in every session, and typically addressed at the outset. The following excerpt from my **field notes** of Group 4 exemplifies the prioritisation of a case concerning therapist difficulties over others:

> "The therapist above me is talking about a case she needs help with, where she will meet a couple with many challenges later today. It is urgent. She says she does not know where to go next and needs help from the others. She says she strives with the alliance and her neutrality. Until now, all the therapists around the table have listened attentively to those who talk about cases they

> want to discuss without commenting. However, now everyone says that this case is essential to proceed with today and that it is important to discuss. The therapist who owns the case says she would have appreciated ventilating before meeting the couple again. Again, all the other therapists agree that this matter needs to be addressed and that is not a problem. To me, the group seems to figure out in collaboration which cases are most important to discuss in the team. It seems decided on there and then, even if the round is not over."

While it is plausible that the therapists may have accentuated cases about therapist difficulties on the day of the observation due to being aware of my research focus, I doubt they would readily concede to this explanation. When I broached the topic of their experiences with being observed and filmed at the conclusion of each supervision session, the therapists uniformly asserted that I had witnessed their usual practice. A representative response is exemplified in the following excerpt from my **field notes** of Group 4.

> "The therapists say they either forgot that I was there or noticed that I was there without perceiving it as disturbing. They might be slightly sharpened because of my presence, but the supervision represented how they usually practice peer supervision."

Prior to the participant observations, I was concerned with how my presence in the supervision groups would affect group performances. Yet, the feedback provided by the participants indicated that they paid little heed to my presence, and that their conduct during the supervision sessions was representative of their typical approach to peer group supervision.

4.4 PERFORMANCES OF THERAPIST DIFFICULTIES

In this section, I furnish an outline of the supervision cases under scrutiny, offering a description of the various supervision requests. Additionally, I delineate how therapist difficulties were performed through stories. The analysis of performances draws upon conversation analysis (CA) to examine the performative dimension inherent in speech. Towards the end of the section, I incorporate fieldwork reflections from participant observations and feedback from the participants, to broaden the perspective about performances of therapist difficulties.

4.4.1 Supervision cases included in the analysis

The table below provides an overview of the supervision cases that engaged with therapist difficulties and, therefore, were included in the analysis. The cases are named from the therapists` descriptions of difficulties when presenting their supervision request.

Table 4: Overview of supervision cases

CASE 1	“I feel insecure talking with the couple about sex”
CASE 2	“I have trouble feeling empathy towards the woman in the couple”
CASE 3	"I am unsure if I reinforced the child's problem through validation"
CASE 4	"I found it difficult to attend to the couple's conflicting needs and was at a loss what to do"
CASE 5	“I need help with feeling more empathic towards the parents”
CASE 6	“I am most concerned with the woman and struggle to help them as a couple”

I applied a CA approach to analyse the supervision cases. The following table displays my mapping of the overall structure of the supervision conversation concerning Case 2.

Table 5: The structural organisation of Case 2

	SUPERVISION ACTIVITIES	**TIME SLOT**	**PERFORMANCES**	**TURN ORGANISATION**
1	Presentation of case and therapist difficulties	2 min., 54 sec.	A story is told to the group	The supervisee is given a lengthy turn to speak without being interrupted
2	Clarifying questions from the group	3 min., 21 sec.	A round of questions, the turn to ask is self-selected	The supervisee is selected to speak by adjacency pairs of question-answer
3	Group responses to provide help and support	29 min., 15 sec.	A round of responses, the turn to respond is self-selected	Self-selection of turns to speak within the slot of a group member The supervisee takes part in the turn organisation operating around responses, in addition to being selected to speak by adjacency pairs of question-answer

4	Ending the supervision	1 min., 50 sec.	Final speech acts in the group, self-selected	The supervisee self-selects a turn to end the supervision and is subsequently selected to speak by adjacency pairs of question-answer

Total duration = 37 min., 20 sec.

After mapping the structural organisation of every supervision case (see Appendix B), a clearer picture emerged of the key activities in which all the supervision groups were engaged:

- Requesting supervision
- Questioning the supervision request
- Responding to the supervision request

The key activities were consistent across all supervision cases. However, upon closer examination, it became evident that the conversational framework shifted slightly in each case from being worked on differently. For instance, it varied how active the therapist seeking supervision was when the group responded to the supervision request. Some actively participated in the turn organisation operating around responses, while others sat in a listening position without engaging in the response activity at all. According to Ten Have (2007), social activities are inherently situated, contingent upon how social actors constantly co-construct the unfolding structure they orient to in organising their conversation. From this perspective, I viewed the supervision conversations as flexible texts negotiated by the peer group members.

4.4.2 Supervision requests encompassing vulnerability

The overall maps of case conversations (see Appendix B) elucidated that each supervision case discussed comprised an overarching request-service pair. According to Ten Have (2007, p.178), institutional interactions typically start with a request for assistance. In my examination of supervision cases, therapists articulated challenges encountered while interacting with and responding to their clients. They expressed feelings of being stuck, incompetent, or unable to proceed in therapeutic practice. These disclosures implied a need for assistance from their peers to navigate or provide a map to find a way through the difficulties. By divulging these challenges, the therapists appeared to be exposing their vulnerability to peers, inviting a supervision relationship characterised by intimacy or closeness.

I identified three distinct categories of therapist difficulties conveyed through supervision requests: i) feelings of insecurity regarding one`s competency, ii) experiencing a lack of empathy towards clients, and iii) struggling to navigate or feeling stuck in therapy. To analyse performances of therapist difficulties (see Appendix M), I scrutinised the sequences of supervision requests wherein therapists presented the most comprehensive accounts of their difficulties. In the following, I provide an illustrative example demonstrating how I applied a CA approach to analyse the performances of difficulties within each category of difficulties.

4.4.2.1 Feeling insecure about own competency

The therapist difficulties in Cases 1 and 3 concerned feeling insecure about own competency as a therapist. The following data excerpt is taken from the supervision request in Case 3, where **Steven** talked about a conversation with a 12-year-old girl whose parents were divorced. The girl had told him about a recent weekend trip with her mother, her mother's friend, and this friend's daughter. She had a nice weekend, but the mood shifted during a lengthy car journey home when her mother and her friend confronted her about her reluctance to stay with her mother following the divorce. Steven described his therapist difficulties as insecurity concerning how he responded to the girl`s story.

> **Steven:** And.. what I notice when I talk with her is.. that I keep thinking.. “Okay, now I'm going to... I'm going to be there for her.” I.. I feel that I just want to be there for her...
> **Isabel:** Mhm..
> **Steven:** And then I notice a kind of.. and then we have this thing with parental alienation.. uhh, a bit like denial, right.. so, some kind of discomfort like that. How are you going to.. get the child to still.. want to come to the other parent?
> **Lisa:** Hmm..
> **Steven:** So there were a lot of experiences like that... many experiences that weren't.. weren't anything like that norm.. but there's one thing or another that makes “My God, now I have to say something that.. becomes a counterbalance” (laughs)
> **Lisa:** Hmm.
> **Steven:** So I go on like.. 10 minutes, 20 minutes, 30 minutes.. just “I can understand you. Just thinking about sitting in that car.. alone. And your friend who was lying there sleeping and a little nauseous. And these adults who just asked you, and.. how were you then?” Right?
> **Lisa:** Hmm..
> **Steven:** And she was like..

> **Britt:** Validated to death?
> **Steven:** Yeah.. And that.. and then I just felt that… the way I do this.. will it make her go more to mummy? Right? And what is the right thing for me to do.. in that session? And that is sort of a problem. Where.. when am I supposed to be the other voice?

In the excerpt shown above, Steven explains how he responded to the girl's story about what happened in the car and questions whether his response was correct. He points towards his inner dialogue from talking with the girl, explaining how he ***"notices"*** his thoughts and feelings when he decides to "***be there for her***". Isabel supports the speaker by saying "***mhm***" to cheer him along. Steven continues referencing his inner dialogue when he says he starts noticing "***some kind of discomfort***" when he thinks about "***parental alienation***" and "***denial***". After this reference, he uses the filler "***right***" as if he assumes that the group is familiar with what he is talking about. Parental alienation is a term that explicates how a child becomes estranged from one parent due to sabotage and harmful manipulation of the other parent (Meland et al., 2023). In this context, the therapist seems afraid of becoming "***the other parent***", who manipulates the girl from staying with her mother by the manner in which he responds to her story about the car trip. By using the word "***still***" when he asks how you will get the child "***to still want to come to the other parent***", he seems to suggest a discrepancy between being there for the child and getting the girl to stay with both parents. Lisa provides speaker support by saying, "***Hmm***". Steven goes on by pointing to having "***a lot of experiences***". In an unfinished sentence, he tries to say something about the characteristics of these feelings. I am unable to understand the meaning. However, "***one thing or another***" from these experiences makes him think he should say something that becomes "***a counterbalance***" to what the girl was exposed to in the car. This sentence includes an ellipsis, which omits the specific element that needs to be counterbalanced. However, the context provides clarity regarded the intended meaning. Steven thinks, "***My God, now I have to say something that becomes a counterbalance***". The expression "***My God***" suggests that Steven is significantly affected by the girl's story, experiencing a strong impulse to take action to help her endure. The emotive language serves as an intensification that brings the story about his inner dialogue to life. Following the statement, he includes a laugh as part of his performance for the group. This laughter appears to signpost that he recognises the humorous aspect of

the stressful situation he endured. It could be interpreted as a means of conveying that he is coping well despite the challenges encountered in therapy, thereby reducing his vulnerability in the eyes of his peers. Lisa gives speaker support by saying, “***Mhm***”. Steven now moves from explaining his inner dialogue to saying what he did in the session. He exemplifies the way in which he validates the girl's experiences for “***10 minutes, 20 minutes, 30 minutes***”. His use of the filler “***right***” shows that he is oriented to the audience and assumes they understand what he is talking about. Lisa responds by saying, “***Hmm***”. He is about to say how the girl reacted, saying, “***And she was like***”, then pausing. When he pauses, Britt steals his turn and finishes his sentence in a question form; “***Validated to death?***”. Steven confirms by saying, “***Yeah***”. He then proceeds by saying he “***felt that***” his way of responding to the girl might stand in the way of staying more with the mother. Again, he uses the filler “***right***” to attract his audience. He then asks if this was right of him to do in the session, explaining that it is “***sort of***” a problem. The phrase “***sort of***”, conveys a sense of approximation, suggesting that something is nearly a problem but not quite. This usage may stem from the informal nature of speech, but it also has the effect of downplaying the severity of the issue. However, by understating therapist difficulties, therapists may find it easier to articulate and discuss feelings of insecurity during peer group supervision. The sequence concludes with Steven pondering when he should assume “***the other voice***”. The precise meaning of the term is unclear from the context, but it could refer to eighter adopting the perspective of the child or advocating for what is deemed to be in the child`s best interest.

Throughout the excerpt, Steven employs typical features of oral speech, including frequent pauses, the use of “and”, vague language, ellipses, and unfinished sentences, as identified by Pridham (2001). The presentation of difficulties appears to be cooperative. Isabel and Lisa work as active listeners, providing speaker support throughout the excerpt without interrupting the flow of the story. Similarly, Steven repeatedly orients to the group by using the filler "right", indicating his assumption that the peers understand his experiences. Britt`s completion of Steven`s utterance when he pauses suggests her attentiveness to the story and her desire to keep it flowing. However, the supervision request itself appears somewhat unclear. While Steven provides detailed accounts of what happened when he experienced difficulties, referencing the conversation with the girl, the description of his difficulties

remains vague. He mentions having “sort of" a problem without elaborating further. Although the peers` responses indicate their attention and support, it remains uncertain whether they fully grasp the problem definition given the limited space allotted to Steven`s difficulties in the story.

4.4.2.2 Experiencing a lack of empathy towards clients

The therapist difficulties presented in Cases 2 and 5 revolved around the therapists` experiences of lacking empathy towards their clients. The following data excerpt is taken from the supervision request in Case 2, where **Liz** discussed a couple's therapy that the group was already familiar with from a previous supervision session. She expressed feeling stuck in the therapeutic process and struggled to provide the planned emotion-focused therapy. The couple`s dynamic had shifted to silence or quarrels, with both partners turning away from each other. Liz described her difficulties as stemming from a lack of empathy towards one of the clients.

> **Liz:** And last time, then... and that's what I told you a little bit about last time as well... I feel such irritation, simply, towards that woman in that relationship. Because it's... it's not often that I feel like that in meetings with clients, that kind of irritation. But my empathy is not triggered, and.. But when she tells me that she's had three abortions, so.. so of course.. I really have to work inward and sort of think "God, how awful". How awful it must have been to make such choices. How painful it must have been to choose to have an abortion when you really want children. But then I also become.. I also feel irritation.. So it's really very special. Um…. and I actually know this couple very well, because.. Or I know her very well, because she has been with me for a long time.. And I feel.. I, I can't seem to get anywhere.. with her. Out of the stories where she is.. uhh.. very much a victim, presents herself time and time again as a victim then.

In the excerpt above, Liz talks about having negative feelings towards the woman in the couple relationship. She appears to have experienced the same problem as the last time she brought the case to supervision, from the utterance, “***And that's what I told you a little bit about last time as well***”. She describes the problem clearly; “***I feel such irritation, simply, towards that woman in that relationship***”. She describes the irritation as an exception, noting that she rarely feels that way in client meetings, which suggests that the situation is unique. She moves on to say, “***My empathy is not triggered***”. The utterance suggests that she has empathy, but something stands in the way of it being triggered. There is an obstacle there,

seemingly her irritation towards the woman. She has to "***work inwards***" when the woman tells her she has had three abortions. She describes the work inward as controlling or steering her thoughts. She says to herself, "***How awful***" and "***How painful it must be to choose to have an abortion when you really want children***". The description of what she does to manage irritation and lack of empathy gives associations to cognitive behavior theory and the idea that what people think determines their feelings (Beck, 2020). However, the thinking does not seem to work, as it also makes her "***feel irritation***". The repetition of the word irritation works as an intensifier and stresses her main point; she needs help with managing her feelings towards the client. She also repeats her point about not usually having such feelings towards clients by emphasising, "***It's really very special***". She then says she knows the client well because she "***has been with me for a long time***". Again, she uses an ellipsed sentence, but the meaning is relatively clear: the woman has been a client of Liz for a long time. Liz says she "***can't seem to get anywhere***" with the client. Her description suggests a lack of movement; the woman is stuck, and Liz cannot seem to move her. It may also indicate that the woman is stuck despite Liz's "***long time***" attempts to move her. She ends the sequence by explaining how the woman is stuck in stories where she "***is very much a victim***". The adjective "***very much***" intensifies and heightens her story about the client. She then repeats her point by saying the woman "***presents herself time and time again as a victim***". The utterance "***presents herself***" suggests that the woman is performing, presenting herself as a victim without necessarily being one. The term "***Time and time again***" works like a repeated intensifier to bring the story about the woman being a victim alive. She also repeats the word "***victim***" with the same effect. She makes a point about the client presenting herself as a victim and that moving on from this position seems impossible.

I find the language in Liz`s story about therapist difficulties clear and coherent. It is easy to follow her request and how she wants it to be heard. She is clear when describing her negative feelings towards the female client and how she experiences the client as being stuck in a victim position. There are pauses and ellipsis, but they never stand in the way of the message or the conversation's flow. Her use of adjectives and repetitions brings the story about difficulties alive and helps emphasise the main points of the story (Pridham, 2001). The implication is that Liz is

frustrated by the woman`s consistent portrayal of herself as a victim and her inability to move beyond this role. I perceive courage in her willingness to openly discuss her challenges and expose her vulnerabilities in front of her peers. Additionally, I am impressed by how effectively she communicates her need for supervision. Despite her brief turn, lasting only 2 minutes and 54 seconds, she manages to articulate her difficulties clearly. This contrasts with the other cases in the analysis, where therapists take longer to present their difficulties due to detailed client stories. However, it is possible that Liz provided more extensive information about the clients during a previous supervision session.

4.4.2.3 Finding it hard to navigate, feeling stuck in therapy

Cases 4 and 6 concerned how the therapists found it hard to navigate and felt stuck in therapy. The following data excerpt is taken from the supervision request in Case 4. **Liam** discussed feeling stuck as a therapist during a recent clarification session with a couple. The man in the couple referenced a past episode where he had called his partner “a cunt” and confronted her during the session with always coming back to this incident instead of moving forward. He attributed his past action to the woman`s persistent nagging, despite having instructed her to stop. The woman remained silent, but Liam observed tears welling up in her eyes. Liam experienced the situation as unmanageable.

> **Liam:** Erm.. and then there was sort of something about that situation. I felt that when he then tells her that.... you.. in a way you have to accept that I call you this when you keep doing what you do to me, then I couldn't quite figure out how to take care.. I was about to say, both of them.. ehh .. in this... considering what they are actually requesting. Which is help for.. for couple clarification. Because I think in a way there, he was sitting showing off his aggression.. eh, which he has said something about.. that he doesn't quite have that kind of faith and trust in.. he is not confident in speaking with us about it yet. And we saw... that she was exposed to this here. And then.. I was.. I just kind of "oh".. Yes, so.... I took the easiest way, because part of the conversation, too.. and then we were sort of there, was.. supposed to be about some further collaboration. Because as of now she lives with her parents, or is with her parents... so they have no particular arrangement regarding the child. So then it started.. like the easiest for me was like (he laughs) to overlook what had happened there and then go to "Let's rather talk about (makes arm movements) ... how you should do it until next time”.
> **Emma:** Hmm, hmm.
> **Liam:** When it came to.. that he gets to be with.. with his son then.
> **Emma:** Hmm.

Liam: But… I think they'll be back. Erh.. so.. then it's like that.. On the one hand, as I started to say, I need to know what I'm doing in this room.
Emma: Hmm.
Leah: Hmm.
Liam: (long sigh)
Leah: If the situation happens again, for example?
Liam: Yeah… I think so
Leah: Happening?
Liam: Big chance of that happening. Because that's a bit of what they're negotiating about, too. If it's going to end, whose story is it going to be about.. or who are right somehow, in it?
Leah: Hmm.
Liam: Erm.. yes, and then there's also how I'm going to.. how we're going to set this up? Because... I feel like there are stories outside that we are kind of provided with, and have kind of asked for in individual sessions, that we kind of don't quite get... in.
Leah: Hmm.

In the excerpt above, Liam explains how he felt stuck when he recently experienced an unmanageable situation in a couple`s session. He was unable to ascertain "***how to take care***" of both when he witnessed the man "***showing off his aggression***" and the woman being "***exposed to***" the man's aggression. He knew that the man was not confident enough to talk about his aggression yet, suggesting that the man`s lack of faith and trust prevented the caretaking of the woman. Also, it was hard to know what to do because the couple's request was couple clarification as opposed to therapy. Liam explains his further action from the difficult moment as "***taking the easiest way***", which was to proceed with discussing visitation arrangements for the father and child. He then repeats that the easiest way for him was to overlook what happened between the couple and turn to what they should "***do until next time***" as to stress the main point; he overlooked the problematic moment because he didn't know what to do. His use of repetitions helps with keeping the attention on the difficulties he is experiencing. He laughs briefly as he mentions the easiest way, perhaps indicating to the group that he finds his challenge laughable. Both the use of repetitions and the performative laugh contribute to bring the story alive. Liam seeks supervision to comprehend the circumstances that led to his feeling stuck and to prevent finding himself in a similar position in the future. From the excerpt, it becomes evident how Emma and Leah, at this point, start providing extensive speaker support by saying "***hmm***" as to cheer him on in his storytelling. Their action might reflect a sensitivity towards Liam talking more deeply about his difficulties. The

conversation appears cooperative, with Emma and Leah working as active listeners. When the therapist sighs after summing up that he "***needs to know what he is doing in the room***", Leah asks a clarifying question. The interruption appears positive, showing that she pays attention and is actively interested in the story being told. The therapist ends the sequence by asking for help with "***how to set up***" the clinical work. He struggles with incorporating undisclosed information from individual sessions into the couple sessions. This aspect of the supervision request appears somewhat vague and lacks further elaboration.

Throughout the excerpt, Liam uses typical oral speech that includes many pauses, voiced phrases like "erm" and "eh", a frequent use of "and", and repetitions (Pridham, 2001). I find his presentation of difficulties somewhat challenging to follow due to lengthy, verbose sentences that are often unfinished. The way in which the story unfolds suggests that Liam is searching for his words while speaking. There is a risk of losing the audience due to this disjointed narrative style. However, he manages to inject vitality into the story by repeatedly emphasising the notion of "the easiest way" and punctuating the last repetition with a performative laugh. Liam seems relatively okay with performing his difficulties vis-à-vis peers, being open about his challenging experience from clinical practice. The peers illustrate by their responses that Liam has their attention and support, maybe making him feel more comfortable with exposing vulnerability.

4.4.3 Characteristics of stories about therapist difficulties

Therapists were afforded a lengthy turn to speak when they presented a supervision request, resulting in these requests take the form of stories (see Appendix C). Pridham (2001) highlights how storytellers interact with their listeners in a specific way to attract them and keep their attention. The narrative sequences detailing therapist difficulties analysed in this study exhibited an interactive quality by the way in which the therapist seeking supervision signposted how the story should be interpreted and peers signalling they were active listening (see Appendix M). In the majority of supervision requests, therapists dedicated a significant portion of time discussing the difficulties faced by their clients, detailing contextual factors and recounting events from previous clinical sessions, while being brief about their own difficulties. However, it was their own challenges that they presented as problematic.

Brief descriptions of therapist difficulties often contributed to unclear or vague supervision requests.

My admiration of clear presentations of therapist difficulties was evident from the field notes. Case 2 stood out from the others due to the brevity of time allocated to present the supervision request and the manner in which the therapist highlighted her difficulties. In my **field notes**, I remarked on the therapist`s commendable openness regarding her challenges:

> "She (Liz) says she struggles with empathy towards a female client in couples therapy and how uncomfortable it feels not to be able to be the empathetic therapist she wants to be. She is triggered by the client putting herself in a victim position and having poor strategies for cooperation and communication. Again, I am impressed by how open the therapist is about her challenges."

In Case 3, the initial descriptions of the therapist's difficulties were scarce and vague. After critiquing the supervision group for not providing new perspectives when evaluating the supervision, the therapist withdrew his difficulties, saying he brought up the case for the sake of his peers. It felt as if the relational process in the group was pushing the conversation in a new direction. I registered not being very fond of the shift in how the therapist difficulties were conveyed, going from being open to all disclosed. I made a note of it in my **field notes**:

> "I find myself being surprised by the direction the conversation takes. I think about how he (Steven) initially said he did not quite know why he wanted to bring up the case. Now, he says he chose to bring it up to help the others. I wonder if it is an attempt to make himself invulnerable in the group. Or maybe vis-à-vis me?"

In Case 6, the therapist dedicated nearly 19 minutes to presenting the supervision request, primarily focusing on the case details with only brief mentions of her own difficulties. Her presentation was relatively coherent, aided by her use of journals to provide additional details and flow to her story. In the **field notes**, I wrote:

> "I feel drawn into the story of the couple seeking help and enjoy all the details, even if it takes a long time. I like the nuances that emerge about the clients and their relationships and the way in which the story is told. She (Mia) has a comfortable pace and a good voice to listen to. At the same time, I notice that the therapist who leads the group process is getting impatient. I immediately understand it concerns taking up too much time in presenting the case."

Observing Case 6 highlighted for me the significance of storytelling in engaging an audience. I experienced how the performative aspect of presenting a supervision request made a difference. Although I typically prefer clear descriptions of therapist difficulties that openly display vulnerability, I found myself drawn into a supervision request that hardly mentioned therapist difficulties at all. I appreciated the pace of the story, the nuances, the flow of the words, and listening to the therapist`s voice.

4.4.4 Challenges with describing therapist difficulties

My initial idea about the vague descriptions of therapist difficulties was that therapists might find it challenging to expose their vulnerability vis-à-vis peers, and possibly me. My perspective was expanded in dialogues with the supervision groups (see Appendix G). After watching a video clip from the presentation of therapist difficulties in Case 5, **Emma** spoke about why she was being vague when describing her difficulties. She explained how the difficulties were unclear to her when presenting the supervision request. She was trying to figure them out as she spoke:

> And then I sit with this idea, and I do not know if it is true, but a belief then, that the request is not completely clear to me. I need the space and the room and sort of the acceptance to find that weighting. It is a bit like what Liam was talking about when we discussed his case, that somehow, I do not quite know what I need help with, so that is what I sit and try to figure out when I talk.

Emma's feedback prompted me to consider how therapist difficulties could manifest as affect, residing somewhat beneath consciousness but still exerting a troubling felt sense in the body. This insight underscored the importance of bringing felt difficulties into peer group supervision, rather than limiting supervision cases to fully thought-out difficulties.

Engaging in dialogue with Group 4 further broadened my perspective. Mia shared her expectations of herself regarding presenting a clear problem definition of her difficulties in supervision. After viewing a video clip from her presentation of therapist difficulties in Case 6, she was puzzled by the lengthy presentation and how vague she was about her difficulties. The group members reassured her that it was acceptable to come to supervision unprepared and that the onus for clarity laid

primarily with Mia. They emphasised that fruitful discussions would arise regardless. **Mia** responded:

> It contrasts with the expectations I have of myself, doesn't it. But when there is room for me to do it like that, I think it becomes so exciting because then the team's reflections will trigger new reflections so I can move on. Right? So then, in a way, the supervision is even better because I have not narrowed myself as much as when I present an already concluded problem definition.

During the group dialogue, Mia appeared to transition from feeling that she had spent excessive time presenting her supervision request to recognising the benefits of not providing a clear problem description in supervision. She suggested that this approach was not always feasible, expressing excitement about gaining clarity through the reflections from her peers. She highlighted how this approach had helped her broaden her perspective. Mia`s feedback underscored for me the importance of being receptive to different approaches to exploring therapist difficulties. Subsequently, I pondered whether we sometimes prioritise efficiency too much in peer group supervision. I considered that identifying therapist difficulties might be just as crucial as resolving them.

In Group 3, **Liam** approached this issue from a slightly different angle. After reviewing my initial analysis of his presentation of therapist difficulties, he reflected on the importance of introspection when presenting a supervision request. He was concerned with ensuring coherence between his words and bodily felt affect, explaining his search for words and frequent use of pauses. He elaborated:

> **Liam:** I think I recognise that I laughed to give permission to “this is where we're going to stop. This is something we need to talk about, and it is perfectly fine”. I can feel that. And then I want to rewind to some of what you started saying about the affect in the room. I cannot quite let it go. I think that part of the reason I like to go back and forth a bit is precisely feeling it. And that is kind of what we have been taught to do as a community. What is in my body? What are the words I come up with, and are they entirely correct? And if we jump forward too quickly, it becomes very much like the story runs ahead.
> **Researcher:** You want to know the story?
> **Liam:** I want to know the story, yes. And then I have to notice that the words fit. And for that it must not go too fast, and there must be some back and forth.
> **Researcher:** And then you must think a bit, as you do have to in spoken language. You need to have some pauses to think, and you must feel it. Right?

> It is interesting that you say this is important to you because it is something I definitely pick up on.
> **Liam:** Because I think that I use the opportunity when I present it as well, because I know telling it will shape me too. I kind of listen to myself, too.

The feedback obtained from dialogues with the research participants indicated that the challenge in describing therapist difficulties may stem from a lack of full consciousness about these difficulties. Bodily felt difficulties could prompt the need for supervision, even if they could not be fully articulated. Finding the appropriate words to describe these bodily sensations could be challenging. Consequently, exploring the dimension of affect and bodily experiences related to therapist difficulties emerged as an important aspect of peer group supervision. However, this particular aspect of difficulties was not addressed in the groups.

4.5 GROUP RESPONSES TO SUPERVISION REQUESTS

In this section, I present findings concerning response patterns in the supervision groups. Following the supervision requests, I identified two main types of response activities in the groups: i) questioning the supervision request, and ii) providing help and support. I have included both in the analysis to capture the unfolding nature of therapist difficulties and get a sense of how they travel in the supervision groups.

The analysis of how supervision requests were clarified drew upon conversation analysis to explore how therapists made sense of and responded to each other in conversational turns (Lester and O`Reilly, 2019). Additionally, CA was utilised to discern the progression of social activities in speech when groups provided help and support to therapists seeking supervision. Through this analysis, recurrent response patterns were identified and subsequently shared with research participants to solicit their insights. Their feedback was integrated into the examination of responses.

4.5.1 Responses to clarify therapist difficulties

Ten Have (2007, p.207) underscores the need for additional information to adequately address a request for assistance, which elucidates why questioning supervision requests was an activity running across the supervision cases discussed. In all cases examined in this study, with the exception of Case 3, a round of clarifying

questions consistently ensued after the presentation of a supervision request (see Appendix B). Through adjacency pairs of question-answer, each participant was afforded the opportunity to ask clarifying questions regarding the supervision request. The therapist invariably responded to these questions as anticipated. Although most clarifying questions were asked directly after a supervision request, they could occur throughout the supervision conversations and across different supervision activities. I identified three categories of questions following a supervision request: i) questioning the formulation of supervision requests, ii) questioning experiences of therapist difficulties, and iii) questioning the case and/or the clients` difficulties (see Appendix D). Owing to my research focus, I only pursued clarifying questions about therapist difficulties in the CA analysis.

Questioning therapists about their experiences of difficulties could yield crucial supplementary information for a supervision request. Novel information was often revealed, and the unfolding distinction of difficulties and needs could potentially play a vital role in offering necessary assistance and support in peer supervision. Nevertheless, I sensed a reluctance among the groups towards questioning experiences of difficulties. This was evident from the few questions per case exploring the experience of therapist difficulties (see Appendix D). It appeared that there might also be a vulnerability associated with being subjected to questions about therapist difficulties. Sometimes, the clarifying question-answer exchanges were straightforward, merely serving to ensure a shared understanding between the group and the therapist. At other times, when the questions were more explorative, there were instances where the therapist seeking supervision seemed to perceive the questioning as demanding. This sentiment is illustrated in the following excerpt from Case 2. Prior to this sequence, Liz had answered questions about her irritation towards the client and the client`s reaction to confrontation. When **Julia** probed Liz's experiences of difficulties further, it is possible she encroached too closely upon the therapist's vulnerability.

> **Julia:** Can I ask you something now?
> **Liz:** Yes.
> **Julia:** Because the feeling I get then..
> **Liz:** Yes?

> **Julia:** It's that.. er.. that you.. or.. what is it like to sit there and feel that you.. that I'm not the therapist I want to be?
> **Liz:** No.. no, it's not good. And then I feel that I really have, in one way or another, empathy with him.
> **Julia:** Yes.
> **Liz:** And it's like.. that's not where we're supposed to be as therapists.
> **Julia:** That you are.. that you think that you are not being fair?
> **Liz:** I.. I'm sure.. I'm probably not, since I feel that way. But.. I don't know if they notice. I don`t know. I feel very drained in that couple, really.. So I work with.. I kind of have to constantly bring up this thing with “She's had it very hard. She's had it very hard. That's your defence” Um.. yes. No, I don't really know where I want to go with this. Erm..

The sequence starts with Julia asking permission to speak. Liz permits her, and Julia refers to “***a feeling***” she gets. When she pauses, Liz gives speaker support by asking, “***Yes?***”. The question form illustrates that she wants to hear more about Julia's feelings and encourages her to proceed with the response activity. The unfinished utterances and pauses at the beginning of the following sentence suggest that Julia struggles to find the right words to explain her feelings. She poses a question instead, asking what it is like for Liz to feel “***I'm not the therapist I want to be***”. The focus thus changes from Julia's feelings to how Liz feels. At the beginning of the utterance, there is also a change of form from “***you***” to “***I***” when she poses the question, which steers it from a more general view to questioning Liz directly. Liz answers by saying, “***It's not good***”, and explains that she “***really have, in one way or another, empathy with him***”. Her explanation illustrates a difference in her feelings towards the man and the woman in the couple. She leaves no doubt about it by using the word “***really***”; this is how she feels. The utterance “***in one way or another***” suggests that she is uncertain about the reason, but she empathises with the man. Julia supports Liz by saying “***yes***” as to cheer her along in the talk-in-interaction. Liz then continues by saying, “***That's not where we are supposed to be as therapists***”, seemingly referring to a general professional idea about being neutral as therapists or feeling the same towards both parties in a couple. Julia explores the idea by asking if Liz thinks she is “***not being fair***”. The word “***fair***” seemingly suggests that there should be symmetry in Liz`s relationship with the clients. Liz replies that she “***is probably not***” being fair since she feels that way, but she is unsure if the couple noticed. Liz displays a pattern of starting and stopping sentences, punctuated by frequent pauses, suggesting a need to carefully consider her feelings before articulating them. The way in which she repeats that she does not

know if the couple notice serves as intensification and stresses this point. When she utters "***I don't know***" the second time, the words come out like a long sigh. It sounds as if she empties all the air left in her lungs while making the utterance. She then says that she feels "***very drained in that couple, really***", adding to her performance of exhaustion. "***Very drained***" is an emotive vocabulary that works as an intensification of her story. The word "***really***" suggests no doubt about it; this is how she feels. She continues by referring to how the client "***constantly bring up this thing with***" how she has had a hard life. The meaning of "***bring up this thing***" nods to how she works inwards, trying to control her feelings by steering her thoughts in a specific direction. She attempts to hold on to the thoughts: "***She's had it very hard. She's had it very hard. That's your defence.***" The illustration of how she repeats these thoughts suggests that she needs to prove the point to herself and might indicate that it is hard for her to be convinced by these thoughts. She then makes a voiced phrase, pauses, and says "***yes***" as to confirm that this is what she does. However, in her next utterance, the last one in the sequence, it feels like she collapses when saying "***I don't really know where I want to go with this***". From the way Liz`s experience of difficulties unfolds throughout the course of this sequence, her last utterance seems to suggest that she wants to take everything back or that even talking about her difficulties is draining.

The excerpt above underscores the significance of delicacy when exploring supervision requests and experiences of difficulties. Essential, new information was revealed concerning how Liz empathised with the man in the couple although she strived to feel empathy for the woman. However, vulnerability connected to being questioned about therapist difficulties was also evident, illustrative of most cases.

4.5.2 Responses to provide help and support

Response activities aimed at providing help and support in peer supervision were the focal point of the groups. I consider this aspect as the core of supervision practice, representing its true purpose, where assistance is provided to therapists in need. The presentation of supervision request and the questioning of therapists' difficulties merely serve as tools to ensure adequate help and support is provided in this phase of supervision.

I studied the expanded case conversation maps (see Appendix C) to identify social activities initiated in the supervision conversations to offer help and support. By examining sequences of talk and outlining activities intended to address the supervision requests, I discerned a pattern consisting of four primary responses that ran through most cases:

i) Understanding the clients
ii) Exploring therapist positions
iii) Suggesting what to do in therapy
iv) Providing verbal recognition and empathy

Understanding the clients concerned understanding the Other. Within this activity, the therapists provided suggestions about how to understand the clients and their challenges, experiences, feelings, actions, etc.

Exploring therapist positions concerned taking a therapist's perspective, seeing something from a therapist`s position, and helping the therapist become aware of alternative positions to expand their latitude of action.

Suggesting what to do in therapy pertained to having ideas, suggestions, or advice about what the therapist might do in the ongoing clinical work.

Providing verbal recognition and empathy was a form of spoken care provided to the therapist seeking supervision. Responses ranged from affiliating responses, validating the therapist experiences and feelings, and empathising with the therapist.

Responses were counted within a sequence of talk-in-interaction. The table below illustrates the quantity of various responding acts per case. A specific response type was only counted once per sequence even though the therapists sometimes went back and forth between different response activities within a sequence. However, I did take note of various response activities occurring within the same sequence.

Table 6: Overview of response activities to provide help and support

	UNDERSTANDING THE CLIENTS	EXPLORING THERAPIST POSITIONS	SUGGESTING WHAT TO DO IN THERAPY	PROVIDING VERBAL RECOGNITION AND EMPATHY
Case 1	5	0	8	2
Case 2	14	3	12	6
Case 3	11	1	10	8
Case 4	4	9	1	5
Case 5	7	4	4	0
Case 6	10	2	12	1
	Total = 51	Total = 19	Total = 47	Total = 22

Even though the total number of response activities missed details and differences, it was useful to point out patterns of communication and interaction in the peer group supervision practice. From this overview, it became evident that understanding the clients and suggesting what to do in therapy was favoured to exploring therapist positions and providing verbal recognition and empathy. During dialogues with the research participants, I shared this overview of responses and my thoughts of the response patterns to get their feedback - as illustrated in the following.

4.5.2.1 Making sense of response patterns

When discussing Case 2 with the first group, I highlighted that they spent nearly twice the usual amount of time providing help and support compared to most other cases in the study. The majority of responses focused on understanding the client and suggesting what to do in therapy. Conversely, responses addressing therapist positions and verbal recognition were notably lower, despite the supervision request centring on Liz`s struggle with empathy towards a client. I questioned whether the responses regarding understanding the client aimed at increasing Liz`s empathy and sought assistance in comprehending the overall response pattern. **Carl** pointed to characteristics with Liz in order to explain the significant number of response activities. He seemed to be establishing a connection between how often a therapist uses the supervision group and being able to pose a clear supervision request. He

suggested that Liz got more from the supervision group, because she used the group frequently and was clear about what she needed feedback on:

> It could also be that Liz is among those who use the supervision group most actively and is clear on what she needs feedback on. We use the supervision group differently.

John, on the other hand, proposed that adherence to habitual practices might trump the specific supervision request, resulting in a response activity that missed its intended focus, insinuating this could have happened in Liz`s case:

> Maybe it's about what you're used to, as a therapist in a way, having your eyes on.

When discussing Case 3 in the second group, I questioned as to why there were so many responses about understanding the clients` actions and none about therapist positions. In this case, Steven's request concerned his position as a therapist. He felt insecure about his actions in a conversation he recently had with a young girl. The data extract below illustrates how **Britt and Steven** discussed the response pattern:

> **Britt:** It is safer to talk about what we have scored high on. Much safer.
> **Steven:** But it can also stem from the way I communicate and the reflections I give. I kind of say “don't talk to me about it”.
> **Britt:** Sure, but it's much safer for me not to go into it.
> **Steven:** At least if I create a narrative where I don't invite you in.

Britt's feedback suggested that talking about clients and what to do in therapy felt safer than exploring therapist positions. It seemed as though she needed to keep some distance from exploring therapist positions to feel safe. At a later stage, she explicated how she often felt that she had crossed a line in supervision. It could be the most minor thing, but the feeling made her very aware of the possibility of offending someone. Steven contributed to the perspective by suggesting that his way of interacting with peers might signal that the group was not invited to explore his positioning as a therapist.

When discussing the pattern of responses in Cases 4 and 5 in the third group, the emphasis was placed on the low number of activities providing verbal recognition and empathy. I shared my idea of providing verbal recognition and empathy as being a

way of addressing therapist difficulties more directly, staying with the difficulties. I suggested that the group might be cautious with providing recognition and empathy, especially in Case 5, where none such responses were given. In the following extract, **Emma and Leah** ruminated on the matter:

> **Emma:** I sit a bit and think that maybe it is here in this, in our clinic, that there is a loss. That this is what we feel we get too little of. That this reflects somewhat the way it is. Because in case 4, that is with Liam?
> **Researcher:** Yes. It's a little better there.
> **Emma:** Yes, but still only half of what we provide on the therapist's positioning.
> **Researcher:** Mhm.
> **Emma:** I think it's a little recognisable, that sometimes things get a little loose around the table. Everyone can say that we are not very good at positive feedback. What we do for work is hard, still we don't give each other that much.
> **Leah:** Recognition of our work?
> **Emma:** Recognition of the therapist, in a way.
> **Leah:** We work on that a lot in therapy..
> **Researcher:** Yes, you do.
> **Emma:** And at the same time, therapeutically, when I work with validation for example, this is what I'm bad at. I validate a lot with the non-verbal but putting it into words I am bad at. So maybe it reflects a little.. For me, it reflects you a little in the reflective team then. That I'm not that good. It is easier for me to find the words for positioning than for recognition.

Emma's feedback suggested that verbal recognition and empathy was a skill that needed to be practiced, important in both therapeutic work and peer group supervision. She found it is easier to show recognition and empathy than to put it into words, and she thought this was the case for many of the therapists at the clinic. Seemingly, there was a discrepancy between utterances about how hard it was to work therapeutically and verbal feedback from peers providing recognition and empathy. She thought of it as a loss and a longing among the therapists. Something was lacking in peer supervision at the clinic, and she felt this could be the missing part. As the dialogue continued, **Emma** reflected on the lack of verbal recognition and empathy she experienced in Case 5:

> I think it is very interesting to line it up like on this form. And then I also think it's like, yes for my own reflection then. I think it's interesting if there's something about me that signals that when I present a request I still say "do not come too close". What is in my half of the court, in a way, and what is in my role as a leader? You, Liam, referred earlier that "you're my boss", right?

> What does that produce? Am I signalling “don't come too close”, or is it this specific case?

The group did not answer Emma's question about whether she signalled that they should keep a distance. Still, she did offer an interesting perspective concerning different roles within a clinic and how such roles might affect interaction in peer group supervision. She held the role of a clinic leader and suggested that it could stand in the way of addressing the difficulties she experienced in the role of a therapist.

When talking with Group 4 about the pattern of responses to provide help and support, they were primarily surprised by the low number of verbal recognition and empathy. The extract below illustrates **Mia**'s response, who was the therapist seeking supervision in Case 6:

> **Mia:** It was surprising that there was only one.. I just call it validation.
> **Researcher:** Yes.
> **Mia:** Because I felt absolutely validated. So then it's more like the way we do it, the way we interact.
> **Researcher:** Yes.
> **Mia:** So, all the other not so clear, direct verbal statements. Because I feel really carried, cared for and framed, and welcomed, and ... uh, yes. So I think that's a bit important to include.
> **Researcher:** Yes, very important. So interesting.
> **Mia:** Yes, very. So that we validate each other in ways other than necessarily the linguistic.

Mia's feedback suggested that if provided in non-linguistic ways, verbal recognition and empathy might not be so crucial in supervision. She pointed to the importance of aspects outside of language to understand what happened when therapists talked about their difficulties. Her reflection imparted relevance to my diffractive approach to analysis, suggesting that the complexity of human relationships and group processes in supervision cannot be made visible by studying the use of language alone.

4.6 ATMOSPHERES WITHIN THE SUPERVISION SPACE

I included the dimension of supervision atmospheres to explore what happened when systemic practitioners talked about their difficulties in peer supervision. In order to identify atmospheres, I read data from my observations through Gernot Böhme`s

(2014) five characteristics of the spatial aspect of atmospheres: 1) the general mood expressed within a space, 2) the dynamic interplay of senses, 3) the disposition towards movement, 4) how the space influence and is influenced by bodies, and 5) the cultural meanings and values carried within a space.

In this section, I present my own and the participants` experiences of the supervision atmospheres and how this dimension might affect what happens in peer group supervision. Sharing my initial analysis of atmospheres (see Appendix O) with the research participants considerably expanded my perspectives. Findings included being affected by the interiors of the supervision room, a general mood expressing sensitivity and support, politeness and agreement producing a distance to difficulties, and the habitus of consensus determining the group interaction.

4.6.1 Being affected by the interior of the supervision room

Several participants within the groups noted that the supervision room had a significant impact on them. The interiors and surroundings of the room seemed to exert a bodily felt influence on the therapists present in the supervision space, myself included. Some participants mentioned feeling unsettled by the interior design of the supervision room. Conversely, others expressed feeling more at ease, tranquil, and in harmony when seated in a room that aligned with their aesthetic preferences. Many pointed to the significance of the amount of space and windows. Still, most participants did not think that the supervision room influenced what they did in supervision. It seemed that they distinguished between bodily felt experiences and what happened in the supervision conversations about therapist difficulties.

In my field notes, I included the look and feel of the supervision rooms, being attentive to how they influenced me. Groups 1 and 2 used the same room for supervision. As a participant observer, I was initially disturbed by the interior of this room. It felt crowded with things, messy, and disharmonic. However, I quickly forgot about it as the supervision conversation unfolded. In the **field notes** from Group 1, I described this supervision room in the following way:

> “I think this must be the children's room at the clinic, and I am a little surprised they have their supervision here. I wonder if the room is suitable. Can a room affect what will happen in a supervision session? I think it matters to me, but I

> am not sure. This room is filled with green chairs with wheels, children's toys, tables of various sizes and children's furniture. One wall is wallpapered, and a large TV screen hangs in the middle of it. The pattern on the wallpaper features white and brown tree trunks with branches extending upwards. Another wall has a window facing the hallway, with grey and white slats that are drawn so that no one can see in. There are considerably more white than grey lamellae, the grey coming as thin, vertical stripes at a certain interval. I think the pattern is outdated. There are no windows here. The light is dim. You would never guess that it was sunny outside. I find the room a bit poor."

When I discussed my experiences with the two groups, the responses from participants were mixed. Some did not take notice of the room's interior at all. Instead, they were focusing on the ongoing supervision conversation. In Group 2, **Britt** explained:

> We were so used to it. That was sort of where we had the supervision in a way. That was where we were.

Others said they were affected by the many things in the room, but more so when they used the room for clinical work than in supervision. **Sarah** described it like this:

> When you talk about it now, I think yes, maybe. Because I can feel that I didn't like that room, in a way. I thought it was messy. Those chairs put me in a bad mood. But perhaps I was more stressed about it when I had clients there, and I felt the discomfort regarding how it was somehow not okay then. But it's clear that a room with less stuff creates more calm, so I think it takes a bit more energy to push it away when there's so much around. I sort of have to zoom in on what we will do, which is sort of an issue at the start. Whether it affects the supervision process to a large extent, I do not know.

From the fieldwork in Group 4, the observations I made while eating lunch at the clinic prior to the supervision made me think they preferred one supervision room above others. In my **field notes**, I marked:

> "The conversation turns to which supervision group will be allowed to use the lunchroom for supervision today, and the therapist who are participating in the project says, smiling, "It has been decided that we are allowed to use this room for supervision today". Furthermore, she says the manager communicated this to everyone at the staff meeting last week. Another therapist explains to me that there is a rift about this room and that the supervision groups share it. Her supervision group "lost" it both at Easter and today because they were assigned the month of April. The therapist participating in the project looks at both me and the therapist next to me when

> she says ironically, “It's a pity for them”. She keeps smiling when she tells the therapist next to me that there is no empathy to be gained from her. The other therapist is also smiling, if somewhat dejected.”

In my dialogue with Group 4, I realised how the room preferences varied. **Pamela** pointed to the differences between supervision rooms and described how she was affected by whether there were windows or not:

> I thought about the difference with sitting here then. We have a windowless room which is even smaller than this. I feel how much I gravitate towards those windows and the air (in the other supervision room). I do not know if I would have said or done anything else, but I do know that I have a much better feeling sitting in a room, and it does not have to be as lovely as up there, but only that there are windows.

Emily revealed that she was affected by the size of the supervision room, preferring a small room over a bigger one as she found it more pleasurable:

> I think it is a little too big (the supervision room they used). I think it is much nicer to sit in your office (looks at Pamela) or one of the offices that is a bit bigger, but with windows and a sofa.

Mia and Grace preferred to using the lunchroom for supervision purposes as they found it to provide harmony, calm, and a good space for thought. **Mia** noted how this supervision room enabled her mind to travel, and how she liked being in the room because of the harmony created by the interior:

> And I love that room (used for supervision). It feels like my mind can travel much further than in a tiny room. And fascinating observations. It is a meeting room where we would like to be when we have time, right? And it's true, as you say (looks towards researcher), it's a bit formal. So, it could have been a law office. It could have been anything. And I think I like it precisely because it is so coordinated with the colours. The only thing is the wall clock that doesn't fit. That was an excellent observation. But I like the colours, I like being there. Here, I can get annoyed by the red cabinet and the stored furniture, and it can disturb me. It is at a detailed level, but as you say (looks at Pamela), I don't think it significantly affects the process in the team. However, if I were to choose, I would happily choose that room (used for supervision). It gives a sense of calm, a visual, sensory calm.

Grace added being inspired by the exterior of the supervision room. She found it inspiring to look out of windows because it expanded her thinking and gave her inner peace to endure long supervision sessions:

> In any case, I get a completely different calm (in that supervision room), and I think I can sit there for a long time. The gaze can travel; we have water, sky and beautiful old buildings outside. I can kind of be inspired by that, too, right? The colours and shapes out there provide something because I can get hold of an inner peace differently than when I sit in this room here. I know sitting here for a while is perfectly fine, but I get so restless. I cannot be staying here for long, in a way. There is something about that. Yes. So, that supervision room gives a freedom of thought, perhaps, and more inspiration.

Although most participants were clearly affected by the interior of supervision rooms, they talked about it as subjective and inner experiences separated from what happened in the supervision conversations.

4.6.2 A general mood expressing sensitivity and support

There was a consistent mood expressed in the supervision rooms that ran through all the groups, characterised by a sense of sensitivity and support towards the therapist grappling with difficulties. Peers exhibited a high level of attentiveness towards the therapist seeking supervision, expressing with their bodies, movements, pace, tone of voice, voiced sounds, and gazes that they were fully engaged as listeners and seriously considering the therapist`s difficulties. From my observations, it was this doing, more so than the actual words spoken, that created the mood within the supervision space. In the **field notes** from Group 2, I documented the focused listening to the description of therapist difficulties:

> “I can see how the other two therapists focus by listening and taking notes eagerly. They look at the therapist talking about the case to show that they are interested, but do not interrupt. The female therapist gives an appreciative nod now and then. It strikes me that they seem to take their roles very seriously.”

My experience from being in the room together with the supervision groups made me very aware of how the feel of a room could open up or restrict conversations about therapist difficulties. In the **field notes** from Group 1, I took notice of the tenor of sensitivity and support expressed in the room and how I myself was affected from it:

> “The supervision process related to this case does not seem as structured as in the first case, but the group's questions and reflections are just as respectful. I catch myself smiling and nodding on two occasions. I cannot remember precisely when, but I feel myself drawn towards this group. I enjoy being with the group. It almost feels like I long to be a part of it. There is something very respectful about how they listen, check out and reflect that I like so much. They seem so sure of themselves and of each other. The relationships seem so equal. From my position, I cannot see anyone taking up too much or too little space, and I do not see anyone fighting for their position.”

There seemed to be a caregiving element from the mood expressed in the supervision rooms towards the therapist experiencing difficulties, important in supporting therapists who made themselves vulnerable vis-à-vis peer. In my dialogue with Group 3, **Liam** illustrated the vulnerability connected with sharing difficulties with peers. He said he could be reluctant to share his difficulties in supervision because they were interpreted and because he lost control of how the peers saw him:

> If I strive, how will it be understood? If I become uncertain about how the various people around the table understand this, then it (being reluctant) can quickly happen. There is something about the fact that we all understand things differently, which can affect me. And then I do not know if I dare to bring it up because I am afraid of being misunderstood or understood differently, and then I hold back a little.

In my dialogue with Group 4, they talked about a preference for showing support towards each other instead of uttering it. Verbal recognition and empathy were practised but felt secondary to the non-linguistic support given by gaze, pace, etc. **Mia**, who presented therapist difficulties in this group, described the energy in the supervision room as bathing in “a flow of love”:

> **Emily:** Because if we did a round and everyone should have said something nice first because that was something we were doing, I think maybe I would have felt that it was not real.
> **Mia:** But there is a flow of love (in the supervision room).
> **Emily:** Yes.
> **Mia:** Well, it's that energy there that I feel I can bathe in.
> **Emily:** Yes, that the words would almost have punctuated, maybe.

The mood in the groups seemed significant for supporting therapists who made themselves vulnerable in supervision. The expressed sensitivity and support felt needed to create a safe place and make it comfortable to request supervision.

4.6.3 Politeness and agreement producing a distance to difficulties

Although the mood in the supervision rooms seemed essential when presenting supervision requests and clarifying difficulties, it sometimes felt restricting for group responses to provide help and support. A dynamic interplay of agreement, politeness and support characterised the group responses in the supervision cases discussed. Therapists often mirrored each other by agreeing with the previous speaker and continuing to talk about something similar. They seemed very concerned with being supportive and polite towards each other. Different themes could appear, but disagreements rarely emerged. It felt as if the lack of creative tensions could stand in the way of providing new perspectives and moving forward in supervision. In my **field notes** concerning Case 2, I reflected on the group's response pattern:

> “I experienced that the therapist (Steven) was merely challenged in the supervision, and that little newness came to light. He is the only man in the group. I wonder if the female therapists feel like taking care of him. No one asked questions about what he did or did not do, and there was little reflection in the group. Were they afraid of creating a negative atmosphere if they asked critical questions? The session seemed to be about supporting the therapist and reassuring him that what he did was right and important for this girl. I think we cannot know if what he did for the girl was good or not.”

In Steven's feedback to the group, it appeared that his perception of the supervision mirrored my own. He began evaluating the supervision by asking if there were any insights he could glean from the group's responses. The question appeared to be a critique of the supervision group, deviating from the prevailing agreeing and supporting that had characterised the room's mood up until this time. Steven indicated a perceived absence of learning opportunities from the supervision conversation. In my **field notes**, I made a note of this observation:

> “I see that she, who manages the group process, takes off her knitted jacket. I notice that I am holding my breath a little. What is happening now? I understand what happens as an explicit criticism of the group. The therapist (Steven), who brought up the case, continues to talk. Now, he says that he has not gained anything new through the group's reflection, but he has received confirmation that his actions are right. He proceeds by saying he finds it is okay with such a confirmation.”

Opting not to explore the therapist's difficulties felt like a deliberate choice to maintain a sense of distance from the therapist's vulnerability. In Case 2, Steven initiated the

supervision by sharing with the group a challenge encountered in clinical practice and expressing his insecurities. However, when the group responded with unanimous support and agreement, it led to a stagnant conversation, as Steven himself pointed out. The pattern of responses appeared to create a movement in the supervision conversation from intimacy to distance. This inclination to maintain a distance from the therapist's difficulties was evident across various cases examined. Group discussions predominantly centred on the clients` difficulties or what to do in therapy, rather than exploring the therapist`s own difficulties (see Appendix D).

I found it intriguing how the groups seemed intent on preserving a pleasant atmosphere during supervision, avoiding any disruption to the comfortable ambiance in the room. In Steven`s case, the group leaned towards affiliative responses to uphold harmony. Instances of difficulties or discontent were effectively diffused through applause and encouragement directed at the therapist seeking supervision. When I shared this observation during my dialogue with the group, it resonated with other members. **Britt** elaborated on her tendency to provide affiliative responses, attributing it to her insecurities. She confessed that when something felt unsafe, she instinctively sought to resolve it. Britt`s reflection shed light on her role as one of the therapists in the group who frequently offered affiliative responses:

> Yes, I set the threshold for hallelujah. And afterwards, it is much more comfortable for me to leave that setting and think, “That was nice, and in 5 minutes, we will start a new conversation”. Because I have probably experienced leaving supervision with a lump in my stomach staying for the rest of the day, right. And then I have not been grossly negligent. But it does not take much in recent years before I feel I have done something wrong. I think I go too far, am rude, or have done something wrong then.

In my dialogue with Group 3, **Emma** talked about having similar experiences to Britt. She reflected on the importance of being sensitive towards therapists displaying vulnerability in peer supervision. However, it could be unclear what the therapist seeking supervision needed, resulting in uncertainty if you managed to meet with the therapist's needs:

> Because I feel that when I have been involved in peer supervision but did not present a case myself, but something personal has been brought up, I can also think, “Was I caring enough?” and “How was this for the other?”.

Addressing therapist difficulties in group supervision was often accompanied by a palpable sense of insecurity among participants. Therapists seemed preoccupied with preserving a positive image within the group and maintaining harmonious relationships with their peers, while also being mindful of respecting peer boundaries. By maintaining a certain distance from the vulnerability of therapists seeking supervision, the group sought to avoid inadvertently causing discomfort or offense to a vulnerable peer, thus fostering a sense of safety within the group. However, this cautious approach to addressing the therapists` difficulties also had its drawbacks. It sometimes resulted in therapists feeling misunderstood or inadequately supported during supervision. **Leah**, a member of Group 3, highlighted the limitations of peer group supervision, expressing how it was not always helpful:

> I think most of the time, we probably say, “Thanks for the input” and “That was useful” (laughter). But then you might go out now and then, it does not happen often, but sometimes I want to say “This gave me no help”. I could have wanted to say that, but I don’t. We do not do that.

Liam agreed with Leah, and described a similar experience:

> It is a bit like this, sometimes it has been profitable while at other times it has been three wasted hours. So, it is somewhat ambivalent to come and go to supervision. Because sometimes, I can think about how lucky I am to have been able to participate, and sometimes it would not have mattered if I had completed my journal notes instead.

From both descriptions above, it sounded unheard of to make a critique of the supervision, even if it had the potential of initiating new learning and development in the group. Politeness seemed to stand in the way of a meta-observation of what was produced in the supervision conversation, thus impeding the entrance of how to improve peer group supervision.

In Group 3, **Liam** elaborated on his strategy of proactively preventing supervision conversations from veering off course by articulating his needs with precision when presenting his difficulties. He emphasised that the clarity of his communication often dictated the level of support he received from the supervision group. If he failed to effectively convey his vulnerabilities, the group discussions would inevitably drift

towards suggesting what he might do in therapy. Liam vividly described the consequences of not being clear about his difficulties:

> And then I notice the times I haven't done it. I'm not fine, but I'm coming out with a bunch of suggestions about what I should have done instead. That's the worst.

Group 3 continued discussing their cautious approach towards exploring therapist difficulties, emphasising the importance of receiving a clear invitation to delve into such vulnerabilities. This caution stemmed from past experiences in peer group supervision where there were instances of eighter overstepping boundaries, lacking sensitivity towards peers, or failing to provide adequate support during supervision. Consequently, they expressed a need for explicit invitations to engage with the vulnerabilities of their peers. When these invitations were ambiguous, they preferred to err on the side of caution by maintaining a certain distance. Additionally, the presence of a hierarchical structure within the group seemed to pose another obstacle to addressing difficulties. In Case 5, the therapist seeking supervision held the dual role of the therapist seeking supervision and the clinic leader. In following excerpt, **Liam** highlighted his reluctance to explore Emma`s vulnerabilities in peer supervision due to her role as a clinic leader:

> So, I just noticed that I would not have explored Emma's vulnerability. I might have done it with Leah, but not with Emma.

4.6.4 Habitus of consensus determining the group interaction

The homogeneous composition of therapists in the supervision rooms, all being white Norwegians, including myself, was a notable observation. It suggested that peer group supervision conversations about therapist difficulties were perceived through the lens of the majority culture in Norway. The white, Norwegian outlook in the supervision rooms implied a shared cultural perspective among the therapists.

Referencing ethnographic insights into Norwegian culture, the Scandinavian value of equality, central to the cultural ethos, is linked with a tendency to form groups based on similarities (Gullestad, 2002; Gullestad, 2010). While individuality and independence are valued, conformity to group norms is also expected, emphasising

the importance of blending in rather than standing out. While working on this analysis, I was struck by how cultural factors might have influenced the pervasive agreement and mirroring of responses within the supervision groups. When discussing this observation with the therapists, they acknowledged the homogeneity of their peer groups and recognised the potential risks associated with excessive similarity among participants. However, they expressed surprise at the extent of consensus observed in their supervision conversations about difficulties. This discovery prompted me to question whether the practice of consensus across supervision groups took the shape of a cultural habitus implicitly reproduced into a distinct supervision practice (Bourdieu, 1998, p.8). I pondered whether therapists had been conditioned into a conversational structure without being fully aware of it, influenced by a cultural aspect inherent within the Family Welfare Clinics. In Group 1, **John** suggested the homogenous outlook of the supervision groups was being representative of the Family Welfare Service:

> Nevertheless, you get the impression that in the Family Welfare Service, especially in our clinic, you are even more homogeneous than in most other workplaces. We are white. We are of the same social class. We have the same background of experience. But, also in terms of age. The Family Welfare Service has few of the very young, so in our world, those who are young are in their late 30s, right?

John`s point about to the risk of failing to produce different perspectives in supervision in the following excerpt, was representative of the feed-back from all supervision groups:

> It could be that if you put forward a vulnerability or a problem, if you are too homogenous, you do not come up with these other angles or other perspectives, or you do not dare touch it (the difficulties).

In Group 4, they discussed if there was allowance for being different in the supervision groups. **Emily** could sometimes feel that they were trying too hard to be similar and questioned if this challenged the supervision aim of providing different perspectives and quality in clinical work. She found the lack of difference as a possible shortcoming of the supervision task:

> Is there sufficient difference for providing a proper quality assurance? And that is not just thinking about professions. It does not just apply to difference

> between professional groups. Perhaps less so than us daring to be ourselves and allowing for difference.

In Group 2, **Steven** questioned the assumed practice of agreeing, given that he experienced much difference in the supervision group. He felt that difference arose from the therapists` various backgrounds despite belonging to the same culture:

> Nevertheless, I believe that our baggage is essential. Now, I know people a little more than you (looks at the researcher), and we are incredibly different, right? Growing up and all the stuff we have in us. But somehow, it does not show up.

In the same group, **Britt** referred to the emotional aspect of agreeing in order to understand the group interaction. She thought it might be easier to agree because then you did not have to defend your point of view:

> It might be that it's not free of cost to disagree either, right? It is perhaps cheaper to go along with the agreement. That it costs then, not necessarily that it is so dangerous, but you have to argue and stand for something else.

In Group 3, the atmosphere of politeness and mutual respect that permeated the interaction within the supervision group was recognised. Despite this, participants felt that there was space for disagreement within the group, even though such disagreements were not apparent on the day of the observation. The group members were familiar with each other, fostering a sense of safety and trust within the group. Upon reflecting on why differences in opinion still did not surface, **Liam** elaborated on how their familiarity with one another enabled him to tailor his responses to meet the specific needs of his peers:

> I know a little bit what Emma wants to hear. I mean, not wanting to hear, maybe, but what she is receptive to then. So, we know each other well. There is no point in coming up with something completely different because they will not listen to that.

4.7 SUMMARY OF THE FINDINGS

Findings from this study illustrated the complexities of addressing therapists` difficulties in peer group supervision within the Norwegian Family Welfare Service. I

identified three categories of difficulties presented through supervision requests: i) feeling insecure about own competency, ii) experiencing a lack of empathy towards clients, and iii) finding it hard to navigate and feeling stuck in therapy. The display of these difficulties suggested the therapists were making themselves vulnerable vis-à-vis peers, inviting the supervision groups into a conversation of intimacy. However, presentations of therapist difficulties were often characterised by their rarity or lack of specificity. Some therapists appeared hesitant to expose their vulnerabilities during peer supervision sessions, citing feelings of anxiety or fear of being misunderstood. Others described their vagueness as stemming from difficulties in articulating bodily sensations that were not entirely clear to them, or from challenges in verbalising such experiences. While the groups signalled their interest in hearing about therapist difficulties through active listening, they seldom delved into the emotional or bodily dimension of these experiences. Instead, most questions following a supervision request focused on the formulating of the request, the specifics of the case, or the difficulties faced by the clients. There was a palpable sense of vulnerability associated with probing into a therapist`s difficulties, underscoring the importance of approaching such explorations with sensitivity.

Four different activities ran through most cases when the supervision groups responded to a supervision request: i) understanding the clients, ii) exploring therapist positions, iii) suggesting what to do in therapy, and iiii) providing verbal recognition and empathy. The response patterns suggested a preference for focusing on understanding clients and proposing therapeutic interventions over exploring therapist positions and providing verbal acknowledgement. Across most supervision groups, there was a reluctance towards exploring therapist positions, driven by concerns about potentially causing offense, violating boundaries, or disrupting hierarchical roles within the group. It felt safer for therapists to discuss clients or therapeutic interventions rather than addressing a peer`s vulnerability directly. While some therapists downplayed the significance of verbal recognition and empathy, viewing care as being expressed through non-linguistic means, others perceived the lack of verbal acknowledgement as a loss in the peer supervision, fostering distance and insecurity among therapists seeking supervision. Some underscored the importance of clearly articulated supervision requests, noting that vague requests

increased the risk of veering off-topic in supervision conversations about difficulties and focusing on client-related issues and therapeutic strategies instead.

The sensitivity and support expressed within the supervision space fostered a pleasant atmosphere for discussing therapist difficulties. However, the prevalence of agreement and mirrored responses posed an obstacle to generating diverse perspectives when responding to supervision requests. While this tendency to agree may aim to maintain a pleasant atmosphere, it could also reflect a cultural inclination towards consensus, influenced by the predominant Norwegian majority culture. Another condition impacting communication and interaction within the supervision groups was the significant responsibility placed on local groups to establish their own supervision structure. In the absence of a formal mandate or institutional framework for supervision within the organisation, therapists often grappled with poor group dynamics, role ambiguity, and a lack of security when exposing their vulnerabilities. The flexible nature of the supervision structures seemed to constrain supervision conversations about therapist difficulties, diminishing the perceived importance of the supervision space. Therapists reported being affected by the interiors and surroundings of a supervision room but distinguished between their embodied experiences and the impact on supervision conversations about difficulties.

In conclusion, the findings from this study suggested a move in supervision conversations about therapist difficulties from inviting to intimacy towards a tendency to maintain distance. Various conditions contributed to the shift and will be further discussed in the subsequent Discussion chapter.

CHAPTER 5: DISCUSSION

5.1 INTRODUCTION

This research project aimed to provide insight into peer group supervisory processes deriving from supervision requests concerning therapist difficulties. I have explored the manner in which communication and interaction processes might contribute to ongoing learning and support of systemic practitioners displaying vulnerability. The objective was to generate ideas about strengthening peer group supervision practice within my organisation. I centred the study around the research question, *"What happens when systemic practitioners talk about their difficulties in peer group supervision within the Norwegian Family Welfare Service?*" The sub-questions were:

1. How are stories about therapist difficulties performed in peer supervision?
2. What are the communication patterns connected to stories about difficulties?
3. What conditions seem to affect the communication and interaction processes?

The analysis revealed a recurring shift from intimacy to distance in supervision conversations regarding therapist difficulties, which systemic practitioners linked to a perceived lack of help and support. Vulnerability was recognised in both the presentation and exploration of therapist difficulties. Presentations of difficulties were frequently ambiguous and brief, primarily focusing on issues concerning the clients and various aspects of the case. Communication patterns observed in stories about difficulties indicated that group responses were more inclined towards comprehending clients and determining therapeutic actions rather than delving into therapist positions and offering verbal acknowledgement. Embodied experiences were left unattended in both presenting and responding to therapist difficulties. While the supervision groups did produce comfortable and supportive supervision atmospheres, they struggled with staying with the therapists' difficulties and connecting with vulnerability. The findings suggested that an absence of institutional framing of the supervision practice contributed to restricting communication and interaction processes by producing insecurity. Furthermore, a cultural habitus of consensus seemed to stand in the way of creating a supervision context of curiosity and providing space for difference.

This chapter discusses central research findings in view of the research aim, literature findings and relevant theoretical perspectives. In line with my ontological view of a changing reality produced by different forces (Fox and Alldred, 2018), I am concerned with what the findings do and what could have been done differently to strengthen ongoing learning and support in peer group supervision. First, findings are discussed under the headings “Organisational workings” and “Relational and emotional workings”. Then, I discuss implications for practice, questions for further research and limitations of the study. Finally, I share concluding remarks on the study.

5.2 ORGANISATIONAL WORKINGS

The findings of this study revealed that the organisation of peer group supervision within the Norwegian Family Welfare Service relied on local practices rather than directions from an institutional level, thereby creating insecurity in the supervision groups. The following section will discuss these findings in more detail.

5.2.1 Taking position in discourse

The supervision groups participating in this study comprised systemic practitioners who met once a week to provide support and help each other navigate complex cases from therapeutic practice. Similarities in the organisation of supervision across groups were striking. The supervision session always started with getting an overview of and prioritising cases brought to supervision. A range from one to three cases would be prioritised. Each case conversations started with a story containing a supervision request. Thereafter, the group members would question the supervision request before responding to it by sharing reflections, points of views, experiences and providing advice. Despite these similarities, findings showed that there was not an institutional supervision mandate or framing of peer group supervision practice within the Family Welfare Service. In dialogues with the research participants, some said that they used a supervision structure decided on by the group members themselves while others relied on a taken-for-granted structure they used out of habit. Nevertheless, peer group supervision was viewed as an unquestioned practice across the supervision groups. In Group 1, Carl described the supervision as *“a custom”* that had become the norm. In Group 3, Emma experienced peer group supervision practice as *“institutionalised”* by the therapists. These findings suggested

that local Family Welfare Clinics were given autonomy to arrange peer group supervision practices. The fact that peer supervision practices are free of cost and relatively straightforward to organise possibly contributed to the opportunity of acting locally. Nevertheless, peer supervisory practice seemed to exist because it was considered necessary on a local level and not because of a mandatory claim from the institution.

Within the Norwegian context, supervision is mandatory in educational and specialisation programs for family therapists and family psychologists but merely a working method in the practice field (Flåm, 2016). Looking critically at this way of organising supervision practice, one could question the status of clinical supervision in Norway. Is supervision primarily regarded as essential for learning a profession? When there are no mandatory claims of clinical supervision within the Family Welfare Service, one is left with the impression of supervision on clinical practice as less important. The absence of an institutional mandate and structure for peer supervision appeared to suggest that the institution does not place value on clinical supervision. Should this be the case, it would contradict the prevailing stance in supervision literature, which often emphasises the significance of clinical supervision. In the literature, clinical supervision is typically described as “a crucial part of clinical practice” (Helps, 2021, p.209) and as “essential to good training and good practice” (Bertrando and Gilli, 2018, p.3). Aligned with this perspective of clinical supervision, the research participants demonstrated a firm belief in the significance of peer group supervision practices. The findings elucidated how they regarded peer group supervision as an essential practice within the institution, even in the absence of an institutional mandate, possibly from taking position in discourse.

Discourse is broadly defined as spoken interactions or written texts conveying a particular understanding of the social world (Potter and Wetherell, 1987, p.7). The way in which the participants legitimised their peer group supervision practice aligned with a persuasive discourse found in systemic supervision literature, which stresses the value of clinical supervision. The discourse was prominently featured in the literature review conducted for this study. Despite the lack of empirical evidence, the systemic literature extolled numerous benefits of clinical group supervision. Group supervision was commonly lauded for fostering the learning of systemic concepts and

practices (Butler et al., 2021; Senediak, 2014; Shaw, 2014; Simon, 2010; Bertrando and Gilli, 2018; Bownas and Fredman, 2017; Storm and Todd, 2014; Sheehan, 2017; Ulleberg and Jensen, 2017), despite the research gap on supervisory relationships and group processes (Clarke and Rowan, 2009; Burck and Daniel, 2018). The presumption of the learning benefits in systemic group supervision led me to ponder whether the discourse surrounding supervision within the professional domain was so influential that it drove an abundance of research on clinical group supervision.

Foucault expanded the idea of discourse by identifying a relationship between discourse and how people think, feel and act (Foucault, 2002; Willig, 2013, p.130). He stressed that a position in discourse offered a subject position that, apart from providing rights and opportunities, could also lead to restricted possibilities and limitations for the subject. This perspective is embraced within an organisational perspective on discourse, where discourse offers both a framework for understanding and a subject position that promotes a unique set of “rights, duties, and behaviours” (Campbell and Groenbaek, 2018, p.14). In this discussion, discourse serves not as an analytic tool but as a means to illustrate the interconnections between language use, supervision activities, subject experiences, and the institutional level of the Family Welfare Service. It appeared that the research participants perceived their “right” to engage in peer group supervision as stemming from their positioning within the discourse of clinical supervision. There existed a disparity between how the practitioners emphasised the importance of peer group supervision and the limited attention given to the clinical supervision practice at the institutional level. However, the study findings suggested that being positioned within the discourse merely facilitated the inclusion of peer group supervision as a regular activity at the Family Welfare Clinics. Despite this, there still appeared to be a need for guidance on group processes. The frequent move from intimacy to distance in peer group supervision conversations implied challenges related to staying with therapist difficulties and exploring vulnerabilities. The absence of an institutional framing of peer group supervision practice seemed to contribute to these challenges by producing a sense of insecurity that restricted how the practitioners engaged in curiosity and displayed emotions. This might not be surprising, considering the fact that there were no clear lines of responsibility or duty concerning the supervision practice, whether on a group or an institutional level. The interrelation between the discourse and the institution

became evident when looking at the organisational context as distinct from the discourse (Chouliaraki and Fairclough, 2010). At an organisational level, there was no contract, no framework to hold the supervision conversations, and no one responsible if anything should go wrong. The missing relationship between the discourse surrounding peer group supervision and its integration into the institutional structure of the Family Welfare Service seemed to lead to a supervisory practice not adequately rooted within the organisation. Ultimately, these findings underscored that a supervision discourse existing solely in language could not hold the supervision practice independently.

5.2.2 The need for guidance on group interaction

Research participants across groups reported that the lack of an overall supervision structure and institutional mandate could have a negative impact on group interaction and supervision outcomes. The findings unveiled a dearth of clarity regarding the objectives of peer group supervision practice. Participants often felt uncertain about their roles, leading to confusion during supervision. Further, the absence of a structured framework could cause anxiety. For example, in Group 3, Liam said that he *"felt unsure of who is the supervisor and the supervisee"* in the group. Stephen, from group 2, described that he could experience *"anxiety"* from being open in supervision because *"there are no guidelines"*. Some also had prior experiences of not being sufficiently helped and cared for in peer group supervision. Like Britt, in Group 2, who had experienced *"leaving supervision with a lump in my stomach staying for the rest of the day"*. Such challenges emphasised the need for a caretaking structure and institutional mandate to clarify how peers should work together in supervision.

The literature search undertaken for this study revealed a gap in the systemic research literature about group processes in clinical supervision. Nevertheless, the need for guidance on group interaction in supervision was commonly addressed. In their book *"Mirrors and Reflections"* about systemic supervision, Burck and Daniel (2018) raised concerns about the systemic supervision literature, noting a lack of attention to group processes and urging for explicit consideration of communication and interaction dynamics in supervision to enhance the overall supervisory experience. Similarly, Clarke and Rowan (2009) critiqued the systemic field for failing

to offer theoretical models to guide group processes in supervision, stressing the need for frameworks to address issues related to group dynamics and therapist support. They argued that the systemic field often idealised team functioning, neglecting the intricacies of communication and interaction. In a conceptual paper about reflecting processes in systemic group supervision, Paré (2016) echoed these sentiments, stressing the importance of structuring supervision conversations to foster a sense of safety within the group and facilitate productive discussions. He suggested that introducing structure in supervision could broaden discussions, allowing for exploration of diverse perspectives. The findings of existing literature underscored the significance of establishing an overarching structure and mandate to regulate peer group supervision activities within the Family Welfare Service.

Storm and Todd (2014, p.2014) claim that a best practice of systemic supervision should be accompanied by an agreed-upon, written supervision contract that clarify supervision terms, expectations, and responsibilities. Despite the absence of a supervision mandate, such a practice might provide some of the needed guidance in peer group supervision within the Family Welfare Service. A contract can be seen an agreement between two parties that creates an obligation to perform a specific duty. A supervision agreement forged between the local Family Welfare Clinic and its practitioners could effectively address the organisational hurdles described in this study. By outlining supervision objectives, delineating roles, and establishing a framework to govern group processes, such a contract could instil a sense of safety among group members and facilitate more effective outcomes in peer group supervision. Moreover, a supervision contract modelled after an institutional mandate could also be established between the institution and the Family Welfare Clinics. This institutional contract would ensure the commitment of local clinics to providing peer group supervision and outline a comprehensive supervision agenda aligned with the goals of the Family Welfare Service. Serving as a form of quality assurance, such a contract would lay the groundwork for continuous learning and support for systemic practitioners. An institutional contract or mandate could describe responsibilities, rights, and duties of systemic practitioners undertaking mandatory peer group supervision within the Family Welfare Service and thus formalise the supervision practice. A formalisation of peer group supervision could also include professional gatekeeping as an essential aspect of supervision, involving the assessment and

evaluation of systemic practice to ensure that therapeutic practice is conducted in adherence to the norms of the profession (Bownas and Fredman, 2017; Storm and Todd, 2014; Shaw, 2014).

5.2.3 Isomorphic learning in supervision

In identifying a supervision frame, it seems crucial to ensure a good fit between the supervision practice and the organisational context. Clinical practice within the Norwegian Family Welfare Service is commonly described as “systemic” (NOU 2019:20). Drawing upon the concept of isomorphic learning in supervision (Bertrando and Gilli, 2018; Simon, 2010), it seems beneficial to apply a systemic supervision frame that transfers to systemic clinical practice. A supervision model isomorphic to systemic practice adheres to established professional standards and facilitates learning through the form of the supervision practice and from engaging with peers. Thus, within this perspective, learning occurs not just through exchanges of information, reflections, and advice, but also through the structure and dynamics of supervision conversations. This linking of therapeutic processes with supervisory processes indicates that participating in supervision contributes to creating the social world and is typically addressed by social anthropologists. Lave (2019, p.117) critiques the dominant view of “learning as knowledge acquisition” in Western society. She finds learning in practice yields more powerful learning results than pedagogical efforts focused solely on acquiring information. Bateson (2000, p.170) characterises isomorphic learning as the repetition of learning experiences within a particular context, leading to the acquisition of habits. Ingold (2000, p.291) defines it as cultivation of embodied skills through practice experiences within a specific environment. Within the field of systemic psychotherapy, “the reflecting team” model is a typical example of a systemic supervision model isomorphic to systemic practice. The model was initially developed for clinical work with clients but also became widely used as a model for the supervision of systemic practitioners (Reichelt and Skjerve, 2013). It positioned the therapist as part of the observed system and applied a reflective team to provide the family system with multiple ideas instead of suggesting a solution to the problem. Opening up listening and talking processes in this way represented a collaborative way of expanding the perspectives of a “stuck” family or therapist.

It strikes me that peer group supervision practice at the Family Welfare Service might have developed from the original reflecting team model, even if the isomorphic perspective is not as strong anymore. Reichelt and Skjerve's (2013) study suggested that supervision based on the reflecting team model might not follow the original collaborative premises anymore. One might *think* of supervision as isomorphic to systemic ideas and practices but still fail to engage in supervision practices corresponding with professional ideas.

5.2.4 Expanding the supervision task

Interestingly, all the research participants agreed that peer group supervision aimed to provide emotional support to therapists and ensure quality in clinical practice. This happened despite the apparent freedom to define the supervision task as they liked due to the absence of an institutional supervision mandate. The findings did not disclose where the idea of supervision aims came from or why it was so synonymous. Nevertheless, my review of systemic literature revealed a distinction made between supervision as a way of learning by doing systemic practice (Bertrando and Gilli, 2018; Simon, 2010) and supervision as reflecting on systemic practice (Bownas and Fredman, 2017; Storm and Todd, 2014; Senediak, 2014). Some stressed the importance of critical thinking on how to engage in different relationships (Senediak, 2014; Simon, 2010; Shaw, 2014) and highlighted the significance of gatekeeping in upholding professional standards (Bownas and Fredman, 2017; Storm and Todd, 2014; Simon, 2010; Shaw, 2014). Others mainly focused on supervision as a means for the professional development of systemic practitioners (Bertrando and Gilli, 2018; Sheehan, 2017; Ulleberg and Jensen, 2017). By chance, I stumbled over yet another handbook in supervision called *Relational Processes in Counselling and Psychotherapy Supervision*. Here, Vetere (2021, p.170) is concerned with exploring relationships in supervision and offering succour to therapists having difficult emotional experiences. In line with the literature review's findings concerning isomorphic supervision processes (Bertrando and Gilli, 2018; Simon, 2010), she sees supervisory relationships as modelling what can happen in therapy. What makes her description of supervision stand out is the emphasis on care in response to emotional experiences. Although the emotional aspect of the therapist was not mentioned in the literature review, Vetere addresses the literature

gap by linking emotions, feelings, and affect more closely to systemic supervisory practice.

In the literature reviewed for this study, the concept of caretaking among practitioners appeared to focus on aiding therapists in adopting systemic approaches. However, participants in this study expanded this perspective by suggesting that therapeutic work could be emotionally taxing and isolating for therapists. An example is Emma from Group 3, who described supervision as an arena *"to ensure the quality of what we do"* but also *"to look after ourselves"* and *"not stand alone"* in demanding cases. Perhaps the oversight of providing emotional support to therapists in systemic supervision literature stems from concerns within the field that addressing therapists` emotional needs align more with psychoanalytic traditions, potentially conflicting with the focus on learning systemic practices and ideas. Nevertheless, supporting systemic therapists to cope with difficult experiences and emotions may foster a personal and professional growth that enhances therapeutic work and improves the quality of systemic practice (Bertrando and Gilli, 2018, p.6). Therefore, providing emotional support and ensuring quality in clinical practice are two closely linked objectives, also within the systemic perspective on supervision, even though the emotional aspect is often overlooked in systemic supervision literature. It appeared that practitioners within the Family Welfare Service had expanded the traditional view of supervision as primarily an arena for learning to include therapist caretaking, more in line with Vetere`s (2021) description of supervision.

5.3 RELATIONAL AND EMOTIONAL WORKINGS

The results of this study unveiled the impact of relational and emotional factors on group dynamics, potentially impeding therapists` capacity to manage challenges in peer supervision. Presenting and responding to therapist difficulties evoked a sense of vulnerability in the supervision groups, thereby constraining communication and interaction processes. The emphasis on linguistic expertise in supervision seemingly overshadowed bodily responses to difficulties, relational experiences, emotions, and the embodiment of cultural norms. This section will discuss these findings in greater depth, examining their implications.

5.3.1 Exposing difficulties to peers

Within this study, it was noted that six out of eleven cases discussed during peer group supervision sessions revolved around challenges experienced by the therapists. The way of prioritising cases for supervision seemed to ensure the inclusion of those concerning therapist difficulties, suggesting their significance. This focus on therapists within supervision aligns with a fundamental systemic concept regarding therapeutic relationships, which emerged from the shift to a second-order perspective in systemic psychotherapy: namely, that the therapist is an integral part of the observed system and collaboratively constructs reality with the clients (Mason, 2018). Consequently, the professional field has embraced reflexivity to explore the therapist's impact on therapeutic endeavours. In accordance with this focus, the supervision requests examined in this study concerned systemic practitioners` experiences of difficulties in their interactions with clients. The therapists reported feeling insecure about their competence, struggling to empathise with clients, and encountering challenges in navigating therapeutic processes. These difficulties indicated a need for emotional support and insights from peers.

According to Flaskas (2018), profound emotional experiences such as feelings of shame and blame can arise when therapists find themselves stuck in therapy, rendering them vulnerable. Sharing difficulties from clinical practice with peers in supervision, as suggested by Paré (2016), may further heighten this vulnerability. This could elucidate why some of the research participants in this study exhibited hesitance in presenting their difficulties during supervision sessions. For example, in Group 3, Liam described that he could *“hold back”* when presenting a case because he was *“afraid of being misunderstood”*. The systemic practitioners made themselves vulnerable by revealing personal difficulties through supervision requests and appeared somewhat ambivalent about expressing the difficulties vis-á-vis peers. The ambivalence was also evident from performances of difficulties. The practitioners requested supervision to deal with personal difficulties experienced from conducting the role of a therapist. However, the story following a supervision request was primarily about the clients. Sometimes, the therapist's difficulties almost drowned in detailed stories about the clients. Other times, using vague language, pauses, and unfinished sentences contributed to making supervision requests unclear. The poor performances of therapists` difficulties and perceived ambivalence might indicate the

emotional strain of therapists feeling stuck in clinical practice and vulnerable within the group setting. Drawing from the literature review, encountering resistance towards sharing personal difficulties in group supervision is not uncommon. In a study examining non-disclosure in supervision, Zvelc and Zvelc (2021) revealed that supervisees withheld information deemed important for the supervision process in 21% of the sessions. It was most prevalent to disclose personal details regarding the ongoing therapeutic work and dissatisfaction with the supervision group. Participants cited feeling unsafe, shameful, and fearing negative repercussions as significant reasons for withholding information. A similar discovery was made by Clarke and Rowan (2009), who noted that despite the commonly reported benefits of systemic group supervision, group members also described negative experiences such as anxiety, self-doubt, competitiveness, shame, and conflicts.

The therapists requesting supervision appeared to encounter challenges in articulating their difficulties, prompting the question of whether they struggled to express vulnerability. Most descriptions of therapist difficulties were notably brief, failing to provide detailed formulations of how these difficulties were experienced on an emotional level. An exception was Liz, in Case 2. When presenting her difficulties, she described feeling *“such irritation, simply”* towards *“that woman”* in a couple she was working therapeutically with. Most often, the therapists requesting supervision were vague, like Steven in Case 3, who described noticing *“some kind of discomfort”* from the way he positioned himself in a conversation with a young girl without providing further explanation. Similarly, in Case 4, Liam described a problematic moment in therapy by referring to what he did and not how the moment was felt, saying*, “The easiest way for me was like (he laughs) to overlook what had happened”*. Therapists tended to present their problems in an objective manner, stressing the main points of their stories by using adjectives and repetitions. References to feeling vulnerable were rare, with occasional hints conveyed through performative laughs. This pattern may reflect that emotions and affect have traditionally not been integrated into the training of systemic psychotherapist (Dallos and Draper, 2015). The professional focus has primarily been on helping clients address relational issues through improved communication, often overlooking emotions, affect, and embodied experiences. In this study, therapists` vulnerability was evident but not explicitly articulated. When vulnerability is only implied, it

becomes challenging for supervision groups to delve into the therapist's emotional experiences. Sundet and Wie Torsteinsson (2018, p.111), along with others advocating for increased attention to emotional exchanges in contemporary systemic family therapy, raise a valid point. Establishing a space for emotional sharing in supervision appeared essential for the ongoing learning and support of systemic practitioners.

In dialogues with the research participants, some explained that their difficulties were ambiguous when they presented the supervision request. They felt something was difficult, but it was hard to describe the problem accurately. Emma, in Group 3, said that she had *“this idea”* about her supervision request, but it was *“not completely clear”* to her, and she needed *“the space”* and *“the acceptance”* in the group to figure it out. In a similar vein, Mia in Group 4 mentioned how focusing on defining her felt problem in supervision *“triggered new reflections”* and helped her *“move on”*. These findings indicated the importance of addressing bodily sensations and experiences when examining a supervision request. However, none of the therapists were probed about their embodied experiences. The findings showed that experiences of difficulties were rarely questioned at all. Despite poor performances of difficulties, most questions about a supervision request focused on the case itself or the formulation of the request. This is noteworthy, considering that the supervision requests pertained to the therapist`s experiences of difficulties, highlighting the importance of exploring these experiences. However, the findings also revealed a vulnerability associated with being questioned about therapist difficulties, contributing to the argument about ambivalence towards disclosing personal challenges. For instance, in Case 2, the supervision conversation nearly faltered when Julia delved deeper into Liz's negative feelings towards the client. It can be inferred that peers may sense the vulnerability of a colleague seeking supervision and, as a result, refrain from asking clarifying questions about emotions, affect and bodily experiences. This approach may stem from a sense of caretaking but could ultimately impede the provision of adequate support. If an unclear supervision request is not scrutinised and explored, providing sufficient assistance and care might become challenging.

5.3.2 Engaging in reflexive practice

Being stuck in therapy can be experienced as emotionally draining for therapists. Flaskas (2018, p.122) calls for supervision practices where the therapists` “inner dialogues about stuckness” are explored to address this dilemma. She views curiosity as essential in systemic, reflective supervision practice. However, this study on peer supervision practice revealed obstacles to reflexivity and the exploration of therapist difficulties. The supervision groups appeared more focused on understanding clients` inner worlds and behaviour than delving deep into the therapists` challenges. A distancing from therapists` experiences of difficulties was observed, prompting speculations about whether systemic therapists were assuming an expert stance in supervision. This pattern not only challenged the systemic notion of self-discovery and the development of systemic practice through supervision but also contradicted the part of the supervision task defined by practitioners as providing emotional care to therapists.

In the literature review conducted for this study, reflexive considerations were consistently highlighted as essential in systemic supervision practice (Givropoulou and Tseliou, 2020; Butler et al., 2021; Senediak, 2014; Reichelt and Skjerve, 2013; Bingle and Middleton, 2019; Smith, 2022). Reflexivity in supervision was generally described as reflections on how practitioners engaged in relationships with clients and their impact on therapeutic outcomes (Givropoulou and Tseliou, 2020; Bingle and Middleton, 2019; Smith, 2022). Smith (2022) differentiated between reflective and reflexive practice, with reflexivity placing emphasis on therapists` emotional experiences. From this perspective, therapists' inner dialogues regarding being stuck in therapy could be considered part of reflexive supervision practice. Givropoulou and Tseliou (2020) discovered that practising reflexivity in supervision groups fostered a safe environment that positively influenced practitioners` emotional coping, professional confidence, and facilitated new ways of thinking. This outcome is intriguing, given that it directly addresses therapist difficulties as described by participants in this research project.

However, the lack of reflexivity and challenges with approaching therapist difficulties may not be unique to the Family Welfare Service. These findings are consistent with various findings from the literature review. For instance, Reichelt and Skjerve (2013) discovered that in their investigation into the use of the reflecting team approach in

systemic group supervision among Norwegian psychologists, therapists were encouraged to discuss the case, and group reflections predominantly stemmed from expert positions. Similarly, two studies focusing on systemic group supervision in UK Child Protection Services (Bingle and Middleton, 2019; Smith, 2022) identified a lack reflexivity. Bingle and Middleton (2019) described the findings of linear statements and pathologising discourses in supervision as failing to grasp the second-order position in systemic practice. Smith (2022) described linear thinking and reductionist cause-and-effect reflections in supervision as “incongruent with systemic practice”. Reichelt and Skjerve (2013) understood the result of their inquiry given the development within the professional field from looking at clients as experts to regarding the therapists as experts, stemming from an increased emphasis on evidence-based practice.

Keeping a distance from therapist difficulties appeared to hinder reflexivity in peer group supervision. However, it might also be the other way around. Givropoulou and Tseliou (2020) found that reflexivity yielded positive outcomes in clinical supervision and should be regarded as a skill that needs to be learned. The absence of playing with various ideas and curiosity in peer group supervision at the Family Welfare Service raises questions about the need for a clearer definition of supervision as a learning environment. There might not be sufficient space for therapists to indulge their curiosity, make mistakes, rehearse, and try again in the process of learning systemic skills and concepts.

5.3.3 Fear of overstepping boundaries

From sharing my ideas and thoughts about what happened in supervision with the research participants, I learned that they needed a clear invitation to explore the vulnerability of a peer for it to feel safe. Such clarity was often not provided through performances and clarifications of a supervision request. For this reason, some practitioners reported insecurity and fear of overstepping boundaries when responding to a supervision request. To illustrate, Emma in Group 3 described how she could worry about being *“caring enough”* after a supervision session. Some practitioners had prior negative experiences from overstepping peers' boundaries that impacted their present experience in supervision. This was the case with Britt, in Group 2, who explained*, “It does not take much in recent years before I feel I have*

done something wrong". Another dilemma could be the fear of overstepping boundaries due to hierarchical roles held within the group. In Group 3, Liam said he *"would not have explored Emma's vulnerability"* because she was the clinic leader. This finding implied that equality was embraced in the supervision groups without considering the manner in which the group composition reflected hierarchical roles within the larger system. The groups acted as equals, although this was not the case. A clinic leader holds power over the therapists in all aspects of the job and can hardly expect that this position only applies in specific work-related contexts. Holding the role of a leader seemed to produce a greater distance to intimacy than holding the role of a therapist.

The apprehension of crossing boundaries in supervision appeared to lead to a move from intimacy to distance in peer group supervisory practices at the Family Welfare Clinics. The pattern of responses subsequent to a supervision request indicated that few delved into therapists` perspectives. When discussing this finding with Group 2, Britt explained that it felt *"safer"* to talk about the clients and what to do in therapy. A reluctance towards pursuing therapist difficulties in supervision seemingly contributed to the overflow of responses addressing the clients and what to do in therapy. While this approach to supervision may have fostered a sense of safety among group members, the therapists seeking supervision were not necessarily satisfied. In Group 3, Liam articulated feeling vulnerable when requesting supervision and coming out with *"a bunch of suggestions"* about what he should have done was *"the worst"* experience. In Group 2, Steven expressed discontent with the supervision he received, claiming that it did not provide him with any new perspectives. These findings indicated that moving away from difficulties and vulnerability in peer supervision was linked to a diminished supervision outcome and a sense of not receiving assistance or support. Considering the supervision task, defined by the research participants as providing emotional support to the therapists and ensuring quality in clinical practice, it appeared that this task was not being fulfilled. There was a discrepancy between how practitioners defined the supervision task and their responses subsequent to a supervision request.

Vulnerability was also noted from receiving responses to a supervision request, giving relevance to the fear of potentially overstepping the boundaries of a peer.

When Steven withdrew his difficulties by the end of the supervision in Case 3, it appeared to be influenced by a challenging group dynamic. This finding underscored the delicate balance between providing support and challenge in group supervision. While some literature on supervision emphasised the importance of critical evaluating therapists` practices (Senediak, 2014; Simon, 2010; Shaw, 2014), the results of this study suggested that being challenged in supervision could lead to feelings of vulnerability or exposure among peers. Mason (2018, p.158) sees taking position within a supervisory relationship as taking relational risks by deciding how much someone should be challenged. He advocates for taking relational risks to initiate change processes and expresses concern that the growing emphasis on collaborative practices within systemic psychotherapy may undermine risk-taking in systemic practice. The findings from this study support Mason`s concern, as the therapists seemed to avoid relational risk-taking and critical examination of systemic practice in peer group supervision.

Turning to Bion's theory about “anti-task” behaviour in groups (Bion, 1968) might be relevant in comprehending interactional patterns in peer group supervisory practice within the Family Welfare Service. Bion`s conceptualisation illustrates how collective group defences arise from group anxieties, manifesting as anti-task behaviour (Stein, 2022, p.243), which serves to shield individuals and groups from emotional distress, potentially becoming entrenched with organisational culture and structure. Observations from Group 4 prompted reflections on whether therapists hesitated to discuss their cases in supervision, despite it being a designated task. From an anti-task behaviour perspective, therapists may avoid discussing cases in supervision due to the emotional toll, even though it is expected. This may also explain the observed response pattern, where avoidance of discussing difficulties appeared embedded in supervision structures. Bion distinguishes between group behaviours driven by rationality and those rooted in emotional needs and anxieties, introducing “work groups” focused on task-oriented activities and “basic assumption groups” characterised by stress-induced interaction patterns (Bion, 1968; Scott and Stradling, 2022, p.152). Practitioners expressing fears of misunderstanding and exposure in supervision suggested underlying anxieties within peer supervision groups. Their struggle to address therapist difficulties and foster a context of curiosity indicated a stressed group dynamic, interpreted as anti-task behaviour, stemming from basic

assumption activity. Similar findings by Smith (2022) in UK child protection services underscored the need to address complex emotions in group supervision to prevent defensive practices denying emotions in clinical supervision and social work practice. Reforming peer group supervision within the Family Welfare Service seems necessary to rebalance group processes and improve group dynamics. Attending to what is being made from the processes of communication interaction in supervision groups provides an opportunity to make something different (Pearce, 2006), crucial for stressed peer supervision groups seemingly conducting anti-task behaviour and basic assumption activity.

5.3.4 Ensuring the safety of group members

Findings from this study indicated that peer group supervision practice was fragile, with many potential hindrances to impactful group processes. In dialogue with Group 3, Emma described the move from intimacy to distance in supervision as *"a loss"* and a feeling there was something they got *"too little of"*. It seems crucial to ensure the comfort and safety of group members to create an arena of curiosity and learning in group supervision (Zvelc and Zvelc, 2021; Smith, 2022; Givropoulou and Tseliou, 2020; Smith et al., 2012). In this regard, there might be a need for increased safety in peer supervision groups within the Norwegian Family Welfare Service to address vulnerability and more successfully explore therapist difficulties.

Zvelc and Zvelc (2021) uncovered a link between non-disclosure in supervision and feeling unsafe within the supervision group and found that the supervisor's ability to create trust in the supervision group greatly impacted group supervisory processes. Givropoulou and Tseliou (2020) and Smith (2022) discovered a correlation between supervision outcomes and a supportive, engaged, and non-judgemental supervision group. It might be relevant to look towards outcome research on psychotherapy outlining the importance of the relationship between the therapists and clients when addressing the importance of safety in the supervision group. Put succinctly, psychotherapy research finds that the strength of the therapeutic relationship determines the outcome of therapeutic work (Wampold and Imel, 2015). Further, the quality of relationships depends on the therapist's ability to engage in an empathic, genuine, and collaborative relationship with the client (p.56). The same principles

seem relevant in peer group supervision, even if the group context holds multiple relationships with less power imbalance.

Mason (2018, p.164) suggests that taking risks and building trust are interconnected processes, with taking risks potentially contributing to greater trust in the relationship. He underscores that trust does not necessarily need to be established before taking risks, as these factors mutually affect each other. In this view, maintaining distance by refraining from probing therapists` experiences of difficulties would be counterproductive. Therapists who seek supervision due to personal challenges are already taking a relational risk by disclosing their difficulties to peers. If peer responses involve maintaining distance from these difficulties, it could impede the establishment of trust within the supervision context. Although the therapists might be signalling it is not entirely safe to explore their difficulties further, they *did* ask for supervision. When peer responses exhibit a tendency to maintain distance, it could further burden vulnerable therapists and reinforce a perception of the supervision context as unsafe.

The peer supervision groups at the Family Welfare Service appointed a therapist to initiate the supervision process and keep track of time. However, none of the group members were tasked with ensuring the comfort of their peers. While not compared with a lack of leadership, insights from the literature review indicated that outcomes of systemic group supervision heavily relied on the leadership style within the supervision group (Smith, 2022; Givropoulou and Tseliou, 2020; Zvelc and Zvelc, 2021). In groups where the supervisor assumed a facilitator role, encouraging group collaboration and fostering reflexive practice, the level of group anxiety tended to be low (Smith, 2022) and reflexivity notably high (Givropoulou and Tseliou, 2020). Conversely, when the supervisor adopted an expert role, the outcomes were contrasting: heightened anxiety levels and a lack of reflexivity. In many ways, these findings align with the perspective of leadership as collaborative practice, emphasising what people can accomplish together through group engagement (Raelin, 2011). Leadership-as-practice involves all members of a group, contrasting with traditional leadership reliant on a single individual mobilising actions on behalf of others (Raelin, 2016, p.4). Within this framework, the conventional supervisory and evaluative leader role is relinquished in favour of collective collaboration. While

certain individuals within the group may take on leadership roles due to perceived insight, ultimately, all members bear responsibility for the group`s outcomes. It appeared that the structure of peer group supervision in the Norwegian Family Welfare Service aligned with a leadership-as-practice model, although its effectiveness is debatable. Echoing concerns raised by Clarke and Rowan (2009), there is a question of whether leadership-in-practice presents an idealised view of group processes. The findings of this study imply the significance of a designated group leader to steer supervisory processes towards staying with difficulties and emotions, attending to safety in the group, fostering trust relationships, and facilitating reflexive practice.

5.3.5 Connecting with embodied experiences

According to Shouse (2005), affect determines the intensity of feelings and felt experiences. Findings from this study illustrated that affect was rarely addressed in the peer groups, and the body was ignored. Nevertheless, there seemed to be a connection between bodily felt affect and the therapists` trouble with describing their difficulties in supervision. Some research participants explained that poor performances of difficulties could appear due to challenges with putting felt experiences into words. Although they felt a distinct need for supervision, they struggled to describe bodily experiences. A poignant case in point is Case 4, where wordy, vague, and collapsed sentences made it difficult to catch Liam's supervision request. When we later discussed his unclear presentation, Liam explained his way of talking from constantly trying to *“notice that the words fit”* with how he was *“feeling it”*. His explanation pointed towards bodily felt affect. Deleuze and Guattari view affect as a preconscious, bodily force outside language and discourse (Deleuze and Guattari, 1996; Brian, 2017). Within this perspective, bodily felt affect is a distinct way of knowing beyond cognition and language. It signifies a nonconscious way of thinking with the body and might explain why the therapists were struggling with putting their felt difficulties into words. The idea links with Shotter's (2004) relational understanding of communication and his description of bodily responsiveness as a way of knowing. Using the body as a source of knowledge can prevent experience from being limited to the mind (Afuape, 2017). Attending to affect and the body represents a significant knowledge source. Csordas (2002, p.241) applies the term “embodiment” to explain how the body relates to the subject's experiences from

engaging in the world. Flaskas (2018, p.17) calls for embracing embodiment to explore the space between conscious and unconscious experiences in order to enrich stories about being in the world. Reading from these literature findings, connecting with embodied experiences in peer supervision bears the potential to expand and enrich stories about therapist difficulties. As far as the literature reviewed undertaken for this study is concerned, affect and emotions are not mentioned. However, being responsive to the body in supervision aligns with Simon's (2010) perspective of expanding boundaries in systemic supervision.

The findings indicated that therapists encountered difficulties in articulating their difficulties, highlighting the need for support in accessing embodied knowledge. Unfortunately, therapists seeking supervision received minimal assistance in this regard. Initially, offering a protected space for presenting supervision requests without group interference may appear benevolent. However, the absence of interaction and verbal support likely led to the generation of unclear supervision requests and adversely affected group supervisory processes. Receiving support from the group in identifying and articulating difficulties could have facilitated their description, making it easier and safer for therapists to express themselves.

When failing to identify an explicit supervision request in Case 6, the group used the supervision conversation to clarify Mia's felt difficulties. Mia described this process as impactful as it helped her stay open to different understandings of the difficulties experienced. Afterwards, she felt *"really carried, cared for and framed"* by her peers. The finding suggested that identifying therapist difficulties could be as important as navigating in peer supervision conversations. Helping therapists uncover unconscious affective knowledge can broaden their perspectives and open up for seeing novel therapeutic pathways. Focusing on the body, senses, and emotions offers vital insights even before conscious awareness kicks in. Therefore, exploring and learning about therapist difficulties alongside peers seemed as crucial as resolving tangible problems brought to supervision.

Simply being a part of an engaged and empathetic peer group can fulfil substantial emotional requirements such as acknowledgement, warmth, and intimacy (Armstrong, 2022, p.136). As a participant observer in this research, I personally

experienced a palpable embodied connection with the supervision groups. For example, in my field notes from Case 1, I noted that *"I feel myself drawn towards this group"*. I further explained*, "There is something very respectful about how they listen, check out and reflect that I like so much"*. This experience illustrated that being part of a group can indeed be a powerful experience. Merely being a member of a peer supervision group can provide a sense of belonging, closeness, and recognition. However, a group membership also provides opportunities to take up authority. Carl, from Group 1, described prior problems with peer group supervision practice by pointing to therapists who became greedy with words and *"could sit and talk endlessly"*. The literature review implied that such problems might not be a rarity. In their study, Reichelt and Skjerve (2013) noted that the reflecting team could become so absorbed with their own conversation that they lost focus on the dilemma presented by the supervisee. This contributes to the notion of possible obstacles in peer group supervision. While being part of a supervision group can offer support in its own right, there is potential for things to veer off course.

5.3.6 Relating to things and surroundings

The findings illustrated how the systemic practitioners related to things and surroundings within the supervision space. The majority of therapists expressed that they were influenced by the environment of the supervision room during their sessions. Nevertheless, they had not previously considered this aspect of interaction to a significant extent until I broached the topic in our group dialogues. For certain therapists, a well-organised and aesthetically pleasing room fostered feelings of tranquillity and serenity. Conversely, they found themselves unsettled by a messy and cluttered space with numerous items. For example, Sarah in Group 2 disliked the supervision room because *"it was messy"* and all the chairs put her in *"a bad mood".* Several mentioned the importance of windows in the supervision room and how they contributed to a better feeling than sitting in a windowless room. In Group 4, Mia described how looking out of the windows of the supervision room helped *"her mind"* to *"travel much further"*. Grace added that she could *"get inspired"* from looking out of the windows and get hold of *"an inner peace"*. Thus, the interior of rooms seemed to influence the felt experience of being in the supervision session. Being comfortable with the things and interiors of the supervision room appeared to provide positive feelings and make it easier to think. Nevertheless, the therapists distinguished

between felt experiences and outcomes of supervision conversations about difficulties. To illustrate, Pamela from Group 4 had *"a much better feeling"* sitting in a supervision room with windows but did not know if she would have *"said or done anything else"* if she had been in a windowless room. These results suggested that therapists endured the physical aspects and décor of supervision rooms even when they found them disruptive or hindering the creation of a peaceful atmosphere. However, it could also indicate that therapists were not accustomed to considering bodily sensations arising from interactions with physical surroundings, leading to difficulties in connecting embodied experiences with supervision conversations. Notably, the literature review conducted for this study did not mention the body, revealing a considerable research gap concerning embodiment as a condition that might affect communication and interaction processes in systemic group supervision. Consequently, descriptions of systemic practice may be criticised for being language-based and reductionist, failing to attend to the embodied mode of understanding.

5.3.7 Co-producing comfortable atmospheres

Although affect was rarely addressed in supervision conversations and an absent theme in the literature review, the peer groups all "did" affect. The participant observations revealed how the supervision groups created a good "felt" atmosphere to explore therapist difficulties and vulnerability. The supervision rooms had a pleasant mood, produced by peers being attentive and supportive towards each other. Disagreement hardly ever emerged, and there was no sense of controversy. The systemic practitioners were very polite towards each other, illustrating their support of peers in various ways. Despite the limited acts of verbal acknowledgement and empathy within the groups, caregiving appeared to be performed through bodily gestures and the creation of comfortable atmospheres within the supervision space. Support was bodily expressed by the way in which the therapists listened attentively to stories about difficulties. Non-verbal cues such as nods were employed to reassure the speaker of understanding, while smiles conveyed warmth and acceptance. Peers respectfully listened to one another without interruptions, using voiced sounds to demonstrate interest and engagement in the shared story or reflections. Afuape (2017, p.102) describes this kind of embodied collaboration as powerful and deeply felt, assuring that group members are physically and mentally stimulated. In line with this kind of description, Mia from Group 4 felt the affect in the

supervision room as *“a flow of love”* and *“an energy”* that she could *“bathe in”*. In her group, the lack of verbal support felt redundant due to the positive energy produced in the supervision room and the sense of support from the group. Emily even suggested words could have *“punctuated”* the felt affect in the room. In contrast, Emma from Group 3 described the lack of verbal recognition and empathy in supervision as *“a loss”*. In her experience, not uttering recognition and empathy could leave the therapist uncertain of the group's evaluation of the difficulties displayed. These conflicting findings suggested that while a supervision atmosphere may indeed foster a comfortable mood for delving into therapist difficulties, this alone may not be enough to adequately support a therapist exposing vulnerabilities. While the atmosphere and sensory experiences within a supervision space seemed important, they did not always provide the necessary level of support and care in peer group supervision.

In the supervision conversations, there was a widespread practice of mirroring responses and agreeing with each other. This communication style generated a strongly felt sense of consensus within the groups and contributed to producing comfortable atmospheres. However, the communication style also prevented different perspectives from emerging in supervision by producing much of the same. In my field notes from Group 2, I noted that Steven was *“merely challenged in the supervision”* and *“little newness came”* from the supervision conversation. In dialogue with Group 3, Leah explained that *“most of the time”*, they would thank each other for the supervision, even if she *“wanted to say”* that the supervision was of *“no help”*. She add*ed, “I don't”* and *“We don't do that”*, as if she was referring to a well-known practice where the therapists kept their inner dialogue about negative experiences with supervision private. In Group 4, Emily felt they were trying so hard to be similar in supervision that she questioned the production of *“sufficient difference for providing a proper quality assurance”*. Regarding similar perspectives as a potential obstacle to the supervision task of ensuring quality in clinical practice corresponds with the conclusion drawn from the literature review. Within the systemic supervision literature, contemporary supervision practice was linked with inviting multiple perspectives into the supervision conversation to broaden the therapists' understandings of clinical practice (Smith, 2022; Reichelt and Skjerve, 2013; Givropoulou and Tseliou, 2020; Bingle and Middleton, 2019; Senediak, 2014; Simon,

2010; Butler et al., 2021). This view of supervision was perceived as a distinctive feature of systemic supervision practice, aligning with the notion of the therapist being an integral part of the observed system (Mason, 2018), along with the emphasis on reflexivity (Givropoulou and Tseliou, 2020; Bingle and Middleton, 2019; Smith, 2022). Prioritising the production of comfortable supervision atmospheres over adhering to systemic supervision guidelines can impede ongoing learning and development in supervision. Further, choosing not to share constructive critique about what is made from supervision can hinder improving and developing peer group supervision practice. To address the risk of stagnation, the therapists need to engage in discussions about what they collectively produce in supervision.

5.3.8 Entangled in cultural practice

In this study of peer group supervision, the supervision space was used by white, mostly middle-aged, well-educated therapists. Most of the therapists were women. Everyone belonged to the majority culture of Norway. The homogeneous outlook in the supervision groups suggested that what happened in supervision might be entangled in a distinct cultural practice. Some of the research participants recognised the homogeneous outlook of the supervision groups as representative of the Family Welfare Service. For example, from Group 1, John was of the opinion that the Norwegian Family Welfare Service was *"even more homogeneous"* than most other workplaces. He alluded to the systemic practitioners within the organisation as *"white", "of the same social class"*, and having similarities *"in terms of age".* This perspective of the supervision practice triggered my interest in the broader Norwegian context and how culture might affect communication and interaction processes in supervision.

The research findings revealed a peer group supervision practice characterised by agreeing and consenting to each other's responses. In the initial analysis, I thus questioned if there was a habitus of consensus across supervision groups. Therapists might be unaware of their cultural habits, as culture often exists outside people's consciousness through embodied modes of knowledge and structures (Krause, 1998). Bourdieu (1998, p.8) uses the notion of habitus to describe the embodied aspect of social interaction following unconscious habits and routines. He describes how human interaction can manifest as ingrained habits shaped by social

norms, leading to repetitive behaviours. These interactions reproduce specific cultural practices, known as habitus. From this perspective, peer group supervision practice at the Family Welfare Clinics might be seen as a structure of habitus reinforcing familiar patterns through the reproduction of sameness. When presented with the initial analysis, the research participants attempted to interpret the perceived consensus-driven habitus. The majority of them pointed to the homogeneous group compositions in order to explain what prevented the production of different points of view in supervision. The finding suggested that similarities blocked the entrance of differences in supervision, and a cultural structuring of the supervision groups impacted what happened during supervision conversations. The emphasis on similarity aligned with ethnographic findings about equality as *likhet* (sameness) in the Norwegian culture (Gullestad 2002; Gullestad, 2010). From her ethnographic study of everyday life in Norway, Gullestad argues:

> "The Norwegian definition of equality implies a considerable emphasis on being and doing the same" (Gullestad, 2010, p.185).

Norwegians are expected to adhere to egalitarian traditions, norms, and values (Dankertsen and Lo, 2023). However, the connection between Norwegian egalitarianism and the cultural notion of equality as sameness challenges the general opinion of equality as entirely beneficial. Consistent with the findings from my study, Gullestad (2010) observed that sameness practice typically resulted in communication processes where social actors emphasised what they had in common while neglecting differences (p.193). If differences became too great, avoidance and distancing were used as "symbolic fences" in social interaction to maintain the cultural idea of equality as sameness. Within this cultural practice, there existed an implicit risk of social actors being alienated if they appeared too different, implying that similarity contrasted the egalitarian notion of equal worth. The cultural sameness idea could elucidate why hierarchical differences within peer supervision groups appeared to be disregarded. Under-communicating hierarchical differences might perpetuate the perception of equal worth. Similarly, a culturally conditioned sameness practice might account for the prevalence of consensus within peer supervision. From a cultural standpoint, a sameness-conditioned supervisory practice could be employed to foster intimacy and closeness in peer relationships. This pursuit of

closeness may be deemed more significant than the exploration of diverse perspectives, positions, and constructions in supervision. Thus, from a cultural perspective, cultivating closeness with peers in supervision may contrast with developing closeness to the difficulties they faced.

The strength of the consensus habitus was implied through observations and bodily felt affect when the practice of agreeing and mirroring responses was challenged. In Group 2, tension was palpable in the supervision room when Steven critiqued the supervision by suggesting that nothing new was produced. In the field notes, I noted that one of the therapists in the group *"takes off her knitted jacket"* as if what happened made her warm. Further, I was *"holding my breath a little"*, nervously waiting for what would happen next. These observations implied that we both reacted bodily when the social interaction deviated from the consensus norm. I personally experienced how this response evoked a sense of intuitive, embodied understanding that diverged from my intellectual comprehension. Despite agreeing with Steven's criticism of the supervision group, I strongly sensed that offering critiques was inappropriate. Reflecting on this embodied reaction, I realised that I too was influenced by the consensus habitus. The cultural norms were embodied in me and impacted the way I perceived the situation. However, a strong cultural idea about sameness does not mean other forms of social interaction can be valued, and the idea is not applicable across all contexts (Bruun, Jakobsen and Krøijer, 2018). It might be easier to achieve benefits from peer group supervision if the value of equality as sameness was replaced by values suggesting the importance of genuine communication, autonomy, and collective group membership.

5.4 IMPLICATIONS FOR PRACTICE

In this section, I summarise and discuss implications for practice and further research questions arising from this study. First, I address the implications for peer group supervisory practice within the Norwegian Family Welfare Service. Next, I discuss the implications for the field of systemic psychotherapy. Eventually, I identify questions for further research and make notes on the study's strengths and limitations.

5.4.1 Implications for peer group supervisory practice

An overall implication arising from this research project is the need to reorganise and restructure peer group supervision practice within the Norwegian Family Welfare Service to strengthen ongoing learning and support within this context.

A key finding emerging from the study underscores that conducting peer group supervision without an institutional mandate negatively impacts supervision outcomes. This contextual backdrop significantly influences what can and cannot happen in peer group supervision when therapists display vulnerability. An implication discerned from this finding is the imperative for an overarching, clearly defined supervision framework that delineates supervision objectives and outlines how practitioners should work together in peer group supervision. Formally aligning peer supervision practices with institutional objectives and attributes serves as a quality assurance mechanism for the Family Welfare Service, safeguarding both the institution`s systemic identity and the standard of clinical practice. Conversely, an institutional framework for peer group supervision could function as a professional gatekeeper (Shaw, 2014; Bownas and Fredman, 2017; Storm and Todd, 2014). An institutional mandate works as a contract, ensuring that all systemic practitioners engage in clinical peer group supervision and, thus, professional development and learning. Peer group supervision grounded as an institutional practice thus addresses the organisational, professional need for clinical supervision, protecting the characteristics of the Family Welfare Service. However, an institutional grounding of peer group supervision practice would also benefit the therapists working at the Family Welfare Clinics. The lack of a defined supervision frame and mandate produces insecurity in supervision conversations about therapist difficulties restricting communication and interaction processes. The implication for practice is that an institutional mandate and framing of the supervision would strengthen group processes by providing a collective sense of security, direction, and guidance in line with institutional tasks and characteristics.

The study further illustrates that the current structuring of peer group supervision conversations is insufficient for providing adequate support and learning to systemic practitioners. Supervision conversations with loose guidelines might appear appealing for autonomic therapists. However, the results from this study imply that a preordained, caretaking supervision structure is required for more impactful

communication and interaction processes in peer group supervision. The supervision structure must address how to support therapists in describing difficulties and clarifying supervision requests, including attending to embodied experiences and emotions. The structure must also guide how to pursue difficulties and explore vulnerability in supervision to address ambivalence and insecurity identified in responding to supervision requests about therapist difficulties. The research findings imply the need for a peer group leader to attend to what is made from supervision and ensure the safety of group members. The literature findings underline the implication. Even with an institutional holding of peer group supervision practice and a preordained supervision structure, it seems prosperous to have a group leader with authority to steer supervision conversations in a systemic, collaborative and caretaking way (Smith, 2022; Zvelc and Zvelc, 2021; Givropoulou and Tseliou, 2020).

Deciding on a preordained supervision structure goes beyond this research project. Nevertheless, the literature findings imply that a supervision structure corresponding with systemic ideas of learning and developing in systemic practice prompts impactful learning processes in the context of clinical supervision (Bertrando and Gilli, 2018; Simon, 2010; Lave, 2019). Such processes include reflexive considerations on how the therapist engages in client relationships (Givropoulou and Tseliou, 2020; Bingle and Middleton, 2019; Smith, 2022; Reichelt and Skjerve, 2013). Reflexivity is commonly described as the cornerstone of systemic supervision, enabling therapists to produce multiple perspectives in supervision conversations (Givropoulou and Tseliou, 2020; Butler et al., 2021; Senediak, 2014; Reichelt and Skjerve, 2013; Bingle and Middleton, 2019; Smith, 2022). However, reflexivity and the production of different perspectives seem to be missing in peer group supervision practice within the Family Welfare Service. Reflexivity appears to be a skill that requires deliberate practice and acquisition, even among experienced systemic therapists. Thus, peer group supervision needs to incorporate opportunities for both learning and practising the systemic skill of reflexivity. Embracing a reflexive approach to supervision holds significant potential benefits, including fostering safe relationships within the supervision group, bolstering emotional coping, professional growth, and enriching clinical practice (Givropoulou and Tseliou, 2020).

Regarding the production of different perspectives in supervision, the findings from this study show that agreeing and supporting each other's views stand in the way of creating differences in supervision conversations. The cultural concept of equality as sameness prevalent in Norwegian social interaction appears to contribute to fostering comfortable supervision atmospheres and relational security, albeit at the expense of diverse viewpoints. Furthermore, it may lead to overlooking hierarchical differences within peer supervision groups. The findings of this study suggest that clinic leaders should refrain from participating in peer group supervision, even if they are actively involved in clinical practice. Hierarchical disparities can engender unsafe supervisory relationships, thereby negatively affecting supervision conversations about therapist difficulties. These findings imply the necessity of challenging the cultural habitus within peer group supervision, as it hampers the efficacy of supervisory processes. Ideally, the implementation of a predefined supervision structure that offer clear guidance for supervision practices would mitigate reliance on the cultural habitus of interaction stemming from the broader Norwegian context.

Finally, this study underscores the significance of the supervision environment. Elements such as surroundings, things and interiors affect the experiences of therapists participating in peer group supervision. A well-organised supervision room with appealing interiors, windows, and pleasant views fosters harmonic feelings and facilitates therapists` cognitive processes during supervision. This discovery highlights the importance of assessing whether the supervision room facilitates or restrains in-depth peer group supervision conversations. Merely utilising the available space may not suffice for a supervision practice that requires therapists to stay with difficulties, delve into vulnerabilities and engage in reflexive practices.

5.4.2 Implications for the field of systemic psychotherapy

The broader implication of this research project underscores the necessity for further research on the practice of systemic peer group supervision. In the wider therapeutic landscape, research holds significant value. The dearth of systemic research on facilitating impactful learning in clinical group supervision suggests a gap in the body of knowledge regarding systemic supervision practice. Without an evidence base, the systemic approach to clinical supervision risks being overshadowed by supervision models from alternative traditions, thereby neglecting to foster systemic concepts

related to therapist positioning, reflexivity, and diversity. From an isomorphic standpoint (Bertrando and Gilli, 2018; Simon, 2010), compromising supervision as a learning arena for systemic ideas and practice could detrimentally affect the professional development of systemic practitioners. The fact that several studies report a lack of reflexivity in systemic supervision (Smith, 2022; Bingle and Middleton, 2019; Reichelt and Skjerve, 2013) might imply that systemic supervision is already losing ground. Knowledge promotes position, prestige, and power within the therapeutic field. For systemic psychotherapy to survive in the multitude of different therapeutic orientations, it seems essential to provide some “evidence” of prosperous systemic practice, both from clinical group supervision and clinical practice with clients.

5.4.3 Questions for further research

Further research is needed to find out how group supervisory processes might contribute to achieving the assumed benefits of clinical systemic group supervision. This study identifies a well-known research gap in the systemic literature concerning how to promote safe relationships, emotional caretaking, systemic learning, and professional development in clinical group supervision (Clarke and Rowan, 2009; Reichelt and Skjerve, 2013; Bingle and Middleton, 2019; Zvelc and Zvelc, 2021; Givropoulou and Tseliou, 2020; Butler et al., 2021; Burck and Daniel, 2018; Paré, 2016, Knight, 2017, Smith et al., 2012). The gap needs to be filled, not merely for the professional development of systemic practitioners, but also to ensure quality in systemic practice and promote systemic psychotherapy within the wider professional practice field. It seems essential to conduct practice-near research to understand the workings of systemic group supervision and how clinical supervision practice applies to clinical practice.

The research findings also suggest the necessity for researching into “knowing from the body” and how embodiment of cultural norms might impact communication and interaction processes in peer group supervision. Bodily-felt affect and emotions serve as a source of knowledge, offering vital insights into therapists` difficulties. Further, embodied cultural norms and modes of understanding derived from the broader cultural context can significantly influence group dynamics and constrain supervisory processes. Therefore, relying solely on language is inadequate for comprehending

the dynamics of interaction and communication in supervision. What the systemic therapists do together can be culturally shaped, and meanings might emerge from shared cultural practices in peer group supervision.

5.4.4 Strengths and limitations of the study

In this research project, I acknowledge my role as part of the researched, recognising that emerging knowledge cannot be understood separately from me as a researcher. Being a part of it also involves my blind spots and potential perspectives of interest not being pursued. Hence, the research findings are to be perceived as different angles of viewing the data and not established facts about peer supervision.

I consider the multi-layered research design to be a strength of the study. By collecting data from diverse sources and allowing for multiple data readings, I aimed to delve into the rich ground beneath the surface of peer group supervision practices. I shared my thoughts and ideas of what happened in supervision with the research participants to expand my perspectives and promote an ethical research practice. Transparency regarding my research choices, subjective reflections, and reflexive considerations throughout the research process was prioritised to enhance the credibility of the study. However, it is also important to acknowledge the limitations of the research. Although I spent several hours with each supervision group, I only included four groups in the research project, and this may limit the validity of the findings. Additionally, including the research participants in every step of the data analysis process, and not merely towards the end, could have provided valuable insights. Nevertheless, I considered broader participation too time-consuming for this limited-sized study.

5.5 CONCLUDING REMARKS

This research project aimed to shed light on communication and interaction processes related to displaying difficulties and vulnerability in peer group supervision, with the objective of generating ideas about strengthening peer supervision practice within the Family Welfare Service. The findings suggested that peer group supervision was an overlooked practice, primarily relying on a discourse about clinical supervision. The absence of institutional endorsement restrained the

supervision practice, fostering feelings of insecurity among participants. Through participant observations and subsequent dialogues with research participants, a sense of vulnerability stemming from displaying and discussing therapist difficulties in peer group supervision was identified. Relational considerations often prevented exploration of various emotions, affect, and embodied experiences associated with therapist difficulties during supervision sessions, leading to a movement from intimacy to distance in supervision conversations. Practitioners noted that this shift hindered both learning and caretaking within the supervision context. Furthermore, the cultural notion of equality as sameness was found to impede the exploration of diverse perspectives in supervision, limiting the potential for learning and growth.

This study underscores the importance of addressing peer group supervision practices within the Norwegian Family Welfare Service. To enhance peer group supervision as an arena for professional development, ongoing learning, and emotional support among systemic practitioners, I propose a reorganising and restructuring of the current practice. This includes institutional recognition of peer group supervision, accompanied by a clearly defined mandate and a systemic framework for structuring supervision sessions. Communication and interaction processes should align with systemic principles, ideally led by a designated group leader focused on fostering safe relationships and facilitating reflexive supervision processes. A key implication of this study is that such changes could strengthen group processes in peer supervision, fostering increased support, systemic learning, and professional development among systemic practitioners. Ultimately, these enhancements could positively influence clinical practice within the Norwegian Family Welfare Service.

REFLEXIVE COMMENTARY

This is a commentary on my position as a researcher, further illustrating how I view myself as part of the research. From a professional standpoint, it was easy to argue the need to research clinical peer group supervision. The supervision practice is widely applied in the therapeutic field. Nevertheless, I identified a research gap concerning group supervisory processes and what is made from systemic clinical supervision – both within my organisation and the broader systemic professional field. In addition, I came into this research project with extensive experience as a family therapist who has participated in peer group supervision. From my experience, peer group supervision practices can be random and inadequately managed. This inconsistency triggered my interest in inquiring into what happens in peer group supervision. However, at the end of the research process, I realised that my motivation for carrying out the research also stems from personal experiences with loss and silencing practices. My lived life has shaped my understanding of the importance of open dialogues and influenced my desire to explore what happens when systemic practitioners talk about their difficulties in peer group supervision. Thus, my private story and this professional doctorate project are strongly connected.

I was born in Norway to teenage parents in the mid-1970s, at a time when abortion was strictly restricted. My parents married only a few months before my arrival, as expected of them at the time so that family life could start without controversies. However, I was only two years old when my mother was diagnosed with brain cancer. This marked the beginning of a five-year-long period where she was in and out of the hospital, often sleeping in a dark room when periodically being home, reduced and trying to recover from surgeries and treatments. I have two good memories of my mother from this period. In the first, she looks at me from the kitchen window, playing with my friends in the playground outside our house. When she discovers that one of the boys starts to chase me around, she knocks on the window and makes him stop. On the other, I have just come home from a weekend trip with my grandparents. My mother is sitting on the living room sofa, smiling warmly at me when spotting me in the hallway, holding out her arms to welcome me. I remember throwing away my bag and running happily into her open arms. However, most of my memories of my mother are of her sleeping in a dark bedroom or lying in a hospital bed. My

grandmother explained that my mother had to stay at the hospital because of a lump in her head that needed to be removed, but I struggled to make sense of the explanation. I was always reluctant to visit my mother at the hospital as it made me feel uncomfortable. The hospital had a distinct smell I disliked, and the elevators felt claustrophobic. Walking through the hospital corridors and seeing metal vases lined up on tables for visitors to put their flowers in made me sad. In the drawer next to my mother's hospital bed was an orange plastic swamp that she used to moisten her lips. I was unsure what to make of it. I remember thinking it reminded me of the swamps used for moisturising the backsides of stamps at the post office. Then, one day, my father came home from the hospital to tell me my mother had passed. He cried. For some reason, I already knew what had happened. I had heard the phone ring a couple of hours before, and although I was only seven years old and no one had told me how critically ill my mother was, I realised that the phone call meant she was dead. The loss of my mother hit my family hard. Nevertheless, we all continued with our lives as if nothing had happened. My mother disappeared from our shared family language, and we carried on, seemingly unaffected by the family trauma. I think there was an idea in our family suggesting that if we did not talk about her, it would not hurt so much. I have no memories of missing my mother as a child, but I remember having panic attacks and being so scared of death that I could not breathe. My grandmother told me they came because of growing pains. Her explanation comforted me as it suggested the hurt would disappear by itself, and eventually, it did. It was not until I started working with traumatised children as a family therapist that I realised the anxiety and chest pains I experienced as a child were trauma symptoms from repressed memories and feelings. The silencing practice in my family came with a cost.

As a young adult, I began to talk about my mother with close friends. Although it often made me emotional, it did me good. When I later started my higher education, I was quickly drawn into the field of family therapy, focusing on communication patterns and open dialogues. Working as a family therapist, I thrived when clients invited me into their inner worlds, talked about their difficulties and openly displayed vulnerabilities. I was not conscious of it at the time, but my early experiences as a therapist were of great importance to me. Taking part in intimate therapeutic conversations had a healing effect on me, holding a therapist's role. Such healing experiences have made

me place great value in dialogues where difficulties and vulnerabilities can be shared openly. This value also motivated my research project. My private story affected my desire to explore group processes and what happens when systemic practitioners talk about their difficulties in peer supervision. Furthermore, I discovered a connection between my private experience of silencing practice in the family and the silencing of therapist difficulties observed in the supervision context. This finding intrigued me and encouraged me to pursue the research more confidently. From holding a researcher's role, revealing and challenging silencing practices in peer group supervision felt very important. This is not to say that clinical supervision should only focus on therapist difficulties, but to encourage a supervision practice where the therapist's difficulties can be explored alongside the clients' difficulties. In line with my values, the research findings suggest that a supervision practice focusing solely on the Other lacks the element of reflexivity and might stir up even more difficulties for systemic therapists.

Working on this research project has made the link between my personal and professional stories more visible. My lived life is entangled in my work as a family therapist and practitioner-researcher, and what I did in this research indulges with who I am and my personal stories about the researched. My mother is still very present in my life, although rarely discussed. Challenging silencing practices has become my ethical commitment, personally and professionally. Inquiring into the unspoken and listening to the voice of silence feels essential, not only because of professional reasoning and solid values but also to honour the memory of my mother.

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APPENDIX A: Overall maps of supervision sessions

The following maps provide an overview of what happened in the supervision sessions observed in this research project. Overall maps of supervision sessions were used to study the different supervision elements and which supervision cases should be included in further analysis.

Overall map of the supervision session in Group 1

SUPERVISION ELEMENTS	TIME SLOT	CHARACTERISTICS	RESEARCH CUT
A round to check who needs supervision today and which cases are to be prioritised	2 min.	An appointed therapist leads the round, pays attention to the use of time, and joins the round	
G1, C1: "I feel insecure talking with the couple about sex"	30 min.	The supervisee presents a challenge concerning himself	
G1, C2: "I have trouble feeling empathy towards the woman in the couple"	37 min.	The supervisee presents a challenge concerning herself	
G1, C3: "I am not sure if the mother gives enough love and warmth to her children"	15 min.	The supervisee presents a concern about a mother's capacity to give care	X
A final round to check the group's experiences with being filmed and observed	1 min.	The researcher joins the group by asking questions	

Total duration = 85 min.

Overall map of the supervision session in Group 2

SUPERVISION ELEMENTS	TIME SLOT	CHARACTERISTICS	RESEARCH CUT
A round to check who needs supervision today and which cases are to be prioritised	2 ½ min.	An appointed therapist leads the round and joins the round	
G2, C1: "I am unsure if I reinforced the child's problem through validation"	29 min.	The supervisee presents a concern about his actions as therapist	
G2, C1: "How might one talk with children who refuse to see custodial parents about re-establishing contact"	13 min.	The supervisee has found a way forward through case 1 but invites a therapist to explain how she talks with these children	X
G2, C1: "I worry that the woman in the couple is a victim of domestic violence"	35 min.	The supervisee presents a concern about a client	X
A final round to check the group's experiences with being filmed and observed	1 ½ min.	The researcher joins the group by asking questions	

Total duration = 81 min.

Overall map of the supervision session in Group 3

SUPERVISION ELEMENTS	TIME SLOT	CHARACTERISTICS	RESEARCH CUT
A round to check who needs supervision today and which cases are to be prioritised	3 min.	An appointed therapist leads the round, pays attention to the use of time, and joins the round	
G3, C1: "I find it difficult to attend to the couple's conflicting needs"	32 ½ min.	The supervisee presents a concern about his actions as therapist	
G3, C2: "I need help with feeling more empathic towards the parents"	36 min.	The supervisee presents a challenge concerning herself	
A round to check the group's experiences with being filmed and observed	1 min.	The researcher joins the group by asking questions	
Pause	10 min.		
G3, C3: "I am not sure if the mother can provide a good enough care situation for the child"	40 ½ min.	The supervisee presents a concern about a mother's capacity to give care	X

Total duration = 123 min

Overall map of the supervision session in Group 4

SUPERVISION ELEMENTS	TIME SLOT	CHARACTERISTICS	RESEARCH CUT
The group determine whose turn it is to lead the process	½ min.	They take turns leading the supervision process (shifts from week-to-week)	
A report from the previous supervision is read out loud, and they decide who will write today's report	2 min.	The therapist appointed to lead today's supervision process ensures that it is done according to plan	
A round to check how the therapists are doing	3 ½ min.	The appointed therapist leads the round and joins the round	
A round to check who has cases of abuse or violence	5 ½ min.	The appointed therapist leads the round and joins the round	
A round to check who needs supervision today and which cases are to be prioritised	4 ½ min.	The appointed therapist leads the round and joins the round	
G4, C1: "I am most concerned with the woman and struggle to help them as a couple"	52 min.	The supervisee presents a challenge concerning herself	
Deciding how to make use of the remaining time	1 min.	The appointed therapist leads this group process and joins it	
G4, C2: "I worry about how this 8-year-old is being swallowed up by her father"	11 min.	The supervisee presents a concern about a father's care for his child	X
A round to check how the therapists have experienced today's supervision session	4 min.	The appointed therapist leads the round and joins the round	
A final round to check the group's experiences with being filmed and observed	3 min.	The researcher joins the group by asking questions	

Total duration = 87 min.

APPENDIX B: Overall maps of case conversations

The following maps provide an overview of what happened in the supervision conversations about cases concerning therapist difficulties. Overall maps of case conversations were used to study broad conversational structures and key activities allocated in supervision, in accordance with CA theory.

CASE 1: "I feel insecure talking with the couple about sex"

	SUPERVISION ACTIVITIES	TIME SLOT	PERFORMANCES	TURN ORGANISATION
1	Presentation of case and therapist difficulties	6 min., 40 sec.	A story is told to the group	The supervisee is given a lengthy turn to speak, only interrupted by group members self-selecting a turn on two occasions
2	Clarifying questions from the group	6 min., 55 sec.	A round of questions, the turn to ask is given by where you sit	The supervisee is selected to speak by adjacency pairs of question-answer
3	Group responses to provide help and support	13 min., 35 sec.	A round of responses, the turn to respond is self-selected	Self-selection of turns to speak within the slot of a group member The supervisee takes part in the turn organisation operating around responses
4	Ending the supervision	3 min., 5 sec.	Final speech acts in the group, self-selected	The supervisee self-selects a turn to end the supervision and then responds to some group members who continue to provide help and support

Total duration = 30 min., 15 sec.

CASE 2: "I have trouble feeling empathy towards the woman in the couple"

	SUPERVISION ACTIVITIES	TIME SLOT	PERFORMANCES	TURN ORGANISATION
1	Presentation of case and therapist difficulties	2 min., 54 sec.	A story is told to the group	The supervisee is given a lengthy turn to speak without being interrupted
2	Clarifying questions from the group	3 min., 21 sec.	A round of questions, the turn to ask is self-selected	The supervisee is selected to speak by adjacency pairs of question-answer

3	Group responses to provide help and support	29 min., 15 sec.	A round of responses, the turn to respond is self-selected	Self-selection of turns to speak within the slot of a group member The supervisee takes part in the turn organisation operating around responses, in addition to being selected to speak by adjacency pairs of question-answer
4	Ending the supervision	1 min., 50 sec.	Final speech acts in the group, self-selected	The supervisee self-selects a turn to end the supervision and is subsequently selected to speak by adjacency pairs of question-answer

Total duration = 37 min., 20 sec.

CASE 3: "I am unsure if I reinforced the child's problem through validation"

	SUPERVISION ACTIVITIES	**TIME SLOT**	**PERFORMANCES**	**TURN ORGANISATION**
1	Presentation of case and therapist difficulties	6 min., 30 sec.	A story is told to the group	The supervisee is given a lengthy turn to speak The storytelling is, on three occasions, interrupted by group members self-selecting a turn
2	A mixture of clarifying questions and group responses to provide help and support	14 min., 55 sec.	A round of questions and responses, the turn to speak is self-selected	The turn to speak within the slot of a group member seems to be self-selected The supervisee takes an active part in the turn-taking organisation operating around responses, is selected to speak by adjacency pairs of question-answer, and self-selects turns to respond to other speech acts on most occasions
3	Ending the supervision	2 min., 1 sec.	Final speech acts in the group, self-selected	The supervisee self-selects a turn to end the supervision, and is subsequently selected to speak by an adjacency pair of question-answer
4	Evaluating the supervision	5 min., 34 sec.	A round of responses to the supervisee's critique, self-selected	The supervisee self-selects a turn to evaluate/critique the supervision session, and is subsequently selected

				to respond to the group's questions, advice, etc.

Total duration = 29 min.

CASE 4: "I found it difficult to attend to the couple's conflicting needs and was at a loss what to do"

	SUPERVISION ACTIVITIES	TIME SLOT	PERFORMANCES	TURN ORGANISATION
1	Presentation of case and therapist difficulties	8 min., 40 sec.	A story is told to the group	The supervisee is given a lengthy turn to speak The storytelling is on five occasions interrupted by group members self-selecting a turn
2	Clarifying questions from the group	6 min.	The turn to ask is self-selected	The supervisee is selected to speak by adjacency pairs of question-answer
3	Group responses to provide help and support	12 min., 38 sec.	A round of responses, the turn to respond is self-selected	Each group member reflects more or less uninterrupted, only experiencing agreeing comments in their turn The supervisee does not take part in the turn organisation operating around responses
4	Ending the supervision	5 min., 7 sec.	Final speech acts in the group, self-selected	The supervisee self-selects a turn to end the supervision and respond to the reflecting team, and is subsequently selected to speak by an adjacency pair of question-answer

Total duration = 32 min., 25 sec.

CASE 5: “I need help with feeling more empathic towards the parents”

	SUPERVISION ACTIVITIES	TIME SLOT	PERFORMANCES	TURN ORGANISATION
1	Presentation of case and therapist difficulties	13 min., 15 sec.	A story is told to the group	The supervisee is given a lengthy turn to speak without being interrupted
2	Clarifying questions from the group	3 min., 25 sec.	The turn to ask is self-selected	The supervisee is selected to speak by adjacency pairs of question-answer
3	Group responses to provide help and support	16 min., 15 sec.	A round of responses, the turn to respond is self-selected	Each group member reflects more or less uninterrupted, only perceiving agreeing comments in their slot

				The supervisee does not take part in the turn organisation operating around responses
4	Ending the supervision	3 min., 10 sec.	Final speech acts in the group, self-selected	The supervisee self-selects a turn to end the supervision and respond to the reflecting team

Total duration = 36 min., 5 sec.

CASE 6: “I am most concerned with the woman and struggle to help them as a couple”

	SUPERVISION ACTIVITIES	**TIME SLOT**	**PERFORMANCES**	**TURN ORGANISATION**
1	Presentation of case and therapist difficulties	18 min., 55 sec.	A story is told to the group	The supervisee is given a lengthy turn to speak On a few occasions the storytelling is interrupted by group members self-selecting a turn or looking at the wall clock
2	Clarifying questions from the group	5 min., 40 sec.	The turn to ask is given by the group leader, whom herself self-selects turns	The supervisee is selected to speak by adjacency pairs of question-answer
3	Group responses to provide help and support	25 min., 13 sec.	A round of responses, the turn to respond is firstly given by where you sit and then self-selected	Each group member reflects without being interrupted, only rarely experiencing minor comments from the group in their turn The supervisee self-selects turns on three occasions to give feedback to the group
4	Ending the supervision	2 min., 58 sec.	Final speech acts in the group, self-selected	The supervisee initiates ending the supervision The supervisee takes part in the turn organisation operating around responses, self-selection of turns
5	Evaluating the supervision	1 min., 14 sec.	The group leader initiates an evaluation of the supervision	The supervisee is selected to speak by an adjacency pair of question-answer

Total duration = 53 min., 40 sec.

APPENDIX C: Sample of an expanded case conversation map

The sample below is the expanded map of the supervision conversation in Case 1 and illustrates the mapping of all supervision cases included in the CA analysis. Expanded case conversation maps were used for a more nuanced study of talk-in-interaction. Sequences of talk were marked with time slots, and social activities allocated in supervision conversations were identified within each sequence.

Case 1: Expanded map of the conversation - "I feel insecure talking with the couple about sex"

SUPERVISION ACTIVITIES	TIME SLOT	PERFORMANCES	TURN ORGANISATION
1. Presentation of case and therapist difficulties	**6 min., 40 sec.**	**A story is told to the group**	**The supervisee is given a lengthy turn to speak, only interrupted by group members self-selecting a turn on two occasions**
Clarifying question about the case	00:02:00 – 00:08:40	The supervisee describes the family and gives account of how the couple present their problem; they have become a working unit and need help with finding back to passion and having sex Says the couple initially asked for a sexologist but "got" him who is not Describes what has happened during the two first sessions Explains how he feels insecure as a therapist, lacks experience with talking about sex in a clinical context, does not know what to do next or how to explore further, finds it difficult to know which words to use on the topic Sums up his difficulties	A group member takes a turn in the story to make an empathic comment about the couple's problem Another group member takes a turn in the story to clarify if the woman in the couple also wants to have more sex *The supervisee's summary marks the end of the passage*

2. Clarifying questions from the group	**6 min., 55 sec.**	**A round of questions, the turn to ask is given by where you sit**	**The supervisee is selected to speak by adjacency pairs of question-answer**
Clarifying question about the case	00:08:40 – 00:11:06	*A question round is opened without explanation, but everyone seems to know what to do* A group member asks about the length of the couple's problem and how they explain the problem	The supervisee answers the questions Another group member, who knows the family, takes a turn to talk about the foster child in the family and how challenging he must have been for the couple
Clarifying question about the case	00:11.06 – 00:12:20	A group member asks if the couple understand each other's needs	The supervisee answers the question; the couple talk about their needs
Clarifying question about the case	00:12:20 – 00:13:30	A group member asks if the couple have a language to talk about sensuality The group member says he can share how he works with sexual issues in therapy after the question round	The supervisee answers the question; confirms The supervisee welcomes the suggestion
Clarifying question about the therapist's difficulties	00:13:30 – 00:15:35	A group member asks the supervisee to repeat what he wants the group to help him with The group member continues to ask how the group can talk about the supervisee's difficulties in a helpful way	The supervisee answers the question; repeats his difficulties The supervisee answers the question; wants the group to share their practice knowledge *All group members have participated in the question round, and the last group member's question seems to mark the end of the question passage*
3. Group responses to provide help and support	**13 min., 35 sec.**	**A round of responses, the turn to speak is self-selected**	**Self-selection of turns to speak within the slot of a group member** **The supervisee takes part in the turn**

			organisation operating around responses
Giving support/recognition **Suggesting what to do** **Giving support/ empathy**	00:15:35 – 00:16:55	*A reflection round is opened without explanation, but everyone seems to know what to do* A group member acknowledges what the supervisee has done for the couple so far and advises him to "fake it until you make it"	Another group member agrees with the previous speaker; it is all about practicing and the therapist will feel more relaxed after a while. Says she recognises the supervisee's challenges
Suggesting what to do **Understanding the client**	00:16:55 – 00:18:30	The group member continues to talk about how she would identify the underlying issue, and problematise gender differences concerning sex	A group member comments on how it can be difficult for the woman to engage in sexual activities if she worries about her foster child
Suggesting what to do	00:18:30 – 00:23:10	A group member says he would examine the couple's sexual difficulties in more depth, gives examples of questions he would ask the couple and models he uses The group member continues to explain the difference between the two models	The supervisee asks for more information about the models The supervisee responds by explaining why he asked the couple to practice being close without having sex between sessions and how the couple responded
Clarifying question about the case **Understanding the clients**	00:23:10 – 00:24:20	A group member asks why the man was given a specific task between sessions The group member further reflects on feeling overwhelmed by the couple's many tasks A group member picks up from the previous speaker and tells a story about a colleague who	The supervisee answers the question; balance A group member picks up on the question and asks if the man got practical tasks; the supervisee confirms

		didn't want to have sex before her husband had vacuumed	The supervisee responds to the story by telling a similar story about deciding to install floor-mouldings at home
Understanding the clients	00:24:20 – 00:25:45	A group member reintroduces the theme of being foster parents and how a challenging foster child might have distressed the woman and the couple over time	A group member agrees that such problems trump lust and the desire to have sex Another group member adds to the response by emphasising that this is a very challenging foster child
Understanding the clients	00:25:45 – 00:26:48	The group member continues reflecting on the effects of not being understood in a relationship and the distance this creates between a couple The group member continues to reflect on the woman's difficult position, wondering if she is self-effacing	The supervisee adds information; the woman in the couple has had other demanding caregiving tasks in addition to being a foster mother, easy to understand her position, difficult that the couple do not want to focus on the foster child in therapy
Suggesting what to do	00:26:48 – 00:28:10	A group member acknowledges what has been said by previous speakers, advises to examine the woman's position further, thematise the concern for her and find out if the man's desire for more sex feels like just another claim	Another group member makes a supportive comment *All group members have now given a response, and the advice might be an attempt to end the passage?*
Suggesting what to do	00:28:10 – 00:28:24	A group member advises the supervisee to read the thesis she has written about the effect a foster child might have on the couple's relationship	
Understanding the clients **Suggesting what to do**	00:28:24 – 00:29:20	A group member reflects on the fact that the couple have sex on vacations as a positive aspect The group member continues to advise about how to include the foster child as a theme in the couples therapy	

4. Ending the supervision	3 min., 5 sec.	Final speech acts in the group, self-selected	The supervisee self-selects a turn to end the supervision, and then responds to group members who continue to provide help and support
Suggesting what to do **Giving support/recognition**	00:29:20 – 00:30:29	The supervisee initiates the end of the session with a vague sentence /compliment to the group A group member responds by repeating that developing a language on the topic demands practicing the language in a clinical context A group member suggests that the supervisee's words could be suitable if representing the clients` language	*The supervisee's utterance marks the beginning of ending the supervision* The supervisee responds by explaining he is not shy talking about sex in a private context with men but lacks the language for speaking with couples in therapy; his words come out wrong The supervisee responds by agreeing
Suggesting what to do	00:30:29 – 00:31:02	A group member advises the supervisee to ask the couple how they feel about talking with him about sexual issues and what words they prefer to use	The supervisee responds positively to the advice; it is something he likes to do in therapy *(pause)*
Clarifying question about the case	00:31:02 – 00:32:20	A group member asks if the couple are good at inviting each other into their emotional states and if they have a language for personal difficulties A group member comments that opposites might attract at first, but trouble can occur *(pause)*	The supervisee responds to the questions; the couple seems to manage The supervisee continues to explain how the couple seems to be very different from each other
	00:32:20 – 00:32:25	A group member asks the supervisee if it is okay to stop the supervision	The supervisee confirms; it is okay

Total duration: 30 min., 15 sec.

The following tables display the counting of response activities in Case 1 and illustrate how social acts were counted from all the expanded case conversation maps. Different activities were identified and counted within a sequence of talk. However, a particular response activity was only counted once.

COUNTING THE ACTS OF QUESTIONING THE SUPERVISION REQUEST: Case 1

Questioning the formulation of supervision requests	0
Questioning experiences of therapist difficulties	1
Questioning the case and/or the clients' difficulties	6

COUNTING THE ACTS OF PROVIDING HELP AND SUPPORT: Case 1

Understanding the clients	5
Exploring therapist positions	0
Suggesting what to do in therapy	8
Providing verbal recognition and empathy	2

APPENDIX D: Overview of response acts across supervision cases

The tables below provide an overview of response acts allocated in supervision conversations across cases. Responses to a supervision request were singled out and counted from expanded case conversation maps to identify communication patterns following stories about therapist difficulties.

Overview of response acts across cases: Questioning the supervision requests

	QUESTIONING THE FORMULATION OF SUPERVISION REQUESTS	QUESTIONING EXPERIENCES OF THERAPIST DIFFICULTIES	QUESTIONING THE CASE AND/OR THE CLIENTS` DIFFICULTIES
Case 1	0	1	6
Case 2	0	3	6
Case 3	0	3	5
Case 4	3	1	3
Case 5	1	0	2
Case 6	1	0	4
	Total = 5	Total = 8	Total = 26

Overview of response acts across cases: Providing help and support

	UNDERSTANDING THE CLIENTS	EXPLORING THERAPIST POSITIONS	SUGGESTING WHAT TO DO IN THERAPY	PROVIDING VERBAL RECOGNITION AND EMPATHY
Case 1	5	0	8	2
Case 2	14	3	12	6
Case 3	11	1	10	8
Case 4	4	9	1	5
Case 5	7	4	4	0
Case 6	10	2	12	1
	Total = 51	Total = 19	Total = 47	Total = 22

APPENDIX E: Sample of field notes from a participant observation

“The therapist who seems to lead the group process talks about what can be important when meeting young clients for the first time. The young, female therapist listens and says they can talk a bit about meeting young clients for the first time. The way she says it makes me think she is somewhat surprised. I feel uncertain whether she really needs supervision about meeting young people for the first time or whether it is more about submitting and accepting whatever is given by the group. I get the impression that it is the latter. I ask myself whether it is crossing the line to continue the supervision when the therapist has said that she does not want to raise the case. I am also curious as to why she will not bring it up. Could it be a result of what unfolded in the group just before? Another therapist joins the conversation and acknowledges what the therapist who leads the supervision process has said about what is important in the first conversation with young people. I still wonder if this is helpful to the therapist who owns the case. I note that the therapist who directs the supervision has rather long reflections. Or are they monologues? I think she gives herself a lot of space in the group, and I cannot quite follow everything she says. I lose my concentration a little. I think it happens because of the few exchanges in the group, but I also notice that I am starting to get tired. On a couple of occasions, the therapist is interrupted by the male therapist. I do not know if it is because he is eager, or if he finds it difficult to get a turn to speak. Suddenly, he says, “Shall we go on?”. I perceive it as abrupt and wonder if it should not be she who manages the group process who should be asking about this. He seems to take over her role as leading the group. However, the group does not seem to react. They do as he says; they move on. An older, female therapist appears as a kind of safe haven in the group. She was the one I shook hands with who had the friendly face. I have noticed that she is good at acknowledging the others in the group. Now she puts on a white knitted jacket with a butterfly on it. It is her turn to present a case.”

APPENDIX F: Sample of a transcription from a supervision

Grace: The stage is yours, Mia.
Mia: Yes.. uhh.. no, the thing with the children and him. She's a little worried because she says that she... she doesn't want to give the baby to him, right? Erm.. and that could be some of the things that make it difficult for her to leave, right. Because she thinks about how he will manage to take care of the children alone without her, both of them maybe, and.. yes.
Pamela: Because you think he will?
Mia: No, I wonder.
Pamela: Oh yeah, like that.
Mia: No, I did not want to discuss it when we met.
Pamela: No.
Mia: And I think it's a bit like that... it's much easier to be straightforward with those who are straightforward themselves. Because I think that she is so unclear, and she has many reasons for that, and there could be many explanations for that. But that is the thing... I really want them to be the ones to sit in the driver's seat and steer the car further, right? Either... whatever direction, and then I can... I can cheer them on if they want to go that way or that way. Right? But becoming all straightforward when they come back, saying, “Here's someone who wants out”, to put it simply and.. uhh.. that.. that I do not find very easy.
Emily: Hmm.
Mia: Right? Just for these two, right? In other couples, it is.. not a theme at all. I find it very easy. But this here... here is something else that makes... it becomes difficult.
Emily: Hmm.
Mia: Yes..
Grace: Do you want us to reflect a bit more on that?
Emily: I felt like doing that.
Mia: Yes, I would like to.
Pamela: (she laughs)
Mia: (she laughs) Now we go deeper and deeper..
Grace: Yeah, but it's exciting.
Mia: Yes.

APPENDIX G: Sample of transcription from a group dialogue

Researcher: When I say that peer group supervision is a kind of institutional practice, it is at least something that all family welfare clinics have set aside time for and that someone has agreed to. I wonder why the institution spends so much time on this practice and what mandate is given to these supervision groups. I would like to hear your thoughts on the matter, and I will take some notes as you speak.
Liam: A bit like when you ask a goldfish what it's swimming in, I think. I do not know. Is it given or is it just the way it has become? Has anyone questioned why we do this? I mean, I have just assumed that is the way it is.
Leah: That is the practice here.
Liam: That's right. I mean, I have not stood up and asked, “Should we do it?”.
Researcher: So, is it kind of taken for granted?
Emma: Yes. There is no basic document I can find that says we should do it, so I think, for my part, that it is a continuation of practice and, as a professional, certainly something you have expectations of. So, I think it's a bit like this; on the other hand, you would have reacted strongly to it if it wasn't there when you came to this service. So, in that sense, the practice is institutionalised in a way.
Leah: But at the same time, there have been some services where it is not.
Emma: Yes.
Leah: Right? Similar services. But I also would have thought it strange if we didn't have it, in a way. And I have thought that our service should have it (supervision) both to ensure the quality of what we do, and to protect ourselves in the work we do. To share experiences, not standing alone in cases, to know that have a place once a week where we can get supervision on cases that are demanding.
Emma: And to make sure it does not get so personal. So, also to ensure that it does not become a private practice in a way where you stand alone. You have your back covered, and the services provided are somewhat similar because we talk together. It is not a private administration. It is a community built on a foundation within our field, holding the belief that more voices add richness, which almost feels mandatory in the theories. Otherwise, it would have felt like life and teaching were not adequately matched.

APPENDIX H: Recruitment advertisement

The Tavistock and Portman NHS
NHS Foundation Trust

RECRUITMENT ADVERTISEMENT - Family Welfare Clinics

I am a student at Tavistock and Portman NHS Foundation Trust, undertaking a professional doctorate in Systemic Psychotherapy. The Tavistock and Portman NHS Foundation Trust is a specialist mental health trust based in London, focusing on training and education alongside mental health services for families, children and adults. The Trust has provided family therapy qualifying courses annually since 1975 and have the longest standing systemic doctorate in the UK. The Tavistock and Portman NHS Foundation Trust work in academic partnership with Essex University, with Essex validating the Doctorate in Advanced Practice and Research: Systemic Psychotherapy.

This is an invitation for supervision groups within the Norwegian Family Welfare Service to participate in a systemic doctoral research project. The overall purpose of my inquiry is to gain a deeper understanding of how to provide quality to peer-group supervisory processes. Strengthening group processes can prompt impactful contextual learning experiences and increase the support of systemic practitioners. Findings from this research project thus have the potential to improve clinical practice.

My interest in the research topic primarily derives from my professional experience as a systemic practitioner within the Family Welfare Service. As you well know, the Family Welfare Service has expanded considerably in recent years due to a greater emphasis on reaching out to marginalised client groups like parents with children in care, minority families, families affected by violence and high conflict families (NOU 2019:20). Following this, there has been a shift in clinical practice, from mostly seeing couples seeking therapy to improve their romantic relationship to working with families with increasingly complex and multi-layered problems. The change of course draws greater attention to clinical supervision. Within the Welfare Services, clinical supervision is usually provided in peer groups consisting of systemic practitioners who meet regularly to reflect on therapeutic practice. From a systemic perspective, the emphasis on how therapists communicate and interact in supervision transfers to working clinically with relations and interaction. Nevertheless, how to provide impactful contextual learning and strengthen experiences of support in group supervision are not given particular attention. Group processes have been under-theorised in the systemic

supervision literature, resulting in a lack of awareness on how such processes can provide an optimal supervision experience.

Research data will be gathered by observations and video recordings of natural occurring peer-group supervision. I will observe from a distance without interfering. The participants do what they usually do in supervision; only they are observed and filmed. Each observation will have a maximum duration of 1,5 hours. Data will be subjected to a multi-layered qualitative analysis. I will invite each supervision group to a second meeting to reflect on my initial analysis. This meeting will last for 2-3 hours and include sharing video material from their supervisory process. Analysis and findings will be adjusted according to the participant's reflections and feedback. Observations and group reflections will take place at the location where the participants work and where they usually have peer group supervision. Local procedures will be followed to ensure the safety of research participants. I have organisational permission to undertake research within the Norwegian Family Welfare Service from Bufdir. I also have institutional ethical consent from the Tavistock and Portman Trust Research Ethics Committee (TREC) to proceed with the inquiry. I will be including 4-6 supervision groups in the project. The first Family Welfare Centres to contact me with interest will be offered participation in the research project, given the supervision group match the following inclusion criteria: practice peer group supervision, have been a group for at least two months by the time of the observation, consent to contribute with reflections on my initial analysis, consist of group members I am unfamiliar with.

Supervision groups participating in this project will contribute to developing systemic knowledge about group processes and support an advanced understanding of creating impactful supervision processes within the Family Welfare Service. They will also get a unique insight into the communication and interaction processes they themselves are a part of, a space to reflect freely, listen to others, be listened to, and develop ideas and thoughts.

Please do not hesitate to contact me for further information about the project. You can reach me by email at hegehelliesen.hadland@bufetat.no or phone XXX XX XXX.

Yours sincerely,

Hege Helliesen Hadland
Clinical Specialist in Systemic Family Therapy and Practice, MFSP
The Family Welfare Clinic in South-Rogaland

APPENDIX I: Participant information sheet

The Tavistock and Portman NHS
NHS Foundation Trust

PARTICIPANT INFORMATION SHEET

The purpose of this letter is to provide you with information that needs to be considered in deciding whether to participate in this research project about peer-group supervision.

Project title:

"Systemic group supervisory practice – from content to process"

Institution of Study:

Tavistock and Portman NHS Foundation Trust

(see the Recruitment Advertisement Letter for more information about the Trust)

Programme of Study: Professional Doctorate in Advanced Practice and Research: Systemic Psychotherapy

The Principle Investigator:

Dr Sarah Helps

SHelps@tavi-port.nhs.uk

Principle Supervisors / Research Group:

Dr Sarah Helps, Tavistock and Portman, UK

Dr Inga-Britt Krause, Tavistock and Portman, UK

Dr Ellen Syrstad, VID Spezialiced University, Norway

Student Researcher:

Hege Helliesen Hadland

Hegehelliesen.hadland@bufetat.no

0047 – XXX XX XXX

Research period: Jan.2022 – Sept.2024

Project Description: The overall purpose of my research project is to gain a deeper understanding of how to provide quality to peer-group supervisory processes within the Norwegian Family Welfare Service. From a systemic perspective, the emphasis on how psychotherapists communicate and interact in group supervision transfers to working clinically with relations and interaction. Strengthening group processes can prompt impactful contextual learning experiences and increase the support of systemic practitioners. Findings from this research project thus have the potential to improve clinical practice.

My research question is: *"What happens when systemic practitioners talk about their difficulties in peer-group supervision within the Norwegian Family Welfare Service?"* The term difficulties points to the broad range of challenges systemic psychotherapists meet in clinical practice from the position of being a practitioner. The inquiry will focus on communication about how therapists find particular issues emerging in their relationship with clients as challenging. My interest as a researcher is in how things are told and responded to within a group context and what makes a difference to having stimulating group dialogues about the therapists` difficulties.

Research data will be gathered by observations and video recordings of natural occurring peer-group supervision. I will observe from a distance without interfering. You do what you usually do in supervision; only you are observed and filmed. Each observation will have a maximum duration of 1,5 hours. Due to the data gathering method, my responsiveness as an observer and reflexive considerations constitute an essential part of the data material. Autobiographical material will be acknowledged and discussed openly. Video recordings will be transcribed and subjected to a multi-layered qualitative analysis. You will be invited to a second meeting with your supervision group to reflect on my initial analysis and findings. This meeting will last for 2-3 hours and include sharing some of the video material from your supervisory process. Analysis and findings will be adjusted according to your reflections and feedback.

I will keep digital recordings on an encrypted hard drive disk for confidentiality. Data will be kept secure and held for up to 10 years before being destroyed. Participation in the inquiry is highly confidential, and any information regarding your identity will strictly be held by me as a researcher. Consent forms and any other information that may potentially identify you will be stored separately and securely. Confidentiality is, however, subject to limitation if a disclosure indicates that a participant or someone else is at serious risk of harm. Such disclosures may be reported to the relevant authority. If you agree to participate in the research project, you will be given a consent form to read and sign in advance of the observation. Participation in the research includes being observed in a supervision session and participating in a reflection group. Both events will take place at your local Family Welfare Clinic. There is no significant risk involved in the inquiry, but it is acknowledged that observations sometimes make people feel uncomfortable. If you are unhappy about any aspect of the inquiry, please discuss this with the Principal Investigator or with me. Agreement to participate in the research will not compromise your legal and employment rights should anything go wrong.

The result of the research project will be written up and submitted as a dissertation as a part of a Professional Doctorate in Advanced Practice and Research: Systemic Psychotherapy. The inquiry may also be published in academic journals or similar forums, media, social media or websites, conferences, internal and external reports, or feedback to the research participants. Identifiable information about participants and Family Welfare Clinics will be removed in publications.

Inclusion Criteria:

- Supervision groups practising peer group supervision
- Supervision groups that have been a group for at least two months by the time of my observation
- Supervision groups that consent to contribute with reflections on my analysis
- Supervision groups with group members I am unfamiliar with

Research locations: Observations and reflection groups will take place in Family Welfare Clinics across Norway. I will follow local procedures to ensure the safety of research participants.

Research Integrity: The Tavistock and Portman NHS Foundation Trust adhere to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research, observing the appropriate ethical, legal and professional frameworks. The institution is committed to preserving your dignity, rights, safety and wellbeing. Thus, it is mandatory that formal ethical approval from the appropriate research ethics committee is granted in advance of research with human participants. The Tavistock and Portman Trust Research Ethics Committee has given me consent to proceed with this inquiry. I also have organisational consent from Bufdir to research within the Norwegian Family Welfare Service.

Confidentiality of the Data: The data generated in the course of the research project will be retained in accordance with the Trust's Data Protection and handling Policies: https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/

Disclaimer: Your participation in this inquiry is entirely voluntary, and you are free to withdraw at any time during the research period. Should you choose to withdraw, you may do so without any obligation to give a reason. Please note that you can withdraw your data up to the point of data analysis - after this, it might not be possible.

Concern about research conduct: Should you have any concerns about the conduct of the researcher or any other aspect of this research project, you should contact Simon Carrington, Head of Academic Governance and Quality Assurance, at academicquality@tavi-port.nhs.uk

General enquiries about the inquiry: For general enquiries about the research project, please feel free to contact the Student Researcher or the Principle Investigator on the contact details at the top of this sheet.

Yours sincerely, Hege Helliesen Hadland

APPENDIX J: TREC approval

Fra: Academic Quality <academicquality@tavi-port.nhs.uk>

Dato: 17. desember 2021 kl. 23:08:58 CET

Til: Hege Hadland <hege.hadland@kleppnett.no>

Kopi: Sarah Helps <SHelps@tavi-port.nhs.uk>, Britt Krause <BKrause@tavi-port.nhs.uk>, Academic Quality <academicquality@tavi-port.nhs.uk>, TELSupport <TELSupport@tavi-port.nhs.uk>

Emne: RE: TREC amendments

Dear Hege,

I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee (TREC) your application has been approved. This means you can proceed with your research.

Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

For information governance purposes and in line with the Trust policies, please be advised that in order to conduct research/interviews using online video conferencing you must contact TEL (copied) to set up a zoom account. With regards to privacy, please ensure that meetings with yourself and your participants are conducting in a safe environment and that confidentiality is maintained.

Your updated TREC form is attached

If you have any further questions or require any clarification do not hesitate to contact me.

May I take this opportunity of wishing you every success with your research.

Regards,

Paru

Mrs Paru Jeram
Senior Quality Assurance Officer
(Research Degrees and Research Ethics)
Academic Governance and Quality Assurance
https://tavistockandportman.nhs.uk/research-and-innovation/doing-research/student-research/

APPENDIX K: Organisational consent

Fra: Wenche Mobråten <wenche.mobraten@bufdir.no>
Sendt: Thursday, September 23, 2021 8:21:21 AM
Til: Hege Helliesen Hadland <hegehelliesen.hadland@bufetat.no>
Emne: SV: Request to carry out research

Dear Ms Helliesen Hadland

I hereby declare with this answer that the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) give Hege Helliesen Hadland permission to carry out research in the Family Welfare Service as described in the request.

Yours truly,
Wenche Mobråten
Departement Director of the division Knowledge
Norwegian Directorate for Children, Youth and Family Affairs
www.bufdir.no E-post: wenche.mobraten@bufdir.no Mobil: +47 466 16 098

Bufdir

APPENDIX L: Sample of a supervision atmosphere analysis

The following sample is my description of the supervision atmosphere in group 3.

The general tenor or mood expressed in the room:

The therapists` friendly faces and attentiveness towards each other in the talk-in-interaction express a good and comfortable tenor in the room. The conversation is very respectful in the way they decide together which cases to prioritise for supervision. Emma is invited to express what she wants from the supervision and decide on the supervision structure. Attention to Emma's needs and responding to her supervision request expresses a caretaking and supportive mood towards the therapist seeking supervision. When Emma is given a lengthy turn to present her supervision request, Liam and Leah seem focused on listening. They are looking at Emma as she talks. Leah sometimes nods as if to acknowledge what Emma is saying. There are no interruptions, merely speaker support like “mhm” and comments conveying that a group member orients to the theme brought up by another group member. The conversation has a comfortable pace. Everyone seems to know how to move on together in the unfolding conversation without confusion or disagreement. The way the supervision is done gives a sense of robustness and safety. Overall, there is generosity expressed in the room from how they are tuned in to each other. The mood is friendly, caretaking, attentive and stable.

The dynamic interplay of senses in the room:

The dynamic interplay of senses is characterised by how the group members are attentive towards each other. When Emma presents her supervision request, Liam and Leah give her full attention. They both look at her and take notes. Leah sometimes nods to what is said, providing a sense of acknowledgement towards what is being said and showing that Emma has her full attention. When one group member responds to the supervision request by giving a reflection, the other one provides speaker support or agrees. The facial expressions in the group are serious, showing attentiveness towards what is said. Leah and Liam seem to mirror each other's faces, adjust to a shared pace in the conversation and agree with each other's utterances to a large extent. Towards the end of the response activity, there is a sense of increased interaction within a sequence as they engage more in the themes

the other brought up. The room has a dynamic interplay of agreement, consensus and support while the supervision conversation unfolds. There might be a difference in themes during the response activity, but there is no sense of controversy or disagreement. Emma and Leah have a cup of coffee in front of them, but I cannot smell it from where I sit. As far as I can register, the room has no smells.

The disposition towards movement in the room:

At the beginning of the supervision, Leah and Liam look at Emma when she speaks and take notes on what is said. They are hardly moving except when they write in their notebook or when Leah nods. The most distinct movement in the group is when Emma turns her chair 45 degrees away from the rest of the group to put herself in a listening position. The movement marks her not participating in the group's response activity. Liam and Leah do not move. They sit across from one another at the meeting table and use the exact positioning while reflecting together. Emma's movement signifies changing the supervision structure while responding to the supervision request. Sitting in a listening position, turned away from the group, she holds her head in one hand and takes notes with the other. Her long hair covers her face in a way that I find intriguing. She seems to have created her own private space within the space and appears to be very focused and attuned to what the group has to say. I wonder if the group makes the same assumption. I catch myself crossing my arms over my chest and hastily put them back on my lap as I fear the pose appears judgmental.

The group reflection moves on, and towards the end, Leah says Emma must signal if she has heard enough. Emma holds her posture without answering. The lack of movement and utterance suggests she wants to hear more. A while after, Emma gently moves her head up, still without speaking, signalling the end of the response activity with this movement. No words are needed. Everyone understands. It means she has heard enough. She smiles and looks at Liam and Emma; they are again a group of three. I feel somehow affected by having Emma back in the group and with her peers. Emma self-selects a turn to give her feedback from listening to the responses. Again, she has the full attention of Liam and Leah, who look at her while she speaks without interrupting. She says she has found a way forward from listening to the reflection. From primarily being concerned with the child, she is now more

concerned with the parents` perspective and being with the parents before moving to the child. The movement in her thoughts has provided her with a way forward in the clinical work.

The space's influence on the bodies and vice versa:

The room is spacious, light and open. A large bookshelf covers one of the walls and is filled with what looks like professional literature and brochures. There are two doors in the room. One leads into another room, separated by a glass wall with a strip of window film along the middle part to prevent insight. The other door enters a hallway and is next to the bookshelf. There are no windows in this room, but the room on the other side of the glass wall has lots of windows and lets in light in this room as well. All the walls are white, and so is the ceiling. A white canvas screen and a large, white wipe board cover the wall opposite the glass wall. White, minor, narrow meeting tables stand on a row against this wall. The white wall opposite the bookshelf is naked, apart from a large picture of three horse heads in the middle. A large meeting table occupies a large part of the room. It is put together by eight narrow, minor meeting tables, similar to the ones standing against one of the walls. The middle of the meeting table is nicely decorated for Easter with twisted hazel, painted eggs in various colours, yellow candles and yellow napkins with white dots on them. The decoration is so nicely done that professionals might have made it. There are black meeting chairs around the meeting table. The carpet consists of black, square-formed carpet tiles. I notice that the ceiling has the same kind of pattern. Apart from the picture on the wall and the bookshelf, all furniture in the room is either black or white. I get a sense of harmony by the way the room is decorated. It is tidy without too many things. There is space between the furniture in the room and a consistency of colours. The bookshelf, the table decoration and the picture of the horses give a hint of personality without being intrusive. It is still a formal room, suggesting important things happening here, but the things in the room and the aesthetics feel somewhat inviting. To me, it is a space that could provide room for extensive thinking. The room's exterior harmony and orderliness might help focus on the unfolding supervision conversation without being too disturbed.

The meeting table might suggest peer group supervision's institutional, more formal dimension. The group sits on one end of the table, leaving an open space on the

other. I see the feet of two of the therapists, but apart from this, my view is restricted to upper bodies and faces. The group members can only see each other's upper bodies and faces. I am unsure if the restricted view of bodies could reveal something important. It might also serve as a form of shielding from being too exposed, making it easier to focus on the talk-in-interaction. However, the table seems convenient for taking notes and drinking coffee.

I am sitting on a chair about two meters from the meeting table, having one of the singular, narrow tables in front of me. The camera is standing on the table, and although I mostly look straight at the group members, I occasionally watch them through the small camera screen to ensure they are all in the picture. On one occasion, I quietly move the camera to the right to get a better angle of all three group members. I do not think anyone noticed. I am very aware of filming the supervision, as the camera is in plain sight. The group is probably also aware of being filmed but does not look at the camera as they focus on each other and what is happening around the meeting table. They do not look my way, but I guess they can sense me looking at them. It probably influences them somehow.

The carrying of cultural meanings and value in the room:

The meeting table, meeting chairs, canvas screen and whiteboard in the room reference a meeting room, a formal setting. The bookshelf might indicate that the room is part of a knowledge enterprise, providing knowledge-based clinical support to people. The Easter decoration on the meeting table is a cultural signifier as Easter celebrates the resurrection of Jesus Christ. It suggests that the people associated with the room are either Christians or celebrating Easter out of tradition. It might also suggest that they share essential Christian values like being kind and forgiving, loving and respecting one another. Apart from the Easter decoration, the room is quite sterile. Everyone in the room is white Norwegians. Based on the group members' educational background, they are all middle-class. Belonging to the same class might also involve sharing values or qualities like working hard, self-discipline, aspiration and ambition, although these are not values exclusive to class.

APPENDIX M: Sample of a CA analysis of therapist difficulties

Before the following excerpt, John described the case he has brought to supervision. He has had two therapy sessions with a couple who wants help returning to intimacy and having sex. John feels insecure because he is inexperienced with discussing sex in a clinical context. He finishes his presentation of the supervision request by summarising his difficulties, as illustrated below.

John: But my.. uhh.. my request to you, I was about to say.. uhh.. it is good tips in relation to the way forward, really.
Ann: Hmmm..
John: Because, as I said, I'm quite like.. inexperienced and fumbling with it. So I'm feeling such a.. probably because it's completely new to me, but, but.. talking about sex in such a clinical... form, in a way. That it, it.. I don't quite know what words to use, or how to talk about it so that it doesn't sound weird or awkward. At the same time, I sort of feel that they.. it's going well, in a way.. where we have put the list.. and they are relatively my age, and then I kind of sit and wonder.. He is sort of a very physically fit fellow... and she obviously has quite a few physical ailments. And is that something I should talk about? Is it... it could be that there are some physical limitations? Yes..
Ann: Hmmm..
John: So it's a bit uncertain, both the way forward and for me to... acquire some form of security around the topic.

In the excerpt above, John asks for ***"good tips in relation to the way forward"*** because he is ***"inexperienced and fumbling with it"***. The context makes it clear that ***"it"*** refers to the couple's request for help returning to intimacy and having sex. John then attempts to provide an explanation to illustrate his problem and make it understandable. He says he is ***"feeling such a"*** without saying what this is. Instead, he explains why it comes; ***"probably because it's completely new to me"***. He then refers to talking about sex in ***"a clinical form, in a way"***, apparently to describe what is new to him. When adding ***"in a way"*** to his description of having difficulties with talking about sex in a clinical form, he makes it vague. However, he continues the attempt to clarify his difficulties by explaining he does not know ***"what words to use"***

or how to talk about it in a way that does not ***"sound weird or awkward"***. This problem description comes across as relatively clear. The difficulties are connected to talking about sex and intimacy in therapy and a fear of talking about it wrongly. ***"At the same time"***, he feels, ***"it's going well, in a way"***, where they have put the list in therapy. The description of it going well is vague by how John adds ***"in a way"***. ***"At the same time"*** works as a discourse marker, pointing to the transition between one idea and another (Pridham, 2001, p.32). The utterance comes across as a contradiction to the difficulties John has been describing. He says the couple are his age, seemingly suggesting this is a factor as to why it goes well. He proceeds by sharing an observation. He is ***"very physically fit"***, while she has ***"quite a few physical ailments"***. He uses adjectives to intensify the contrasting features of the parts of the couple. He is ***"very"*** fit, and she has ***"quite a few"*** ailments. The description serves to bring the picture of the couple alive for an audience (Pridham, 2001, p.19). John then questions if he should talk with the couple about ***"that"*** and if there could be ***"some physical limitations"***. It is clear from the context that he refers to the couple's problems with having sex, although the sentence is ellipsed. He utters ***"yes"*** and pauses to signpost the end of explaining his difficulties. Ann provides speaker support with the utterance ***"hmmm"*** and a pause, seemingly to to illustrate that she is interested in John's story. Pauses and voiced pauses provide thinking time and are considered necessary because of the spontaneous nature of the spoken language (Pridham, 2001, p.10). John finishes his turn by explaining it is ***"a bit uncertain"***, both ***"the way forward"*** and for him to acquire ***"security around the topic"***. He sums up his supervision request by using an ellipsed sentence, clearly referring to the way forward in therapy and the topic of talking about sex in a clinical context. The way he repeats his difficulties stresses the main point, which seems to be that he is inexperienced with talking about sex in a clinical context and feels insecure about how to help the couple.

APPENDIX N: Sample of a CA analysis of questioning difficulties

The excerpt below was the last sequence of the question round in Case 1 to clarify John's supervision request. Prior questions had evolved around the couple's difficulties. In this sequence, Liz asked about the therapist's difficulties.

Liz: But what were you.. I didn't quite catch, John, what you wanted input on from the team?
John: No, it was a bit like two things really..
Liz: Yes.
John: Ehh.. it's kind of practical the way forward..
Liz: Yes.
John: Erh..how do we explore this further, what can I help them with..
Liz: Yes.
John: Ehh.. but at the same time maybe also a little for my own part.
Liz: Yeah, because you said something about it being very new to you, and..
John: Yes. I have low self-esteem on the subject, in a way.
Liz: Yeah, yeah.
John: Little experience talking about it in the therapy room.
Liz: Yes, and as you say, what language and words to use, and..
John: Yeah..
Liz: How could we have talked about it in a way that is helpful to you then? The last part there. Because I can only give you a lot of recognition and say that I have felt the same in those cases. Searching for words, can feel a little uncomfortable. A bit clinical and artificial perhaps, even.
John: Yeah..
Liz: So I don't know what you could need from us on the last one..?
John: Maybe a bit like.. your experiences around it, in a way.. erh…. yes. I think that, in a way, would have given me a bit of that... security then, right. When you, when you sit and are... with an experience of little experience, little self-confidence about it, then... then everything becomes scary. And then it's often so in life that when others tell their stories, what I was thinking somehow becomes more advanced.

The sequence starts with Liz saying she "***didn't quite catch***" what John wanted "***input on***" from the team of peers. The rising intonation towards the end of the utterance indicates that it is a question that needs to be answered. Although the question is posed to John, it feels like it is also directed to the group who focused on the couple's problems and not John's difficulties. John answers that it was "***two things, really***" and pauses. Liz gives speaker support by saying "***yes***", indicating that she pays attention. John uses a voiced phrase before pointing out what he wants input on. He describes it as "***kind of practical***" and refers to "***the way forward***". Liz continues to give speaker support by saying "***Yes***". Then, John uses another voiced phrase before explaining his prior utterance in more depth, saying, "***How do we explore this further?***" and "***What can I help them with?***". He seems to be referring to both the exploration he needs to do with the couple and his task as the therapist in charge of the therapeutic process. Liz continues to support the speaker by saying "***Yes***". The intonation when she utters "***yes***" sounds encouraging and as if she expects John to go on. John uses a voiced pause yet another time before adding, "***At the same time, maybe also a little for my own part***". The utterance points to the presentation of the supervision request and his description of feeling inexperienced and insecure when talking with the couple about their sexual problems. Liz illustrates that she listens actively by saying "***Yeah***" and seems to help him along in the conversation by reminding him about what he said before; "***because you said something about it being very new to you***". She adds "***and***", which suggests that there is more to say. However, when she pauses, John takes back his turn. John confirms what he said before by saying "***yes***" and explains his "***low self-esteem on the subject***". Liz supports the speaker by saying, "***Yeah, yeah***" to cheer him along. Without pausing, John continues by explaining that he has little experience talking about sex in the therapy room. Liz confirms she has heard him by saying "***yes***" and refers to his previous descriptions when suggesting, "***What language and words to use***". Again, she adds "***and***", suggesting there is more to say. However, as she pauses, John takes back his turn to confirm that she understands him correctly by saying "***yeah***". This could be seen as an interruption to denote that Liz should not explore his difficulties further or merely indicate that he is eager because he seems to understand him well. Liz leaves the focus on John's difficulties behind when she asks him how to structure the group's response to his requests. She questions how the group might talk about "***the last part there***" in a way that is helpful for John, making

it very clear as to how John's needs are focused. “***The last part there***” refers to John's description of having low self-esteem on the subject. The context-dependent language demonstrates sensitivity by avoiding the repetition of John's difficulties; they are simply referred to as **“the last part there”**. Prior to allowing John to respond to the question, Liz expresses empathy towards him, saying she recognises his difficulties and has felt the same in “***those cases***”. The reference “***those cases***" seems to suggest a category of couple's cases at the Family Welfare Clinic where the problem concerns sexuality and intimacy. Liz points out that she has been searching for her words in similar cases and felt the conversations as "***a little uncomfortable***” and “***artificial perhaps***”. John responds by giving speaker support in uttering “***yeah***” and pausing as if he wants Liz to proceed. Liz, on the other hand, chooses to repeat her initial question. She starts her response by saying “***so***”, signposting that she is closing off the point about recognising John's difficulties. Instead, she asks what John needs from the group on “***that last one***”, again using context-dependent language to avoid addressing John's difficulties directly. John responds by stating that he would like to hear about the group's experiences on the same matter as he thinks this will give him a sense of safety. He adds “***right***” after the utterance, seemingly to engage with his peers. However, given that “***right***” is also a discourse marker, it could be a way of signposting the end of the sequence concerning how to talk about his difficulties in a helpful way. John says, “***Everything becomes scary***” when you have little knowledge and low self-esteem. He then refers to general knowledge, saying, “***It's often so in life***”, before explaining that what you are thinking “***somehow becomes more advanced***” from listening to others telling their stories. His last utterance suggests he is not ruling out that he might be on the right track with this couple, but he needs insurance. It seems the gentle approach to exploring John's difficulties and providing support while questioning his experiences has provided a level of comfort.

APPENDIX O: Sample of an outlined initial analysis report

The following sample is the table of content of the initial analysis report in Case 4 and illustrates the outline of all initial analysis reports presented to research participants.

CASE 4 – INITIAL ANALYSIS

Material to share with the supervision group to get their feedback, reflections and have a dialogue together about the social actions of supervision talk.

TABLE OF CONTENT:

APPENDIX P: Demographic Questionnaire

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DEMOGRAPHIC QUESTIONNAIRE

The questionnaire aims to gather information about the background of research participants. General qualifiers like age, gender, education level, etc. provide a picture of who the participants are and context to research findings. The questionnaire will not reveal personal identification information about participants.

1. What is your gender?
   A. female
   B. male
   C. other
   D. prefer not to say

2. What is your age?
   A. 25-39 years
   B. 40-55 years
   C. 55 +
   D. prefer not to say

3. What is your ethnicity?
   A. white Norwegian
   B. samisk / native Norwegian
   C. Asian or Asian Norwegian
   D. black, African, Caribbean or black Norwegian
   E. Arab or Arab Norwegian
   F. white Scandinavian
   G. white European
   H. another ethnic group……
   I. prefer not to say

4. What is your level of education?
   A. high school + various diplomas
   B. bachelor's degree
   C. bachelor's degree + 2 years specialisation in family therapy
   D. master's degree
   E. master's degree in family therapy

F. psychologist
G. clinical specialist in psychology or family therapy
H. prefer not to say

5. How long have you been practising as a psychotherapist?
   A. less than a year
   B. 1-2 years
   C. 3-5 years
   D. 6-10 years
   E. 10 +
   F. prefer not to say

6. How long have you been working within the Family Welfare Service?
   A. less than a year
   B. 1-2 years
   C. 3-5 years
   D. 6-10 years
   E. 10 +
   F. prefer not to say

7. How long have you participated in regular peer-group supervision within the Family Welfare Service?
   A. less than a year
   B. 1-2 years
   C. 3-5 years
   D. 6-10 years
   E. 10 +
   F. prefer not to say

8. How long have you participated in clinical group supervision after finishing your formal qualification?
   A. less than a year
   B. 1-2 years
   C. 3-5 years
   D. 6-10 years
   E. 10 +
   F. prefer not to say

Thank you for participating!

APPENDIX Q: Consent form – research participants

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NHS Foundation Trust

INFORMED CONSENT TO PARTICIPATION IN RESEARCH

Consent to participate in a research project involving the use of human participants

Research project title: "Systemic group supervisory practice – from content to process"

Name of researcher: Hege Helliesen Hadland

Institution of study: Tavistock and Portman NHS Foundation Trust, UK

	YES	NO
I have read the participant information sheet relating to the research project I have been asked to participate in. The nature and the purpose of the research have been explained to me, and I was allowed to discuss the details and ask questions about the project. I understand what is being proposed, and the procedures I will be involved in have been explained to me.		
I have been explained that observations and reflection groups will be video recorded and communication from supervision transcribed as part of the research method. I confirm my consent to this procedure.		
I understand that my involvement in this research, and data from the inquiry, will remain confidential. Data will be shared with a research team of principle supervisors, but only the researcher has access to data that can identify participants. Data will be kept secure and held for up to 10 years before being destroyed.		
I understand that anonymised participant quotes will be used in publications.		
I understand that the result of the research will be written up in a dissertation and submitted as part of a Professional Doctorate in Advanced Practice and Research: Systemic Psychotherapy. The inquiry may also be published in academic journals or similar forums, media, social media or websites, conferences, internal and external reports, or as feedback to research participants. All identifiable information about participants and Family Welfare Centres will be removed in publications.		
I understand that maintaining strict confidentiality is subject to limitation if a disclosure indicates that a participant or someone else is at serious risk of harm. Such disclosures may be reported to the relevant authority.		
I understand that my participation in this project is entirely voluntary and that I can withdraw at any point without an explanation. I understand that it may not be possible to withdraw my data after the point of data analysis.		
I hereby freely and fully consent to participate in the research project, which has been fully explained to me and for the information obtained to be used in relevant research publications.		

Participant's Name (BLOCK CAPITALS) ……..

Participant's Signature ……..

Investigator's Name (BLOCK CAPITALS) ……..

Investigator's Signature ……

Date: …….