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Cognitive Behavioural Therapy Supervision: Recommended Practice

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Abstract. In the absence of good quality evidence for the effectiveness of specific aspects or formats of Cognitive Behavioural Therapy (CBT) supervision, it is necessary to consider what is recommended as good quality CBT supervision. This review of the literature aims to provide an overview of the recommended practice of CBT supervision by considering general principles and goals of CBT supervision; the format of individual supervision sessions; the course and stages of CBT supervision; attending to supervisees' cognitions and affects; the importance of the supervisory relationship as well as the recording and rating of therapy sessions. This could provide a framework for setting standards to aspire to and stimulate further research in this field. Conforming to such practice would be an important step toward quality assurance in CBT supervision.

Keywords: Supervision, cognitive behavioural therapy.

Introduction

Itis generally agreed that a complex topic like psychotherapy cannot be learned through lectures or independent study alone, and that supervised practise is an essential part of psychotherapy training. All accredited CBT training courses include or require supervision. The requirement for quality assurance in health care provision and training continues to grow in prominence. A government White Paper, *The New NHS: Modern, Dependable* (DoH, 1997), formalized quality assurance in the NHS as a statutory duty and another White Paper, *Clinical Governance in the New NHS* (DoH, 1999), identified clinical supervision as an important mechanism to support and develop staff.

Supervision plays an essential role in quality control of all psychotherapies (including CBT) during initial training and throughout therapists' careers. It is not sufficient to provide supervision, without consideration of what constitutes good practice and current best evidence in the field. It is essential to assure the quality of supervision itself in order to train and maintain competent therapists who help their patients understand and overcome their psychological difficulties. This review focuses specifically on aspects unique to CBT supervision rather than addressing all aspects of health-professional supervision in all its complexity.

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Method

Various electronic databases (Journals at OVID; MEDLINE, 1966–2004; PsychINFO, 1974–2004; EMBASE, 1980–2004; CINAHL, 1982–2004 and EBM Reviews, 1991–2004) were searched. Search terms included *cognitive, behavior, therapy and supervision*. Due to limited sources, the search was widened to include terms like *counselling, training, teaching and education*. Next, the references of all the useful sources, especially review articles and chapters in textbooks, were studied and articles from less well-known publications found. Indexes of several cognitive and/or behavioural therapy journals were scanned. By writing to some prominent authors, further useful recommendations were obtained.

Review of findings

The literature reviewed is organized under the following headings: General principles and goals of CBT supervision; Format of individual CBT supervision sessions; Course and stages of CBT supervision; Attending to the supervisee's cognitions and affects in CBT supervision; Importance of the relationship in CBT supervision; Recording and rating therapy sessions in CBT supervision.

General principles and goals of CBT supervision

The primary goal of CBT supervision is to help the therapist adopt the philosophy of CBT as the basic approach for changing clients' cognitions, emotions and behaviours to facilitate improvement or recovery. A secondary goal is to teach the therapist specific skills or techniques. By combining the principles outlined by Newman (1998), Padesky (1996) and Rosenbaum and Ronen (1998), many similarities and differences between CBT treatment and supervision emerge. Both CBT and its supervision are systematic, goal-directed, structured, time-limited, collaborative, person-focused, confidential and active, with clear boundaries and a power-imbalance that requires to be managed ethically. The emphasis of both CBT and its supervision is on mutual trust, openness, practice, experience, facilitation of change, building on existing strengths, building conceptualization skills, developing more complex and balanced "meaning-systems", application of new skills in natural environments, empowering the subject with self-change skills, using objective measures as well as actively eliciting and responding to feedback. CBT supervision has different goals, content of sessions, parameters for termination (generally continuing longer) and more flexibility in the evolution of the relationship, compared with therapy. In CBT supervision, unlike therapy, there is usually shared responsibility to a third party, multiple supervisors may improve the outcome and the subject's personal problems tend to be addressed only when they interfere with the therapy being supervised.

As a general rule, according to Perris (1993), CBT supervision tends to follow a relatively didactic model, with the focus more often being on theoretical and technical aspects or the practical conduct of therapy. The schema-focused model of supervision advocated by Greenwald and Young (1998) bridges CBT and depth-oriented approaches and includes developmental, interpersonal, and experiential elements. Schema focused therapy principles provide a method for organizing case information about how clients operate and it is valuable in case conceptualization, developing a strategy, implementing interventions, resolving difficulties and understanding the role of the supervisee's own schema in the therapy process.

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The format of individual CBT supervision sessions

Major contributors in this area, Liese and Beck (1997) as well as Liese and Alford (1998), suggest the following structure for each CBT supervision session: checking in; setting the agenda; bridging from the previous supervision session; enquiring about previously supervised cases; reviewing homework (reading, case conceptualization or experiments); prioritizing of agenda items; discussing an individual (recorded) case; using direct instruction and guided discovery; using standardized supervision instruments; assigning new relevant homework; summarizing and eliciting feedback from the supervisee.

A significant part of the supervision session will be dedicated to the discussion of an individual (recorded) case. Schmidt (1979) suggests the following format for this discussion: the therapist presents a difficult issue; theoretical hypotheses about its meaning are discussed; the therapist's emotive responses (especially anger, boredom, frustration, guilt and anxiety) to the issue are considered; and, finally, therapeutic approaches are discussed. With regard to direct instruction, Liese and Beck (1997) identified the following learning goals: diagnosis of problems; associated cognitive models; cognitive case conceptualization; basic counselling skills; structuring therapy; cognitive techniques and behavioural techniques.

Writing about Schema-Focused Therapy, Greenwald and Young (1998) suggest that an agenda be set for every supervision session. Depending on the needs of the supervisee, they offer seven types of help: case conceptualization; case strategizing; case implementation; resolving technical case problems; working on therapy relationship issues; providing support and personal help for the supervisee; discussing general conceptual and treatment issues.

Armstrong, Twaddle and Freeston (2003) identified and described four interacting levels to be considered as part of a conceptual framework in CBT supervision. The first level, *primary inputs*, includes the context within which supervision occurs, what is brought to supervision, the client's impact on supervision and the selectivity with which the supervisee reports therapy. The second level, *parameters*, outlines the characteristics, structure and development of the supervisory project. The third level, *dynamic focus*, includes the changing focus on case conceptualization, technique, and the therapeutic relationship. The fourth level, *learning process*, is framed within a model of experiential learning, with the stages through which supervision should proceed to achieve new knowledge, skill and application.

A survey of UK cognitive behavioural psychotherapists (Townend, Iannetta and Freeston, 2002) confirms that 16 topics were discussed during supervision, in order of frequency: case formulation; cognitive analysis; cognitive interventions; behavioural interventions; three systems analysis; functional analysis; application of techniques; emotional responsibility; goal setting; therapeutic bond; client safety; homework; ethical issues; evaluation methods; therapist safety; and exclusion criteria.

The course and stages of CBT supervision

In Table 1, Padesky (1996) combines the different methods (columns) and foci (rows) as a supervision options grid. Liese and Beck (1997), Padesky (1996), Perris (1994) and Schmidt (1979) suggest that the focus of supervision for trainee therapists includes the beliefs they bring to the new therapy situation and involves, first, making these self-statements explicit and then replacing them with more sensible or balanced beliefs. Gradually, the focus shifts to mastering CBT methods, clinical processes, and case conceptualization skills to a deeper

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Table 1 Supervision options grid

	Case-discussion	Video/audio/live observation	Roleplay/demonstration	Supervisor co-therapy	Peer co-therapy
Mastery of CBT methods					
Case conceptualization					
Client-therapist relationship					
Therapist reactions					
Supervisory process					

and deeper level. Supervision of intermediate therapists continues to focus on these areas, with additional attention being given to the client-therapist relationship. With experienced therapists the focus may be on the therapist or on the process of supervision. Most authors recommend individual supervision for at least 1 hour on a weekly basis. Dobson and Shaw (1988, 1993) as well as Shaw and Wilson-Smith (1988) recommend that beginning therapists should start practising techniques with easier cases. Dobson and Shaw (1988, 1993) warned us that therapists sometimes develop a preference for certain techniques and neglect others. Supervisors should aim to promote flexibility and consideration of alternative techniques.

Attending to supervisees' cognitions and affects in CBT supervision

Just as it is essential for therapists to conceptualize their patients, it is for CBT supervisors to conceptualize their supervisees and to explore cognitive schema. Therapists' personal issues as well as problems that may develop between the supervisee and the supervisor in supervision should be addressed when they interfere with therapy (Greenwald and Young, 1998; Liese and Alford, 1998; Liese and Beck, 1997). The approach recommended by Schmidt (1979) focuses primarily on the cognitive activity of the supervisee and aims to produce a clinician who can respond in a relatively anxiety-free way, to develop hypotheses about clients' problematic cognitions, and to choose and test appropriate techniques to alter them.

Common dysfunctional beliefs of trainee therapists include: "I must show the supervisor how perfect I am at therapy", "I must make the right decision, or something terrible will happen" and "I must always love doing therapy to be a good therapist". Yogev (1982) points out that early interventions by the supervisor should aim to make the therapist aware of such dysfunctional expectations that are a likely source of anxiety. Common misconceptions regarding CBT include beliefs that it focuses only on immediate symptom reduction, while ignoring personality reorganization; that it is superficial and mechanistic; that it ignores early experiences; that it neglects interpersonal factors; that it sees the therapeutic relationship as irrelevant; that it does not address the motivation for maintaining symptoms and that it does not view emotions as important. Liese and Beck (1997) recommend challenging and correcting such misconceptions early.

According to Perris (1993), supervisees' emotions are usually dealt with in a straightforward manner when it interferes with therapy, without intruding into supervisees' personal life or encouraging regression. Reilly (2000) places more emphasis on emotion as a primary variable

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in the CBT model of therapy and supervision. It is important to recognize and identify emotions, explore their origins (perhaps in negative automatic thoughts), and collaboratively generate alternative perspectives for client, therapist and supervisor.

The importance of the relationship within CBT supervision

Perris (1994) reminds us that any supervision must take into account aspects of the relationship between therapist and client as well as supervisee and supervisor. Both supervisee and supervisor need to be aware of the need for both dependence and autonomous action on the part of the supervisee. As a general rule, coherent application of the collaborative principal and consistent use of Socratic dialogue strongly contribute to limiting the experience of dependence in the trainee. Safran and Muran (2001) emphasize two principles: as supervision takes place in a *relational context*, the supervisor should always be monitoring the nature and quality of the relationship with the therapist; and that supervision should be *experiential* in nature. Dobson and Shaw (1993) suggested that the three principal activities of cognitive therapists (and supervisors), in descending order, are relationship activities, case conceptualization, and learning techniques.

Fostering a learning alliance in supervision forms the basis for acquisition of pivotal CBT competencies, according to Friedberg and Taylor (1994). They emphasize that supervision requires relationship skills, sensitivity to individual and developmental differences and technical flexibility. Exposure of the work in therapy is one of the main aims of supervision and anything that interferes with supervisees' safety around exposing the work will impact negatively on the learning. It has been suggested that a "parallel process" exists, whereby the supervisee's relationship with the client mirrors the relationship with the supervisor, and vice versa. This allows the valuable opportunity for the supervisor to gain insight into the therapeutic relationship and also to model ways of dealing with specific styles and problems in a facilitative fashion. Perris (1994) argues that *collaborative empiricism* and a *secure base* (Bowlby, 1988) in supervision, from where supervisees can explore unfamiliar areas of therapy, forms the basis of successful CBT supervision.

Recording and rating therapy sessions in CBT supervision

As early as 1958, Kubie (and numerous authors since) suggested that therapy sessions should be recorded, as what the supervisee brings to supervision is a limited and distorted version of what really happened in therapy. Muslin, Thurmblad and Meschel (1981) determined that medical students failed to report 54% of themes in videotaped interviews in supervision and that there was a degree of distortion in 54% of reported themes. Holloway and Neufeldt (1995) highlight that supervisors, who have the responsibility to ensure the therapist's competent practice with clients, are perhaps more influenced by the trainee's interpersonal involvement in supervision than their effectiveness with clients.

Various authors, including Shaw (1984) and Goldberg (1983) have emphasized the potential of video recording sessions, as this also captures non-verbal communication, enabling therapists to become more aware of their behaviour during sessions. Video allows for greater focus on patient-therapist interchanges and can be an excellent way to introduce supervisees to the affects, behaviours and interactions that occur in therapy, including the "latent processes" as they are expressed through the therapist-patient dyad. The use of audio- and videotapes

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have from the beginning characterized CBT and is equally suitable for supervision training (DiGuiseppe, 1993 and Padesky, 1993).

Recording of therapy sessions may leave supervisees feeling vulnerable to criticism and therefore anxious. Concerns about its use should be made explicit, examined for cognitive distortions and corrected. Ultimately, most supervisees find the use of recordings of sessions extremely helpful (Friedberg and Taylor, 1994). Video and audio recordings can also be used relatively successfully for supervision from a distance, augmented by telephone calls, emails or video-conferencing.

Given the unique advantages that video-technology can afford psychotherapy training, it is unfortunate that the medium is not used more frequently. Factors that contribute to the under-use of video in psychotherapy training include a lack of consensus about psychotherapy training goals; lack of clarity about the impact of various teaching styles and methods; supervisors and supervisees feeling intimidated by technology; and limits to time, facilities and funding within organizations (Goldberg, 1983).

Dryden (1984) suggests that, in addition to recording therapy sessions, supervisees should use Kagan's Interpersonal Process Recall method (to identify their own key cognitions that may have impeded effective implementation of therapeutic interventions) as well as Hill's work on Therapist Intentions (to identify their intentions in making each of the interventions). In their paper on the Schema-Focused Therapy supervision, Greenwald and Young (1998) encourage the use of self-supervision and list some activities that this may involve. Regularly rating recordings of therapy sessions during supervision or evaluation adds an element of objectivity and empiricism to CBT supervision. Some well-known instruments to measure therapist skilfulness or competence include: Cognitive Therapy Scale (Young and Beck, 1980, 1988), Revised Version of the Cognitive Therapy Scale (Blackburn et al., 2001) and Cognitive Therapy Adherence and Competence Scale (Liese, Barber and Beck, 1995).

Conclusion

Within CBT supervision there is an opportunity to discuss the cognitions and emotions of patients, to develop case conceptualization, to consider treatment options and techniques and to discuss goals as well as stumbling blocks towards them. CBT supervision also offers an opportunity to acknowledge, explore, challenge and modify the cognitions and emotions of the therapist within the setting of therapy as well as supervision. Taking account of the supervisee's level of experience and adjusting the focus of supervision accordingly is widely recommended. The potential benefits of regularly recording CBT sessions, reviewing and rating these and also discussing it in supervision is widely recognized, but frequently met by resistance. It may be helpful to consider the supervisory grid (Table 1) and be aware of various methods for various foci in supervision over the course of time.

As an important step toward quality assurance, supervisors in CBT can compare their supervision with the picture of recommended practice of CBT supervision that emerges from this review of the literature. It is important to note that the literature on CBT supervision reviewed here neglects areas such as the importance of well-defined boundaries, ethical behaviour and modern educational theory. It is recommended that the interested reader supplement what is reviewed here with more generic texts on supervision in the mental health professions as well as modern educational theory. Unfortunately, the evidence for the

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effectiveness of various aspects or formats of supervision is largely lacking at present and requires further research.

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