Transference and countertransference in clinical supervision: relational and ethical perspective on practice and professional development

ARTICLE

Sewanu Awhangansi

SUMMARY

Clinical supervision is a cornerstone of mental health practice and professional development, yet the relational dynamics underpinning supervision are often underexamined. This article explores the roles of transference and countertransference within the supervisor–supervisee relationship and their implications for learning, evaluation, professional development and patient care. Drawing on contemporary literature, it argues that these processes are not merely obstacles to effective supervision but valuable sources of insight into both clinical and supervisory relationships. The article examines how transference may influence supervisees' perceptions of authority, feedback and evaluation, and how countertransference can shape supervisors' judgements, emotional responses and decision-making. Particular attention is given to the effects of power differentials, cultural influences and organisational contexts. The risks associated with unrecognised relational dynamics, including non-disclosures by supervisees, bias, weakened supervisory alliances and compromised clinical decision-making, are critically discussed. Finally, evidence-informed approaches for managing these processes are outlined, including reflective practice, collaborative exploration of relational dynamics, role clarification and psychologically safe supervisory environments.

LEARNING OBJECTIVES

After reading this article you will be able to:

- define and differentiate transference and countertransference in the context of clinical supervision and understand how these processes influence the supervisor–supervisee relationship
- evaluate the impact of transference, countertransference and parallel process on supervisory effectiveness, supervisee development and patient care
- apply evidence-based strategies to recognise and manage transference and countertransference constructively in clinical supervision while maintaining ethical and professional standards.

KEYWORDS

Transference; countertransference; clinical supervision; reflective practice; supervisory relationship.

Sewanu Awhangansi is a consultant child and adolescent psychiatrist with the Child and Adolescent Mental Health Services at Leicestershire Partnership NHS Trust, Leicester, UK. Through his clinical academic interests, he has a growing portfolio of work in medical education and practice research. He supervises trainees, doctoral researchers and candidates for the Royal College of Psychiatrists' (RCPsych) Clinical Assessment of Skills and Competencies (CASC) examination, and mentors early-career psychiatrists through the RCPsych Aggrey Burke Fellowship for Black medical students at UK universities.

Correspondence Sewanu Awhangansi. Email: sewanu.awhangansi1@nhs.net

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Clinical supervision is a central component of professional development in mental health practice, serving as a space for reflection, accountability and skill acquisition. Within this relational context, psychodynamic processes such as transference and countertransference inevitably emerge, shaping the supervisor–supervisee interaction (Grinberg 2018). Although traditionally associated with therapist–patient relationships (Gelso 2014; Prasko 2022), these processes are increasingly recognised as fundamental to supervision dynamics (Ladany 2005; Fink 2007; Uren 2024). Understanding and managing these phenomena is essential for effective, ethical supervision. This article critically examines transference and countertransference in clinical supervision, highlighting their manifestations, risks and potential as powerful learning tools. Evidence-based insights are integrated to offer practical suggestions for supervisors and supervisees, as well as service-level recommendations to strengthen reflective practice, supervisor development and psychologically safe organisational cultures.

Conceptualising transference and countertransference in supervision

Transference, first described by Sigmund Freud (1912), refers to the unconscious redirection of

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feelings, expectations or relational patterns from past significant relationships onto another person – in this context, the supervisor. For instance, supervisees may experience supervisors as parental figures, authority figures or evaluators, thereby shaping their responses to feedback, authority and perceived judgement (Prasko 2022). Countertransference, traditionally understood as the therapist's emotional response to a patient (Remmers 2023), extends in supervision to include the supervisor's emotional, cognitive and behavioural reactions to the supervisee. Contemporary perspectives see countertransference as a co-constructed, relational phenomenon rather than solely a personal distortion in the supervisor (Tishby 2022; Barreto 2024).

In supervision, these dynamics are often intensified by power differentials, evaluation processes and the dual role of supervisors as both mentors and assessors (Hayes 2023; Uren 2024). These structural features make the supervisory relationship particularly susceptible to unconscious processes.

Manifestations in the supervisory relationship

Transference in supervision may take various forms. Supervisees may idealise supervisors, seeking approval and fearing criticism, or conversely, react with resistance, defensiveness or mistrust if the supervisor is unconsciously experienced through the lens of earlier relational patterns and expectations (Bernard 2021; Prasko 2022). For example, a supervisee who experienced punitive parenting may perceive constructive feedback as harsh criticism, leading to avoidance or compliance rather than reflective engagement. Countertransference can manifest as overidentification, frustration, rescue fantasies or disengagement (Abrams 2025). As in practitioner–patient relationships, a supervisor might feel unusually protective of a supervisee who reminds them of a younger self or become overly critical of one who triggers unresolved personal issues (Gelso 2007). Importantly, these dynamics often mirror what occurs in the supervisee's clinical work with patients, through what is known as parallel process (Ekstein 1958). For instance, a supervisee struggling with a 'difficult' patient may display similar resistance towards the supervisor, reflecting unconscious relational patterns being replayed across contexts.

Implications: risks and opportunities

Unexamined transference and countertransference can compromise the quality of supervision. Supervisees may become overly dependent, avoid disclosure of mistakes or disengage from learning (Ladany 2005). Similarly, supervisors' unchecked reactions may lead to biased evaluations, boundary crossings and violations, or ineffective guidance (Prasko 2022; Uren 2024). Research has shown that non-disclosure by supervisees, which is often linked to fear of negative evaluation, is a significant issue in supervision which can directly affect patient care (Tinsley 2022; Apostol 2025). Unaddressed transference-related anxieties may exacerbate this tendency, limiting opportunities for learning and growth.

Countertransference, implicit biases and unconscious preferences

Countertransference can also affect supervisory judgement, although it is important to distinguish it from broader personal biases or unconscious preferences. Countertransference refers specifically to the supervisor's emotional and relational responses to the supervisee that arise within the supervisory relationship, whereas personal biases may reflect wider social, cultural or organisational influences. For example, a supervisor may experience countertransference-based overidentification with a supervisee who evokes personal memories or unresolved experiences, leading to greater or lesser protectiveness or leniency.

Separately, implicit biases and unconscious preferences related to factors such as ethnicity, gender, professional background or communication style may influence perceptions of competence. These processes may contribute to cognitive biases in assessment, including the halo effect, whereby positive impressions in one area lead to overly favourable judgements across other domains, and leniency bias, in which supervisors consistently rate performance more positively than warranted (Gonsalvez 2014; Kennan-Miller 2019). Together, these processes may contribute to supervisors evaluating supervisees either more favourably or more critically than warranted, thereby compromising fairness, objectivity and professional standards (Falender 2004; Gelso 2007; Uren 2024).

Also, supervisors may consciously or unconsciously avoid difficult evaluative conversations, minimise concerns about competence or delay remediation when strong positive feelings about a supervisee are present. In some cases, this may contribute to the well-described 'failure to fail' phenomenon, whereby trainees who are not meeting required standards nevertheless progress because supervisors are reluctant to deliver negative evaluations or confront performance concerns (Yepes-Rios 2016). Such outcomes not only

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undermine the integrity of training and assessment processes but may ultimately have implications for patient safety and public trust in professional regulation.

Meta-competence: learning from transference and countertransference

When recognised and explored, these dynamics become powerful pedagogical tools. Transference can illuminate supervisees' relational styles, attachment patterns and clinical blind spots, while countertransference provides supervisors with valuable data about the supervisory and clinical process (Gelso 2007). Addressing these processes fosters meta-competence, the ability of supervisor and supervisee to reflect on their own internal experiences and their impact on professional practice, and to use this shared reflective awareness to guide flexible, contextually responsive and ethically informed supervisory processes (Falender 2004). Furthermore, discussing these dynamics openly can strengthen the supervisory alliance, which is consistently linked to positive learning outcomes (Bernard 2021).

Managing transference and countertransference in supervision

Developing reflective practice

Both supervisors and supervisees must cultivate a habit of reflective practice during supervision. Supervisors should engage in ongoing self-reflection or access supervision-of-supervision, via a peer or mentor, to be aware of their own countertransference reactions (Prasko 2022). Similarly, supervisees should be encouraged to explore unresolved relational issues and their emotional responses within supervision, normalising the presence of transference rather than pathologising it (Soliman 2023). Structured reflection models, such as Graham Gibbs's reflective cycle (Gibbs 1988) and Donald Schön's concept of reflection-in-action and reflection-on-action (Schön 1983, 1987), can support the development of self-awareness and reflective practice within supervision.

Establishing a strong supervisory alliance

As in practitioner–patient relationships, a clear, collaborative supervisory relationship between supervisor and supervisee reduces anxiety and promotes openness. Establishing expectations, roles and evaluation criteria early in supervision can mitigate transference-related misunderstandings (Bernard 2021). Evidence from recent literature shows that supervision characterised by mutual trust, empathy and transparency enhances supervisees' openness, strengthens the supervisory working alliance and supports professional development (Mehr 2022; Meydan 2023).

Making the implicit explicit

Supervisors should sensitively but directly bring relational dynamics into discussion when appropriate. For example, when particular interactional patterns become evident, such as a supervisee appearing hesitant, self-critical or overly compliant in response to feedback, the supervisor can invite reflection in a collaborative and non-judgemental way. This approach helps create a psychologically safe environment in which supervisees can explore their internal responses and relational tendencies, including transference, as understandable and informative aspects of the supervisory process rather than as problems to be corrected.

Evidence suggests that the quality of the supervisory relationship, particularly the degree of safety, trust and openness, is closely linked to supervisees' disclosure and engagement (Mehr 2022; Apostol 2025). This aligns well with relational supervision models that emphasise co-construction and mutual exploration, where meaning is developed jointly through dialogue, fostering greater awareness of interpersonal processes and supporting deeper reflective learning (McNamee 2021).

Managing power and evaluation

Given the evaluative function of supervision, supervisors must be particularly attentive to how power influences transference. At times, the dual responsibilities of supervisors as both assessors and supporters can create inherent tensions, increasing anxiety and shaping how supervisees perceive and respond to feedback. Clearly defined supervisory roles, particularly the distinction between clinical and educational supervision used in postgraduate medical programmes for instance, can help reduce these tensions by separating day-to-day performance oversight from broader developmental support (Said 2023).

Separating supportive and evaluative roles where possible, or explicitly acknowledging this dual role when separation is not feasible, can reduce anxiety and foster trust. Where such separation is implemented, supervisees may feel more able to engage openly in reflective discussion without fear that their disclosures will directly or indirectly influence formal assessment outcomes. There is robust evidence that supervision models involving multiple or clearly differentiated supervisory roles help manage

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the potentially conflicting demands of service delivery, evaluation and professional development (Rothwell 2021).

Clear, transparent feedback processes also mitigate the risk of projection and misinterpretation. When expectations, criteria and evaluative frameworks are made explicit, supervisees are less likely to interpret feedback through the lens of prior relational experiences or perceived authority dynamics. This way, transference responses can be recognised early, explored and used constructively.

Using parallel process constructively

Supervisors can use parallel process as a teaching tool, helping supervisees recognise how their interactions in supervision may reflect dynamics with patients. When approached thoughtfully, this can deepen supervisees' awareness of how relational patterns are enacted across contexts, linking their experiences with patients to their responses within supervision. This process is most effective when explored collaboratively and tentatively, with curiosity rather than certainty, to avoid blame or premature interpretation (Prasko 2022).

Ethical considerations

Maintaining high professional standards in supervision requires ongoing attention to boundaries, power dynamics and personal biases, underpinned by strong ethical awareness from both supervisors and supervisees. Countertransference, although a valuable source of clinical information, can also introduce risks if left unexamined. For supervisors, emotional reactions may lead to subtle boundary crossings, such as over-involvement, preferential treatment or excessive self-disclosure, potentially compromising objectivity and professional integrity (Prasko 2022). Equally, supervisees may bring unresolved relational issues and personal needs into supervision that can influence their expectations of the supervisor, potentially leading to dependency, avoidance or blurred professional boundaries (Ladany 2005). Alongside exposure to vicarious trauma from clinical work, supervisors are also required to contain and process the emotional and relational material brought by supervisees. This dual responsibility increases the risk of burnout and blurred boundaries if not adequately supported.

Reciprocal openness in supervision

Supervisors have an ethical obligation to actively monitor their internal reactions and seek consultation, supervision-of-supervision or peer support when needed. This reflective practice helps identify blind spots, reduce bias, and maintain fair and consistent evaluation. At the same time, supervisees also hold ethical responsibilities within the supervisory relationship. These include engaging openly in the process, reflecting on their own emotional responses and transference reactions, and disclosing relevant clinical uncertainties or difficulties. Failure to do so, which is often linked to fear of negative evaluation, can compromise learning and may negatively affect patient care (Farley 2025).

Ethical supervision further requires creating a supportive space in which supervisees feel able to raise concerns about the supervisory relationship without fear of retaliation. Supervisors should actively invite feedback and model openness, while supervisees have a responsibility to communicate worries in a timely and constructive manner. This reciprocal openness supports transparency and helps prevent misunderstandings or unaddressed relational tensions.

Cultural competence

Cultural competence is also a critical ethical dimension for both parties. Transference and countertransference are shaped not only by individual psychology but also by broader social and cultural contexts, including race/ethnicity, gender, identity, systemic power structures, socioeconomic status, cultural background, familial upbringing, sexuality, religion, worldview and experiences of marginalisation or privilege, all of which influence how relational dynamics are perceived and enacted within supervision (Vekaria 2023; Pérez-Rojas 2024). Supervisors must therefore be mindful of how their own cultural positioning and biases influence their perceptions and interpretations, while supervisees should be supported to explore how their identities and life experiences shape their emotional responses in clinical and professional settings (Mendu 2025). Failure on either side to attend to these sociocultural dimensions may result in misinterpretation of relational dynamics and the perpetuation of unhealthy bias (Vekaria 2023; Pérez-Rojas 2024).

Enhancing professional development in clinical supervision: service-level practice recommendations

At a mental health service level, effective supervision requires more than procedural oversight; it involves creating organisational conditions in which relational dynamics can be safely recognised, reflected upon and used constructively. By embedding structures that support awareness of transference and countertransference, service managers can enhance professional development, improve supervisory relationships, and ultimately contribute to

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BOX 1 Key learning points on transference and countertransference in clinical supervision

(a) **Transference and countertransference are inherent components of clinical supervision.** They are not limited to psychotherapy and can significantly influence supervisor–supervisee interactions, learning, assessment and professional development.
(b) **Unrecognised relational dynamics can adversely affect supervision and patient care.** Consequences may include non-disclosures by supervisees, dependency, boundary difficulties, biased evaluations, leniency bias, halo effects and 'failure to fail' decisions.
(c) **Power, culture and organisational context shape supervisory relationships.** Transference and countertransference do not occur in isolation but are influenced by supervisory authority, cultural identities, workplace norms and systemic factors.
(d) **Reflective practice is essential for recognising and managing these dynamics.** Approaches such as reflective supervision, psychological safety, Gibbs's reflective cycle and Schön's reflective practice framework can help supervisors and supervisees develop greater relational awareness.
(e) **Effective supervision requires relational competence as well as technical competence.** When explored thoughtfully, transference and countertransference can become valuable sources of insight that strengthen supervisory alliances, enhance professional growth and contribute to safer, higher-quality patient care.

safer and more effective patient care. Services that prioritise reflective practice, psychological safety and role clarity enable clinicians to engage more openly with emotional and interpersonal dynamics, thereby enhancing learning and safeguarding patient care (Rothwell 2021; Prasko 2022; Apostol 2025).

The following recommendations outline practical, service-level actions that supervisors, trainers, service managers and leaders can adopt to facilitate the constructive use of transference and countertransference in supervision, supporting ongoing professional development and reflective practice.

Implement structured supervision frameworks across the service

Establish clear supervision policies, including protected time, regular sessions and documentation, that provide a stable and predictable space for supervision. This signals that supervision is a core organisational priority, not an optional activity, improving both training quality/professional development and patient safety. Consistent structures also help contain emotionally charged situations, allowing transference and countertransference to be explored safely rather than enacted or avoided.

Separate or clearly define evaluative and supportive roles

Where possible, allocate different individuals as clinical and educational supervisors, or explicitly acknowledge the dual role when separation is not feasible. Reducing evaluation-related anxiety helps minimise defensive transference responses such as fear of criticism and overcompliance, encouraging supervisees to engage more openly with relational dynamics.

Provide training in recognising and managing transference and countertransference

Ensure supervisors receive adequate training that explicitly addresses relational processes, including emotional awareness, unconscious personal biases, boundary management and cultural competence. This equips supervisors to recognise their own countertransference reactions and use them constructively rather than allowing them to influence supervision or assessment.

Foster a culture of psychological safety and openness

Promote supervision as a reflective and non-punitive space where emotional responses, uncertainties and relational difficulties can be discussed openly. A psychologically safe clinical environment reduces non-disclosure and enables supervisees to explore transference phenomena as meaningful clinical data rather than sources of vulnerability.

Embed feedback and supervision-quality monitoring systems

Introduce mechanisms such as structured reflective tools (e.g. Gibbs's reflective cycle and Schön's reflective practice framework), supervision audits and anonymous feedback processes. These approaches can help identify patterns such as avoidance, dependency, conflict or non-disclosure within supervisory relationships, making relational dynamics more visible and available for reflection. Beyond supporting quality improvement, such systems may also generate valuable qualitative data that could inform future research into transference, countertransference and supervisory processes.

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MCQ answers
1 b 2 c 3 b 4 c 5 d

Limitation

This article is primarily narrative in nature and does not present new empirical data. Given that transference and countertransference are largely unconscious and relational processes, they can be difficult to measure using traditional quantitative approaches. Future research may therefore benefit from qualitative methodologies that explore lived experiences of supervision, as well as data generated through monitoring of supervision quality, reflective feedback systems and organisational evaluation processes.

Conclusion

Transference and countertransference are not incidental but central, dynamic features of clinical supervision, reflecting the inherently relational nature of professional development in clinical practice. Although these processes, if left unexamined, can introduce risk through bias, misunderstanding or boundary challenges, they are also powerful sources of insight into both clinical work and the supervisory relationship. When recognised and engaged with reflectively, supported by psychologically safe environments and clear organisational structures, these dynamics can be transformed from potential liabilities into essential tools for learning, self-awareness and professional growth. At the same time, recognising and working with transference and countertransference is rarely straightforward. These processes are often unconscious, emotionally charged and shaped by power differentials within supervisory relationships, making them difficult to identify, articulate and address openly. Developing relational awareness therefore requires ongoing reflection, curiosity, humility and organisational support.

Embedding such awareness at both individual and service levels enables supervision to move beyond a purely evaluative or performance-management function, becoming a space where complex emotional and interpersonal processes are explored constructively. Ultimately, effective supervision depends not only on technical competence but also on the capacity of both supervisors and supervisees to engage thoughtfully with relational dynamics, ensuring that transference and countertransference are used to enhance reflective practice, strengthen supervisory alliances, and improve the quality and safety of patient care.

Key learning points of this article are outlined in Box 1.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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References

Abrams Z (2025) How to manage countertransference in therapy. *Monitor on Psychology*, **56**: 40–5.

Apostol AE, Turner K, Hoshi R, et al (2025) Contributory factors to self-disclosure in clinical supervision: a meta-ethnography. *Clinical Psychology & Psychotherapy*, **32**: e70068.

Barreto JF, Matos PM (2024) Navigating the countertransference experience: a transtheoretical specifist model. *British Journal of Psychotherapy*, **40**: 295–309.

Bernard JM, Goodyear RK (2021) *Fundamentals of Clinical Supervision* (6th edn). Pearson.

Ekstein R, Wallerstein RS (1958) *The Teaching and Learning of Psychotherapy*. Basic Books.

Falender CA, Shafranske EP (2004) *Clinical Supervision: A Competency-based Approach*. American Psychological Association.

Farley S, Karwatzki E, Mason B (2025) 'It would probably do more harm than good': mental health nurses' experiences of non-disclosure within individual clinical supervision. *British Journal of Mental Health Nursing*, **14**: 1–11.

Fink K (2007) Supervision, transference and countertransference. *International Journal of Psychoanalysis*, **88**: 1263–73.

Freud S (1912) The dynamics of transference. Reprinted (1953–1974) in *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (trans. & ed. J Strachey), vol. 12: 97–108. Hogarth Press.

Gelso C (2014) A tripartite model of the therapeutic relationship: theory, research, and practice. *Psychotherapy Research*, **24**: 117–31.

Gelso CJ, Hayes J (2007) *Countertransference and the Therapist's Inner Experience: Perils and Possibilities*. Routledge.

Gibbs G (1988) *Learning by Doing: A Guide to Teaching and Learning Methods*. Further Education Unit.

Gonsalvez CJ, Crowe TP (2014) Evaluation of psychology practitioner competence in clinical supervision. *American Journal of Psychotherapy*, **68**: 177–93.

Grinberg L (2018) On transference and countertransference and the technique of supervision. In *Supervision and Its Vicissitudes* (eds BV Martindale, M Morner, ME Rodriguez, et al): 1–24. Routledge.

Hayes AL (2023) The lived experience of dually-roled counseling supervisors working in settings that require simultaneous clinical

https://doi.org/10.1192/bja.2026.10245 Published online by Cambridge University Press

and administrative supervisory roles: a qualitative hermeneutic phenomenological study. *DPhil doctoral dissertation*. Department for Counselor Education & Family Studies, Liberty University.

Kennan-Miller D, Belik O, Falender CA (2019) Competency-based assessment and evaluation: advancing clinical supervision. *California Psychologist*, **52**: 32.

Ladany N, Friedlander ML, Nelson ML (2005) *Critical Events in Psychotherapy Supervision: An Interpersonal Approach*. American Psychological Association.

McNamee S (2021) Theoretical foundations of relational processes in supervision. In *Relational Processes in Counselling and Psychotherapy Supervision* (eds O Ness, S McNamee, Ø Kvello): 9–24. Springer International Publishing.

Mehr KE, Daltry RM (2022) Supervisor self-disclosure, the supervisory alliance, and trainee willingness to disclose. *Professional Psychology: Research and Practice*, **53**: 313–7.

Mendu E, Long C (2025) The internal world of the supervisor: navigating race and culture in supervision. *International Forum of Psychoanalysis*, **34**: 188–99.

Meydan B, Sagkal AS (2023) Unraveling the direct and indirect effects of supervisory working alliance on supervisory satisfaction: the mediating role of supervisee disclosure in supervision. *International Journal of Psychology and Educational Studies*, **10**: 291–300.

Pérez-Rojas AE, González JM (2024) A critical comparison between cultural comfort and countertransference. *Journal of Psychotherapy Integration*, **34**: 544–56.

Prasko J, Ociskova M, Vanek J, et al (2022) Managing transference and countertransference in cognitive behavioral supervision: theoretical framework and clinical application. *Psychology Research and Behavior Management*, **15**: 2129–55.

Remmers A (2023) Transference and countertransference. *Global Psychotherapist*, **3**: 75–9.

Rothwell C, Kehoe A, Farook SF, et al (2021) Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review. *BMJ Open*, **11**: e052929.

Said UN, Al-Hashimi K, Khan TN, et al (2023) Exploring the roles and responsibilities of an educational supervisor in medical training within the United Kingdom. *Cureus*, **15**(7): e41244.

Schön, DA (1983) *The Reflective Practitioner: How Professionals Think in Action*. Basic Books.

Schön, DA (1987) *Educating the Reflective Practitioner*. Jossey-Bass.

Soliman S (2023) Attachment in supervision: using a relational lens to understand supervisory dynamics. *Psychotherapy and Counselling Journal of Australia*, **11**(2): 90756.

Tinsley EA (2022) Non-disclosure of supervisee disagreement to supervisor feedback: a qualitative study. *DPhil doctoral dissertation*. Department for Counselor Education and Counseling Psychology, Marquette University.

Tishby O (2022) Countertransference – introduction to a special section. *Psychotherapy Research*, **32**: 1–2.

Uren S (2024) Psychotherapy supervision and countertransference in professional psychology training. *DPhil doctoral dissertation*. Department of Psychology, University of Johannesburg.

Vekaria B, Thomas T, Phiri P, et al (2023) Exploring the supervisory relationship in the context of culturally responsive supervision: a supervisee's perspective. *Cognitive Behaviour Therapist*, **16**: e22.

Yepes-Rios M, Dudek N, Duboyce R, et al (2016) The failure to fail underperforming trainees in health professions education: a BEME systematic review: BEME Guide No. 42. *Medical Teacher*, **38**: 1092–9.

MCQs

Select the single best option for each question stem

1 Transference in the context of clinical supervision may be described as:

a a supervisor's unconscious emotional reaction to a supervisee
b the supervisee's projection of expectations, feelings or relational patterns from previous significant relationships onto the supervisor
c the supervisor's formal evaluation of clinical competence
d the transfer of clinical skills from supervisor to supervisee
e the supervisee's conscious disagreement with supervisory feedback.

2 A supervisor finds themselves becoming unusually protective of a supervisee and reluctant to provide critical feedback. This is most likely an example of:

a idealisation
b parallel process
c countertransference
d projection
e reflective practice.

3 The concept of parallel process in supervision refers to:

a simultaneous supervision of multiple trainees
b the replication of relational dynamics across patient, supervisee and supervisor interactions
c joint supervision by two supervisors
d conducting supervision and therapy at the same time
e the use of parallel treatment plans for patients.

4 Research suggests that one consequence of unrecognised transference within supervision may be:

a enhanced supervisee autonomy
b increased evidence-based practice
c supervisee non-disclosure and reduced supervisory alliance
d greater objectivity in evaluation
e elimination of power differentials.

5 Of the following, the most appropriate supervisory response to potential transference and countertransference dynamics is to:

a avoid discussing relational issues to maintain objectivity
b interpret unconscious processes immediately when identified
c focus exclusively on case management and clinical technique
d engage in reflective practice and explore relational dynamics collaboratively and sensitively
e minimise feedback to the supervisee to preserve authority.

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