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Supervision in Motivational Interviewing: An Exploratory Study

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Background: Although supervision is believed to be an important strategy for training practitioners in evidence-based practice, little is known about how it should be organized and conducted to promote implementation fidelity. **Aims:** To explore supervisor behaviours that might facilitate supervisees' proficiency in motivational interviewing. **Method:** In this exploratory study, ten supervisors from a primary prevention intervention of childhood obesity responded to semi-structured interviews about their supervision behaviours. A mixed method approach was used; both qualitative and quantitative data were collected and analysed. **Results:** The supervisors reported using several sources of information for evaluating and providing systematic feedback on supervisees' performance. However, the majority did not

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use the available objective measures of proficiency as the primary source. Moreover, half of the supervisors argued that objective feedback might have a punishing effect on the supervisees. **Conclusions:** Variation in the use of supervision components that previous research has proposed to be potentially influential to the process and outcome may lead to less efficient supervision. Findings suggest that appropriate supervision activities conducted in each supervision session require clear supervision principles that specify the content and procedure of the supervision, as well as regular adherence monitoring of the supervision sessions.

Keywords: Motivational interviewing, clinical supervision, training, objective feedback, MITI

Introduction

Research on evidence-based treatments (EBT) rarely leads to evidence-based practice (EBP) in routine clinical care without careful training and quality assessment of the delivery of treatment. Beidas and Kendall's (2010) review of empirical evaluations of strategies for training clinicians in EBP shows that didactic training alone has some impact on practitioners' perceived declarative knowledge, but minimal influence on their treatment adherence and skilfulness. Motivational interviewing (MI) is an EBT with a firm evidence base across a wide variety of health behaviours (Hettema et al., 2005; Lundahl et al., 2010, 2013). MI is a client-centred and directional therapeutic method for strengthening clients' motivation and commitment to change (Miller and Rollnick, 2013). Miller and Rollnick (2013), the founders of MI, have emphasized that MI is not a set of specific techniques, but a skilled style of counselling that requires careful training. As interest in MI continues to grow, training in MI is also becoming more established. However, there is a lack of knowledge regarding the content and structure of effective MI training. Previous research indicates that the most common training format, a two-day workshop consisting of didactic instructions and experiential exercises, may not be sufficient for providing the majority of practitioners with long-term proficiency in MI, and that subsequent supervision, including systematic feedback and coaching, is more likely to enhance skills (Madson et al., 2009; Barwick et al., 2012; de Roten et al., 2013; Schwalbe et al., 2014).

Supervision theory and research

In general, supervision suffers from an absence of empirical support of effectiveness as well as a lack of well-defined supervisory procedures that can be reliably observed and measured (Reiser and Milne, 2011). However, there is some previous research indicating that supervision has a beneficial effect on supervisees in terms of self-awareness, skills, self-efficacy, theoretical orientation, and the supervisee–client relationship (e.g. Wheeler and Richards, 2007; Watkins, 2011). In recent years, scholars have emphasized the importance of competency-based clinical supervision (Borders et al., 2011; Falender and Shafranske, 2012; Bernard and Goodyear, 2014). Competency-based supervision is a meta-theoretical approach to supervision that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, inform learning strategies and evaluation procedures, and meet criterion-referenced competence standards consistent with EBP (American Psychological Association, 2015; Falender and Shafranske, 2007). This type of supervision often relies upon direct observation of practice, performance feedback and coaching as a means to

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train therapists to become adherent and competent in their practice of EBTs (Falender and Shafranske, 2012; American Psychological Association, 2015), particularly in clinical trials (Martino et al., 2008; Roth et al., 2010). However, certain elements of competency-based training and supervision have often been neglected in the transmission of new treatments to routine clinical settings (Roth et al., 2010; Olmstead et al., 2012). One example of a competency-based supervision approach used in several MI effectiveness trials and developed as a toolkit for use in clinical settings is the Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA: STEP) (Martino et al., 2006). In a recent randomized controlled trial of the MIA: STEP used in community treatment programmes, when compared with supervision as usual (SAU), clinicians allocated to the MIA: STEP showed greater increases in the skill in which they used MI strategies, although not in the frequency of MI than clinicians allocated to SAU. Moreover, there were no differential beneficial effects by types of supervision on client treatment retention or outcomes, and MIA: STEP was substantially more expensive to deliver than SAU (Martino et al., 2016). Clearly, more research is needed concerning how clinical supervision should be conducted to promote effective implementation of EBP in routine clinical care.

The aim of the present study was to explore ten supervisors' behaviour in a primary prevention intervention of childhood obesity (PRIMROSE) conducted at child health centres in Sweden (Doring et al., 2014). The PRIMROSE study results showed no significant intervention effect on either body mass index (BMI) or physical activity, but a small positive effect on children's eating habits (Doring et al., 2016). Additionally, two previous studies showed that the relatively comprehensive MI training package offered to intervention nurses in the trial, including both initial workshop training and nine supervision sessions, was not effective in developing sufficient proficiency in MI among the supervisees (Bohman et al., 2013; Eno Persson et al., 2016). Results suggest the need to examine more closely the way the supervisors behaved while conducting supervision and the attitudes they had towards some of the key components of the supervision they were expected to deliver during the trial. The present study used mixed qualitative and quantitative methods to address these questions

Method

Study setting: the PRIMROSE trial

The present study was conducted with supervisors of the PRIMROSE trial, a randomized controlled primary prevention intervention of childhood obesity conducted in eight county councils of Sweden (Doring et al., 2014). Nurses at child health services conducted the manual-based programme with participating families. Focus for the individual sessions was for parents to improve and/or maintain their own healthy eating and physical activity habits. In the programme, behaviour changes were primarily conceptualized in terms of MI, but were additionally informed by learning theory and principles of cognitive behavioural therapy (CBT). Manual content was designed to be congruent with the style of MI. Prior to the trial, nurses in the intervention group were trained in MI and dietary and physical activity interventions, as well as the basic principles and procedures of learning theory (e.g. stimulus control, conditioning) and CBT (e.g. monitoring, homework). The training in MI, which consisted of a workshop followed by supervision including systematic feedback

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and coaching, has been described in detail elsewhere (Bohman et al., 2013). Following the MI training, which included four supervision sessions on practice samples, nurses received systematic feedback based on 20-minute segments of audio-recorded practice samples in five additional supervision sessions. For a detailed description of the supervision, please see 'Supervision in the PRIMROSE Trial' below. The audio-recorded samples were coded according to the Swedish translation of the Motivational Interviewing Treatment Integrity (MITI) Code version 3.0 (Forsberg et al., 2007), a standardized assessment instrument that can be used as a treatment integrity measure for clinical trials of MI, and to provide structured, objective feedback to increase clinical skills in the practice of MI. The MITI coding was performed by the Motivational Interviewing Coding (MIC) Lab at the Department of Clinical Neuroscience at Karolinska Institutet in Stockholm, Sweden. According to a system for interpreting an intra-class correlation coefficient (ICC) proposed by Cicchetti (1994), the coders' inter-rater reliability ranged from fair (i.e. an ICC between 0.40 and 0.59) to excellent (i.e. an ICC between 0.75 and 1.00) during the three-year period of supervision within the PRIMROSE study (Bohman et al., 2013). The PRIMROSE study has been registered (ISRCTN16991919), and approval was obtained from The Regional Ethical Review Board in Stockholm, Sweden, for both the PRIMROSE trial and the present study (2006/525-31/2).

Participants

Participants were the ten supervisors in the PRIMROSE trial. The mean age was 49.4 years (SD = 9.9, range = 34.0–68.0). Seven were females and nine had previous training in CBT. Five were psychologists, three were nurses, one had a university degree in behavioural sciences, and one was an occupational therapist. On average, the supervisors had 7.0 years (SD = 6.5, range = 2.5–25.0) of experience as MI trainers, and 4.0 years (SD = 3.7, range = 1.0–15.0) of experience as MI supervisors. All supervisors were members of the Motivational Interviewing Network of Trainers (MINT), which organizes practitioners trained to train others in MI. Participation was voluntary and confidential, and prior to the interviews all the supervisors signed an informed consent form.

Supervision in the PRIMROSE trial

The supervision was conducted from May 2008 to April 2011. Even though the PRIMROSE trial was based on both MI and CBT, the supervisors' sole focus during supervision was the nurses' skills in MI. On average, the ten supervisors had 4.8 supervisees (SD = 2.8, range = 2.0–11.0) in supervision. To establish and facilitate a good working relationship, all the supervisors attended the last day of the MI training workshop in which they engaged in role-plays with the supervisees, discussed the procedures related to recording of practice samples and planned for the forthcoming supervision sessions. All the supervisees in the trial were offered a total of nine individual telephone-based supervision sessions based on practice sample recordings. The first four practice samples contained self-selected families who were not participants of the PRIMROSE trial. Supervision of these samples was conducted to help the supervisees gain proficiency in MI. The last five recordings were randomly sampled from the available intervention families. The primary purpose of the supervision of these samples was to facilitate further development of MI skills and to ensure that the supervisees were

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following the basic principles of MI. The recordings were uploaded on the project website for supervisors to listen to before the sessions. The first and the fifth to the ninth of the recordings were coded according to the MITI. The protocols were then sent to the supervisors before supervision, and to the supervisees before or during the supervision sessions. Hence, the first and the fifth to the ninth supervision sessions were based on both the session recordings and the MITI protocol, whereas the remaining three supervision sessions were based on the session recordings only. The MITI protocols included both summary scores related to the recommended reference values for basic MI competence, and written examples of good MI practice along with examples of areas of improvement. Each of the supervision sessions was planned to last for 30 minutes with intervals of 3 weeks between the first four sessions, 2 months for the following two sessions, and 3 months for the last three supervision sessions. Additionally, the supervisors had at their disposal 30 minutes for preparation (e.g. listening to the recorded practice samples) and 30 minutes for compiling the supervision for each session. The supervisors were asked to record the total amount of time spent on the three parts. On average, the supervisors spent 18.6 minutes ($SD = 7.6$, range = 5.0–75.0) on preparation, 32.1 minutes ($SD = 6.5$, range = 15.0–60.0) on supervision, and 11.2 minutes ($SD = 4.6$, range = 5.0–30.0) on compiling the supervision. The ninth supervision session was extended to 45 minutes to allow time for a summary of the training period, with a focus on the supervisees' MI progress and maintenance of the acquired skills.

The intention was that the PRIMROSE supervision would be conducted according to the following instructions. When available, the supervision would be based on the results of the MITI. The supervisors would structure each session using a form with four questions: (1) What did the supervisee do well?; (2) What can the supervisee do more of?; (3) What can the supervisee do less of?; and (4) What does the supervisee take into consideration for future practice? The purpose of the questions was to find and reinforce MI-consistent behaviours, and to identify the MI-inconsistent behaviours that could use improvement. The supervisors should always start by asking what area the supervisees would like to focus on in the development of skills, and then initiate a discussion of that area while blending in the results of the MITI. Lower scores on the MITI should be framed as starting points in the learning process. The supervisors had access to telephone supervisory meetings once a month throughout the supervision period and were also supported by local PRIMROSE trial coordinators in case of practical difficulties with the practice sample recordings.

Data collection

Data on supervision content and process were collected in one-to-one semi-structured telephone interviews with the supervisors. As there was no existing tool in the literature to assess the supervisors' perception of their behaviours during supervision, the study authors developed the interview protocol to ascertain the supervisors' behaviours and attitudes as they related to the expected supervision practice (Table 1). The final protocol consisted of 32 questions presented in a consistent order. The first eight questions covered aspects of participants' demographics (gender, age, education and professional experience). The remaining 24 questions covered PRIMROSE trial-specific aspects of MI supervision, as well as generic aspects of supervision based on supervision research. Several response formats were used, including forced-choice, free text, and visual analogue scales. The protocol was sent by e-mail prior to the interview so that the supervisors would have time to reflect on

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Table 1. Questions 9 to 32 of the interview protocol

9	Below you will find several possible starting points for the agenda setting. Please rate them in terms of how important they are to you when structuring your sessions by ranking them in descending order. You may also add starting points important to you. The MITI coding Requests from the supervisee The audio recorded practice sample Feedback from previous sessions . . . . .
10	Please outline the way you usually structure your supervision sessions. List the main features in the order you utilize them, and report the approximate time required for each one.
11	What component(s) of supervision do you think is/are most important for the supervisee's acquisition of MI skills? If more than one component, please rank them in descending order.
12	Do you think any component(s) of supervision might have a negative effect on the supervisee's MI's skill acquisition? If more than one aspect, please rank them in descending order.
13	To what extent do you usually practice supervision in a style consistent with MI? Please choose a number between 0 (not at all) and 100 (to a very large extent).
14	Which MI principle(s) and/or strategy(ies) do you typically use in your supervision? If more than one principle and/or strategy, please rank them in descending order.
15	What is your most crucial tool for identifying the strengths in the supervisee's MI practice? Please check off one alternative below or describe a tool of your own. The MITI coding The audio recorded practice sample The supervisee's judgement of their practice sample Other, please specify . . . . .
16	What is your most crucial tool for identifying the weaknesses in the supervisee's MI practice? Please check off one alternative below or describe a tool of your own. The MITI coding The audio recorded practice sample The supervisee's judgment of their practice sample Other, please specify . . . . .
17	Please rate your balance in focus on the supervisee's strengths and difficulties during sessions. Estimate the balance in per cent (with the total sum 100). . . . . . % Strengths . . . . . .% Difficulties
18	What rationale do you provide to the supervisee to help them use the ratings in the MITI protocol in a constructive way?
19	How do you use the MITI as part of your supervision practice?
20	When and how do you provide the MITI protocol outcome to the supervisee?
21	When listening to the recorded practice sample, to what extent do you usually focus on what the supervisee says in relation to what the client says? Estimate the balance in per cent (with the total sum 100). . . . . . % Focus on supervisee . . . . . .% Focus clients
22	Do you think 30 minutes is enough time to prepare ahead of the supervision sessions? Please check off one of the alternatives. YES NO

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Table 1. Continued

23	Do you find 30 minutes is enough time for the supervision sessions? Please check off one of the alternatives. YES NO
24	Do you find 30 minutes is enough time to compile the supervision sessions? Please check off one of the alternatives. YES NO
25	How many minutes of the recorded practice samples do you usually listen to?
26	How many sequences of the recorded practice samples do you usually listen to?
27	What part of the recorded practice samples do you usually listen to?
28	Please explain the reasons why supervision sessions are not always conducted according to the time instructions. Reasons related to me as supervisor Reasons related to the supervisee
29	How do you think telephone supervision compares to face-to-face supervision? Please choose a number between 0 (not at all) and 100 (to a very large extent).
30	Do you think MI is consistent with a manual-based intervention, such as PRIMROSE? Please check off one of the alternatives. Not consistent Partially consistent Fully consistent
31	Are the monthly telephone supervisory meetings helpful for your supervision practice? Please rate their helpfulness from 0 (not at all) and 100 (to a very large extent).
32	In what way do you find the monthly telephone supervisory meetings helpful to your supervision practice? Please provide a brief answer. If more than one way, please rank them in descending order. Additional comments and suggestions: . . . . .

the questions. As the first author was a supervisor in the PRIMROSE trial, the second author interviewed the first author to avoid response bias. Thereafter the first author interviewed all other supervisors. The interviews lasted between 28 and 34 minutes.

Data analysis

This was an exploratory study using a mixed method approach; both qualitative and quantitative data were collected. *Qualitative analysis*: A conventional qualitative content analysis (Hsieh and Shannon, 2005) was used to analyse the textual data from the interviews. Coding was developed inductively (from the data content) as opposed to employing a predefined coding scheme. Following the transcription of the interviews, two members of the research team independently analysed the supervisors' qualitative statements. Common themes and contrast statements (either words, phrases or sentences) across interviews were extracted; data were coded and similar elements were summarized thematically. The two research team members then compared their results and discussed the ratings they disagreed upon until they reached a consensus. *Quantitative analysis*: Descriptive statistics were generated and presented as mean (*SD*, range) for the demographic characteristics and for the amount of time spent on preparing, conducting and summarizing the supervision session. For the forced-choice questions and the visual analogue scales, frequencies and percentages (*SD*,

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range) were reported. All these analyses were performed using the SPSS (version 22, SPSS Inc., Chicago, IL, USA).

Results

The five primary themes identified in the analysis were: Structure of the sessions, Educational methods and techniques, Assessment of learning needs, Supervision in an MI-consistent manner, and Difficulties and opportunities.

Structure of the sessions, Educational methods and techniques, and Assessment of learning needs

As the most important starting point for the agenda setting, five supervisors indicated their own listening to the supervisees' recorded practice samples, two reported the results of the MITI, two reported the supervisees' individual requests, and one described elements of focus from earlier supervision sessions. Three parts of the supervision sessions could be discerned from almost all the interview responses: All ten supervisors mentioned an initial and a middle part of the supervision session that included somewhat different educational methods and techniques, and six of the them also mentioned a third part at the end of the supervision session (Table 2):

> In the introduction, which takes about 7 minutes, I begin by asking if she has listened to the recording and received the protocol. Then I ask for her thoughts and give her feedback. I also follow up on my notes from previous sessions and check to see if she has been practising. Finally, we set the agenda – what should we talk about this time?
>
> In the end I let her summarize: What does she take with her from the supervision session? What does she think would be a good focus for practice? What's her plan for practice? When will she do it and when will she record her next practice sample? I always give a maximum of two things to practise. The last thing we do is to evaluate: What worked in this session and what would she like more of in the next? This takes about five minutes.

The majority of the supervisors reported that listening to the recorded practice samples were their most crucial tool for identifying strengths and weaknesses in the supervisees' MI practice (Table 3). On average, the ten supervisors reported spending 72.0% (SD = 12.3, range = 40.0–85.0) of supervision session time focusing on strengths in supervisees' MI practice, and 28.0% (SD = 12.3, range = 15.0–60.0) focusing on weaknesses.

Supervision in an MI-consistent manner

On average, the supervisors estimated that 44.4% (SD = 11.3, range = 30.0–70.0) of supervision session time was used for talk produced by themselves, and that they on average influenced 55.6% (SD = 14.0, range = 25.0–70.0) of the supervision session content. The supervisors also estimated that they focused on the supervisees' talk 66.0% (SD = 15.2, range = 50.0–85.0) of the total time, relative to the client's talk, when listening to the recorded practice samples. All ten supervisors reported that they tried to deliver the supervision in a style consistent with MI, with somewhat different MI strategies and techniques (Table 4):

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Table 2. Educational methods and techniques in the three parts of the supervision session

Educational methods and techniques	*n* (%)
Initial part of the supervision session	
Collaboratively set the agenda	3 (30)
Review homework from previous session	4 (40)
Create a bridge between the previous and the current session	8 (80)
Elicit supervisee reflections of the practice sample	5 (50)
Middle part of the supervision session	
Systematic feedback based on the MITI protocol	10 (100)
Systematic feedback based on the audio-recorded practice samples	10 (100)
Elicit supervisee reflections of the practice sample/the MITI	10 (100)
Verbally adjust behaviours that could be improved	10 (100)
Verbally reinforce MI-consistent behaviour	10 (100)
Role play	5 (50)
Assign homework	2 (20)
Last part of the supervision session	
Summarize the session	4 (40)
Evaluate the session	5 (50)
Assign homework	6 (60)

Table 3. The supervisor's tools for assessment of the supervisee's learning needs

Tools for assessment	*n* (%)
The most crucial tool for identifying the supervisee's strengths	
The audio recorded practice sample	9 (90)
The MITI coding	1 (10)
The most crucial tool for identifying the supervisee's weaknesses	
The audio-recorded practice sample	7 (70)
The MITI coding	2 (20)
The supervisee's judgement of their practice sample	1 (10)

Table 4. The five most common MI strategies and techniques practised by the supervisors

MI strategies and techniques practised by the supervisors	*n* (%)
Reflective listening	7 (70)
Open-ended questions	5 (50)
Affirmations	4 (40)
Elicit change talk	4 (40)
Summaries	4 (10)

I use my listening skills; affirmations, reflections and also give support to the supervisee during the session. I also always set an agenda, structure the goals for the session and use collaboration skills.

MI is difficult and time is limited. It means that I cannot always be as MI consistent as I want. Sometimes, for example, I inform rather than explore.

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On average, the supervisors estimated the extent to which they practised MI in the supervision sessions to 68.0 ($SD = 18.1$, range = 25.0–85.0) on a scale ranging from 0 (not at all) to 100 (to a very large extent).

Difficulties and opportunities

Five supervisors reported the supervisees' individual thoughts and reflections about the practice samples being the most important factor for learning MI skills, while four supervisors reported their own feedback, and one the role-plays. None of the ten supervisors described the results of the MITI as the most important factor for learning MI skills, and five supervisors argued that feedback based on the results of the MITI might have a negative effect on the supervisees' learning:

> The protocol sometimes has a punishing effect. I try to moderate it by highlighting the positive aspects of the codings and supporting her confidence in her ability to learn and develop.
>
> The supervisee's experience of her MI performance as poor – which is compounded by her listening to the protocol – sometimes gets confirmed by the protocol. I try to highlight what worked and normalize the difficulties of learning a new skill.

Nonetheless, the majority ($n = 8$) of the supervisors tended to conceptualize feedback according to the MITI as an opportunity for learning, and four supervisors did not believe that the MI supervision involved any negative features whatsoever:

> MITI gives you a picture of the supervisee's skills in that session, especially where she's strong. It's a tool for identifying strengths and difficulties, and opportunities for development. It also gives you the opportunity to monitor progress over time. It's one of many ways to obtain information about the supervisee's skills.
>
> It's a tool for learning MI. We have this tool to learn. It provides areas to choose from when considering learning objectives. It gives an overview of the session and helps to set priorities.

Supervisors estimated the extent to which telephone supervision is as useful as face-to-face supervision to 78.6 (SD = 21.7, range = 25.0–100.0) on a scale ranging from 0 (not at all) to 100 (to a very large extent). Four supervisors believed that a manual-based intervention such as the PRIMROSE trial was consistent with MI, whereas six supervisors believed it to be only partially consistent.

Discussion

The aim of the present study was to explore the supervisors' experiences of MI supervision in a primary prevention intervention of childhood obesity (Doring et al., 2014). The results from the interviews showed that many of the reported MI supervision behaviours were similar among the supervisors during supervision, but also that a number of behaviours varied. The results also showed that none of the supervisors felt that the MITI was relatively important for supervisees to learn MI, and half of them felt that MITI-based feedback might have a negative effect on supervisees' learning.

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Supervisor's use of MITI as a training tool

The most surprising finding was that not all supervisors used the available objective measure of proficiency (i.e. the MITI protocol) as the primary source for performance evaluation and systematic feedback: eight of the ten supervisors reported using sources other than the protocol as the most important basis for the supervision sessions, nine supervisors suggested listening to the recorded sessions and not the MITI as being the most crucial tool for identifying the supervisee's strength in practising MI, and seven supervisors suggested their own listening and one the supervisees' individual judgement as the most crucial tool for identifying the supervisees' weaknesses. Additionally, although eight of the supervisors conceptualized feedback according to the MITI as an opportunity for learning, none of them reported the results of the MITI as the most important factor for learning MI.

MITI-based feedback

Five of the ten supervisors argued that feedback based on the results of the MITI might have had a punishing effect on the supervisees. This illustrates the impact of the emotional context in the process of developing competence during clinical supervision. Some previous research proposes that supervisees may be anxious and fear negative evaluations from their supervisors (Friedberg et al., 2009; Lombardo et al., 2009; Abernethy and Cook, 2011; Clarke and Giordano, 2013). Other findings suggest that the common belief that recording and monitoring of therapy sessions is debilitating to the supervisee or to the supervision process is a misconception (Ellis, 2010). In a summary of sixteen studies investigating supervisee anxiety over approximately 20 years (Ellis, 2010), supervisees were not found to be overly anxious, and the results showed that supervisees in general quickly adopt to the recording and monitoring of therapy sessions. However, the summary also showed that when there was a deficient working relationship between supervisor and supervisee, anxiety ran high, as opposed low anxiety with the existence of a satisfactory working relationship. Also, in a study of 128 supervisees' experiences of supervision, both positive and challenging feedback seemed to be uniquely beneficial to supervisees, leading to the conclusion that supervisors should recognize that supervisees can handle challenges, especially within a positive supervisory relationship (Ladany et al., 2012). Conducting MI supervision in a manner consistent with MI, in which both the knowledge and techniques are tailored and used as learning strategies, has been proposed as a way to provide the supervisee with experience of the method, to model its use during supervision, and to work with the supervisory relationship (Martino et al., 2008; Clarke and Giordano, 2013). Moreover, an MI approach to MI supervision has the advantage of relying on theoretical principles and empirical knowledge of factors facilitating behaviour change (Martino et al., 2008; Stein et al., 2015), and is consistent with the proposed components of the supervisory relationship (American Psychological Association, 2014). All the supervisors of the PRIMROSE trial reported delivering an MI-consistent supervision style with reflective listening, using open-ended questions and eliciting change talk about supervisees' MI behaviours as the most common strategies.

Supervisor drift

Therapist drift is a well-known concept with a range of origins: cognitive bias, emotional reactions and context-driven behaviours (Waller, 2009). Just as practitioners must keep in

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mind that they are prone to the same biases as their clients, supervisors must be cognizant of distortions that could drift them off track; and just as practitioners need to be both skilled and adherent for their practice to be effective, supervisors must deliver supervision in a competent manner. In this study, eight of the ten supervisors used their own listening to the recorded sessions instead of the MITI protocol as the primary source for performance evaluation and systematic feedback, and half of them expressed concerns that MITI-based feedback might have had a negative impact a on supervisees' skill acquisition. It is not clear how the supervisor practices affected the learning of the supervisees in the trial, or the non-significant intervention effect. However, standardized assessment, such as the MITI, provides an objective and structured form of feedback and may, in addition to checking for adherence, have an important training function. Increasing evidence base for supervision practice (American Psychological Association, 2015) also raises demands for adherence to these practices. Adherence monitoring of supervision sessions together with step-by-step guidelines, or a more broad focus on core supervision competencies, might be essential training elements for efficient implementation of EBP in routine clinical care.

Limitations

This exploratory study contained a number of limitations. The supervisors' behaviours were self-reported and not based on observations or objective measures of performance, which may raise questions about the reliability and validity of the results. A standardized instrument with known psychometric properties would have improved the reliability and validity of the results. However, a significant number of open-ended questions and a mixed method approach were deemed necessary because of the exploratory nature of the study. In future supervision studies the supervisory sessions would ideally be recorded in order to provide objective data. Despite these limitations, the present study provides important insights to help advance the scientific knowledge about supervision in MI.

Conclusion

Many of the reported supervisory behaviours were in line with both the study instructions and with recommendations from the supervision literature (Falender and Shafranske, 2007; Martino et al., 2008; American Psychological Association, 2015). However, the supervisors' drift away from key practices might have had a negative effect on supervisees' learning, which may have affected both the supervisees' skill acquisition and, indirectly, the intervention effects of the trial. The present study suggests that, in addition to clear supervision structures and principles that specify the content and procedure of the supervision, adherence monitoring of the supervision sessions may be crucial to ensure that appropriate supervision activities are conducted in each MI supervision session.

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