Supervision and Reflective Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



Supervision and Reflective Practice

Using supervision well, becoming a reflective practitioner, and the skills of giving and receiving clinical feedback.

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Supervision and Reflective Practice course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 4. This printing was set on 9 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

Supervision is the single structure the profession relies on to keep practice safe and growing, yet almost no one is taught how to use it well: what to bring, how to bring it, and how to let it change what you do. This course teaches supervision and reflective practice as active skills, for practitioners at any stage who suspect they are getting less from both than they could.

The first module examines what supervision is for, its normative, formative and restorative functions, and the models that structure it, including Hawkins and Shohet's seven-eyed model, then teaches the active skill of bringing material: choosing what to present, presenting it honestly including the uncomfortable parts, and working with supervisory feedback rather than merely receiving it. The second module takes reflection beyond the buzzword: frameworks that produce actual change in practice, the evidence on feedback and self-assessment, whose inaccuracy is one of psychology's more humbling findings, and preparation for one day supervising others.

Substantial written lessons with key points and immediately applicable practice tasks, supported by a study tutor. Ten hours of CPD with around nine months of access, a final assessment, and a personalised certificate on passing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in

supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Use supervision at depth, bringing process, countertransference and mistakes, not only cases
- Apply a structured model of supervision, including the seven-eyed model, from both chairs
- Build reflective practice into your working week with discipline
- Recognise parallel process and use it as information
- Give and receive feedback in supervision honestly and usably
- Develop your internal supervisor: reflection-in-action during the session itself

PART 1

Foundations of Supervision and Reflective Practice

This module explores core supervisory models, the supervisory alliance, and integrating theory with self-awareness.

CHAPTER 1

Functions and models of supervision

Supervision sits at the heart of professional accountability and development in the mental health professions, acting as the primary mechanism by which practice is kept safe, effective, and ethically sound. Understanding the purposes that supervision serves is therefore a prerequisite for any practitioner who wishes to engage with it in a purposeful way. The three-function model proposed by Proctor (1986) remains the most widely cited framework for articulating these purposes. Proctor identified a normative function, a formative function, and a restorative function, and argued that a robust supervisory contract must attend to all three simultaneously. The normative function is essentially an accountability mechanism; it ensures that the supervisee's work conforms to the standards set by the profession, the regulatory bodies, and the employing organisation. In this capacity the supervisor monitors adherence to ethical codes, risk management procedures, and evidence-based practice, and may intervene when the supervisee's conduct threatens client safety or breaches statutory obligations. The formative function, by contrast, is developmental. It provides a structured space for learning, skill acquisition, and the refinement of therapeutic technique. Here the supervisor adopts the role of teacher and mentor, offering feedback, modelling interventions, and encouraging reflective enquiry into the supervisee's growing competence as a therapeutic instrument. Finally, the restorative function attends to the emotional and relational toll that therapeutic work inevitably exacts on the practitioner. It offers a safe container for processing feelings of fatigue, frustration, grief, or vicarious trauma, thereby preventing burnout and preserving the practitioner's capacity to continue providing effective care. Proctor's model stresses that these three functions are interdependent; neglecting any one creates an imbalance that can erode the quality of both the supervisee's work and the client's experience.

While Proctor's functions provide a macro-level map of what supervision is for, Hawkins and Shohet's seven-eye model (2012) offers a more granular guide to where supervisory attention can be directed in any given session. The model is often visualised as a series of concentric circles, each

representing a distinct “eye” through which the supervisor may view the material presented by the supervisee. The first eye focuses on the client’s narrative content – the symptoms, history, and presenting problem as they are articulated in the session. The second eye examines the interventions that the practitioner employed, including the techniques chosen, the timing of their deployment, and the alternatives that were not pursued. The third eye attends to the therapeutic relationship itself, observing patterns of alliance, ruptures, and repair between client and practitioner. The fourth eye turns inward to the practitioner’s own internal experience, noting the emotions, bodily sensations, and personal resonances that the case evokes. The fifth eye expands the focus to the supervisory relationship, recognising the parallel process whereby dynamics that occur between client and practitioner are often mirrored in the interaction between supervisee and supervisor. The sixth eye reflects on the supervisor’s own internal responses, using these resonances as additional data to inform the supervisory dialogue. Finally, the seventh eye situates the work within the broader organisational, cultural, and legal context, acknowledging the influence of policies, team structures, and systemic pressures on the therapeutic encounter.

The power of the seven-eye model lies not merely in its descriptive richness but in the agency it confers upon the supervisee. Because the model delineates multiple possible foci, the supervisee can actively steer the supervisory conversation towards the eye that best serves the current need. For example, a supervisee who feels overwhelmed by a client’s trauma narrative may request that the supervisor adopt the fourth eye, thereby opening a space to explore the supervisee’s own emotional reaction and to engage in restorative processing. Conversely, a supervisee who is uncertain about the efficacy of a particular intervention can invite the supervisor to adopt the second eye, facilitating a formative discussion about technique and decision-making. In this way, the supervisee moves from the role of passive recipient to that of navigator, selecting the functional lens that aligns with the immediate priority – whether that priority is normative, formative, or restorative.

The interplay between Proctor’s functions and Hawkins and Shohet’s eyes can be illustrated through a concrete worked example. Emma, a newly qualified cognitive-behavioural therapist, is supervising a case involving a 34-year-old client, Sam, who presents with severe symptoms of

post-traumatic stress disorder following a motor vehicle accident. Sam's PHQ-9 score is 18, indicating moderate to severe depression, and his GAD-7 score is 15, reflecting high anxiety. Emma has been using exposure-based techniques, but after three sessions she reports feeling a "tightness" in her chest whenever Sam describes the accident, and she notes that she has begun to avoid exploring the most distressing memories. In supervision, Emma first presents the client's narrative (eye one) and the interventions she has employed (eye two). The supervisor, Dr Patel, recognises that Emma's physiological response is a signal of an emerging restorative need. Dr Patel therefore invites Emma to shift to the fourth eye, asking her to describe the bodily sensations and emotions that arise when Sam recounts the accident. Emma articulates a sense of helplessness and identifies a personal history of a similar loss, revealing an unconscious identification with Sam's trauma. Dr Patel then moves to the fifth eye, pointing out the parallel process: Emma's avoidance mirrors Sam's avoidance of the most painful memories, and this pattern is being reproduced in the supervisory dyad. By making this parallel process explicit, Dr Patel helps Emma see that her own defensive stance is influencing her clinical work.

Having identified the restorative need, Dr Patel now integrates the normative function by reviewing the risk management protocol for clients with severe PTSD, ensuring that Emma's avoidance does not compromise client safety. Dr Patel reminds Emma of the professional guidelines regarding exposure therapy, highlighting the importance of maintaining a balance between client readiness and therapeutic challenge. This normative check reassures the service that the case remains within the bounds of acceptable practice. Subsequently, the supervisor returns to the formative function, using the second eye to explore alternative interventions that might be less overwhelming for Emma while still progressing Sam's treatment. Dr Patel suggests a stepped exposure approach, beginning with imaginal exposure in a controlled setting, and proposes the use of grounding techniques to manage Emma's own anxiety during sessions. Emma is encouraged to practice these techniques in a role-play scenario, thereby strengthening her competence and confidence.

Through this sequence, the supervisory dialogue has traversed all three of Proctor's functions while moving fluidly among the seven eyes. Emma's experience illustrates how a supervisee can deliberately steer the supervisory process: she initially presented the case content (eye one), but

when she sensed an emotional overload, she requested a shift to the fourth eye, thereby accessing restorative support. The supervisor's subsequent attention to the normative and formative aspects ensured that the therapeutic work remained safe and that Emma's skill set continued to develop. The example also demonstrates the importance of the parallel process (eye five) as a diagnostic tool for recognising how client-practitioner dynamics can be replicated in supervision, a phenomenon first described by Searles (1955) and later elaborated by Hawkins and Shohet.

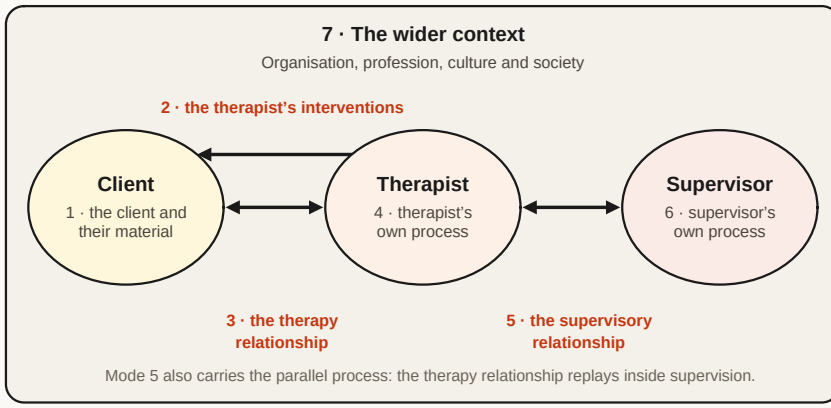
In practice, supervisors often develop preferred patterns of focus, gravitating towards the function and eye that feels most comfortable or that aligns with their own training background. A supervisor whose primary experience lies in risk management may habitually adopt the normative eye, while a supervisor with a counselling background may favour the restorative eye. However, the skilled supervisee is not obliged to accept this default pattern. By explicitly naming the function required – for instance, stating, "I need restorative support today because I am feeling overwhelmed by the client's trauma narrative" – the supervisee asserts agency and guides the supervisor towards the appropriate eye. This collaborative negotiation reinforces the supervisory alliance and ensures that supervision remains responsive to the evolving needs of the practitioner.

It is also essential to recognise that the balance among Proctor's three functions shifts over the course of a practitioner's career. Early in professional development, the formative function dominates, as the novice practitioner requires intensive teaching, modelling, and feedback to acquire core competencies. As the practitioner gains experience and begins to manage more complex or high-risk cases, the normative function gains prominence, demanding rigorous adherence to ethical standards and organisational policies. Throughout, the restorative function remains a constant undercurrent, because the emotional labour of therapeutic work never fully dissipates. In fact, for practitioners working with traumatised populations, the restorative function may become the primary focus for extended periods, necessitating regular opportunities for processing vicarious trauma and preventing burnout.

The seven-eye model also reminds supervisors that the context of the therapeutic work (eye seven) can exert a powerful influence on both the client and the practitioner. Organisational culture, funding constraints, and

legislative mandates can shape the therapeutic agenda, sometimes creating tensions between normative expectations and the practitioner's clinical judgment. By bringing the seventh eye into supervision, the supervisor can help the supervisee navigate these systemic pressures, negotiate realistic treatment goals, and advocate for necessary resources. This systemic awareness is particularly relevant in the UK context, where the National Health Service's commissioning frameworks and the requirements of the Health and Care Professions Council (HCPC) impose specific standards that must be integrated into everyday practice.

In summary, the integration of Proctor's three-function model with Hawkins and Shohet's seven-eye framework provides a comprehensive map for both supervisors and supervisees. The normative function safeguards client safety and professional standards, the formative function cultivates therapeutic competence, and the restorative function sustains the practitioner's wellbeing. The seven eyes offer a flexible lens through which supervisory attention can be directed, allowing the supervisee to steer the conversation towards the most pressing need at any given moment. Mastery of these concepts enables the supervisory relationship to move beyond a perfunctory case review, evolving instead into a dynamic, collaborative process that simultaneously protects clients, develops practitioners, and nurtures the emotional health of the therapist. The next lesson will build on this foundation by exploring concrete strategies that supervisees can employ to assert their steering role, ensuring that supervision remains a truly reciprocal partnership.



After Hawkins and Shohet.

FIGURE 1.1 The seven-eyed model of supervision

Hawkins and Shohet's seven modes give supervision its lenses: the client and their material, the therapist's interventions, the therapy relationship, the therapist's own process, the supervisory relationship itself (including parallel process), the supervisor's process, and the wider organisational and social context around all of it.

Points worth keeping

- Proctor: normative, formative, restorative, all three
- Seven eyes: from client content to parallel process and context
- The supervisee can and should steer

PRACTICE TASK

Review your last supervision: which function dominated, which was starved, and what will you ask for next time?

CHAPTER 2

Bringing material: the active skill

Supervision is the crucible in which clinical practice is refined, and the quality of that crucible is determined not merely by the expertise of the supervisor but by the material that the supervisee elects to bring into the hour. The research on disclosure in supervision shows a consistent pattern. In the study by Ladany, Hill, Corbett and Nutt (1996), almost all of the trainees surveyed (97.2 per cent) had withheld information from their supervisors, most often negative reactions to the supervisor, personal issues, clinical mistakes and concerns about evaluation. Supervisees tend, in other words, to conceal the moments that carry the greatest learning potential. The sessions that have gone wrong, the fleeting feelings of shame that accompany a client's resistance, the subtle boundary drift that feels like a betrayal of professional standards, the client who provokes a visceral dislike, and the precise instant when the therapist freezes – these are the pieces of data that most often remain hidden. This concealment is understandable; supervision is simultaneously a space for evaluation, a gate-keeping function, and a venue in which the supervisee wishes to be seen as competent. Yet it is precisely this concealment that undermines the developmental purpose of supervision, allowing the hour to become populated by polished case narratives while the real growth work stays at home. The antidote, therefore, is encapsulated in the lesson's headline: the material you least want to bring is the agenda. Reluctance itself becomes a flag, a signal that the most valuable material is being avoided. The case you would rather not discuss, the moment you have edited out of every account, the exception you have not mentioned for three weeks – that is the material for Tuesday's supervision, and it should be named explicitly as 'there is something I notice I do not want to tell you, which is presumably why I must.'

Preparation transforms supervision from a reactive, often perfunctory encounter into a deliberate, data-driven investigation. Arriving with a precise question, rather than a vague story, gives the hour a target and the supervisor a brief. A question such as 'I want to understand why session nine derailed,' or 'I need a decision about the risk plan for client X,' or 'I want to explore why I dominate the conversation with this client,' frames the

supervision as an inquiry into a specific phenomenon. In contrast, presenting a narrative without a question invites a pleasant but aimless review, where the supervisor may drift into summarising rather than probing. The craft of presenting is equally important: verbatim moments must be brought in preference to paraphrased summaries. When a supervisee says, 'She said, "I feel hopeless," then I replied, "Tell me more," and there was a silence that I filled with a reassurance,' the texture of the interaction – the tone, the pause, the therapist's immediate response – is preserved. This texture is where the pattern hides, and it cannot be captured by a smooth summary that has already been filtered through the presenter's interpretive lens. Recordings, where consent and setting allow, are the gold standard for this purpose; where recordings are not feasible, the disciplined habit of writing down key exchanges immediately after the session safeguards the material from the eroding effects of memory.

Parallel process, introduced in the preceding lesson, becomes a working instrument here: the supervisee must treat the client-practitioner dynamic that re-enacts itself between supervisee and supervisor as data, not as embarrassment. Searles's (1955) classic observation that the supervisory relationship can mirror the therapeutic relationship is not merely a theoretical curiosity; it is a source of clinical information. When a supervisee presents a client in an unusually vague manner, or adopts a defensive stance that mirrors the client's defensiveness, or expresses hopelessness that reflects the client's hopelessness, these are not accidental; they are the parallel process carrying information that no summary can convey. The skilled supervisee learns to notice this first: 'I am noticing that I keep apologising as I describe this case, and I think that mirrors the client's own apologetic stance.' Recognising the parallel process allows the supervisee to bring to supervision the very data that illuminate the underlying relational patterns.

Feedback, in this model, is not a one-way transmission of advice but a piece of material that is worked with, tested, and either integrated or challenged. Supervisory observations should be treated like any other data set: they are explored against the verbatim record, trialled in practice, and reported back in subsequent sessions. Disagreement is not only permissible but essential. A supervisee who cannot voice disagreement has imported the compliance that ultimately fails clients. The supervisory dialogue therefore becomes a collaborative experiment, where hypotheses are generated, data are

examined, and interventions are refined.

To illustrate these principles, consider the following worked example. Dr. Patel, a psychotherapist with three years' experience, booked her supervision session with a written question: 'Why did I allow client M to reduce his fee when I hold fees firmly with everyone else?' She arrived with a transcript of the exact exchange from the session in question: 'M: "I'm struggling financially, can we lower the fee?"; Me: "I understand, but the fee is important for the work we do."; M: "If you can't, I might have to stop."; Me: (silence) "Okay, let's discuss a plan."' Dr. Patel also noted her internal urge to justify the decision rather than examine it, and she reported a feeling of unease that she had not shared with anyone else. In the supervision hour, the supervisor asked, 'What does the silence after M's statement tell you about your own stance?' Dr. Patel reflected that the silence was a moment of discomfort, mirroring the client's own hesitation. The supervisor then highlighted the parallel process: Dr. Patel's reluctance to confront the fee issue mirrored the client's reluctance to discuss financial strain. Together they explored the pattern, naming it as 'fee negotiation as relational negotiation,' and decided that the fee should be restored, but with a clear, compassionate explanation of the therapeutic rationale. Dr. Patel left the session with the agenda – the fee issue – no longer hidden, and with a concrete plan to monitor how similar negotiations unfold in future sessions. The hour had been driven by a specific question, anchored in verbatim material, and enriched by the parallel process data, resulting in a clear learning outcome.

The implications of this active skill extend beyond any single supervision hour. By consistently preparing a question, the supervisee cultivates a habit of enquiry that aligns with the evidence-based practice of reflective practice, as championed by Schön (1983) and later by Kolb's experiential learning cycle (1984). By bringing verbatim moments, the supervisee ensures that the supervisory conversation is grounded in the lived reality of the therapeutic encounter, preserving the phenomenological richness that is essential for pattern recognition, a process highlighted in the work of Safran and Muran (2000) on ruptures and repairs. Treating parallel process as data aligns with the systemic perspective advocated by Minuchin (1974), which locates individual difficulties in the patterns of the relationships around them. Finally, embracing feedback as material to be tested respects the scientific ethos of the evidence-based practice movement.

In practice, the supervisee should adopt a three-step routine for each supervision session. First, formulate a concise, focused question that captures the specific dilemma or curiosity. Second, select a verbatim excerpt – ideally a direct transcript or a detailed, contemporaneous note – that exemplifies the phenomenon under investigation. Third, attend to the parallel process, noting any emotional or behavioural mirroring that occurs in the act of presenting the material. During the supervision hour, the supervisee presents the question, the verbatim excerpt, and the observed parallel process, inviting the supervisor to treat each element as data. The supervisor, in turn, offers observations that are explicitly linked to the presented material, and together they generate hypotheses, experiment with interventions, and plan for follow-up. This structured yet flexible approach ensures that supervision remains a site of genuine learning rather than a venue for superficial case review.

It is worth noting that the reluctance to bring the agenda is not a sign of weakness but a natural protective response. Studies of what supervisees withhold, including that of Ladany and colleagues (1996), in which concerns about evaluation were among the things most often left unsaid, suggest that fear of judgement is a powerful inhibitor of honest reporting. By naming the reluctance – 'there is something I notice I do not want to tell you' – the supervisee externalises the internal barrier, making it visible and therefore amenable to collaborative exploration. This act of naming is itself a therapeutic intervention: a feeling that has been acknowledged and named becomes something that can be explored and worked with.

In summary, the active skill of bringing material to supervision rests on three interlocking pillars: the preparation of a precise question, the presentation of verbatim moments, and the treatment of parallel process as data. These pillars draw on a long tradition, from Bion's early work on containment to contemporary reviews of what makes supervision effective (Milne & James, 2000). By adhering to this framework, supervisees move from a passive role – where supervision is a space for the supervisor to dispense advice – to an active role, where the supervisee drives the learning agenda, supplies the raw data, and engages in a collaborative inquiry. The result is a supervision hour that not only addresses the immediate clinical dilemma but also cultivates the reflective capacity that underpins lifelong professional development. The ultimate aim is not merely to resolve a single case but to embed a habit of honest, data-driven reflection that will enhance therapeutic

competence across the entire spectrum of practice.

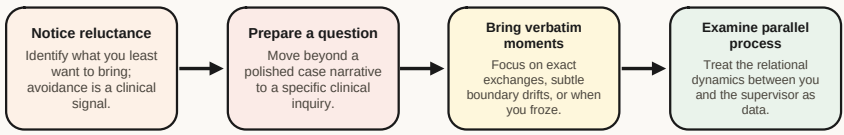


FIGURE 2.1 Bringing Material: The Active Skill
Preparation transforms supervision from a reactive account into a crucible for growth. Follow these steps to bring the material that truly matters.

Points worth keeping

- Prepare a question; bring verbatim moments
- Parallel process is data
- What you least want to bring is the agenda

PRACTICE TASK

Identify the case you have not brought to supervision, and the sentence with which you will open it.