

CONCEPTUALIZING COGNITIVE-BEHAVIORAL SUPERVISION: AN  
EXPLORATORY STUDY OF SUPERVISING PSYCHOLOGISTS

A DISSERTATION  
SUBMITTED TO THE FACULTY  
OF  
THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY  
OF  
RUTGERS,  
THE STATE UNIVERSITY OF NEW JERSEY  
BY  
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IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE  
OF  
DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY

OCTOBER 2013

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## ABSTRACT

Although supervision plays a key role in the training of psychologists and in improving adherence to Cognitive-Behavioral Therapy (CBT), there is a scarcity of systematic knowledge on the supervision of CBT therapists. In response, Judith Beck's supervision model has been a valuable development. However, there remains a dearth of research on the supervision practices of doctoral-level CBT supervisors in the field, and whether they adhere to Beck's model. The current exploratory study investigated the practices of doctoral-level CBT supervisors along the following five dimensions: (a) the structure of CBT supervision, (b) attending to supervisees' emotions, thoughts and behaviors, (c) relationship factors, (d) evaluation of supervisees, and (e) self-evaluation. In addition, this study assessed the extent to which supervisors followed Beck's supervision model. A semi-structured interview was conducted with 10 experienced doctoral-level CBT supervisors. The participants had a median of 10 years of experience as CBT supervisors and 70% attained Diplomate or Fellow Certification with the Academy of Cognitive Therapy. The interviews were analyzed using a content analysis approach based on the five major topic domains outlined above. Case examples were also provided to further illustrate the supervision practices of three individual supervisors. Findings indicated that the supervision practices of supervisors in this sample were very similar along the five dimensions, and were also mostly consistent with Beck's supervision model. More specifically, supervisors described their supervision structure as mirroring CBT therapy sessions (e.g., check-in, agenda setting, and problem solving); emphasized attending to supervisee's thoughts if they interfere with the patient's treatment; and stressed the importance of creating a collaborative and collegial relationship with supervisees. On the

other hand, supervisors did not generally listen to entire therapy tapes and use rating scales to assess therapy sessions due to time constraints. Moreover, supervisors emphasized the importance of attending to supervisees' emotions in supervision as well as the importance of increasing autonomy in CBT supervision, neither of which are explicitly discussed in Beck's supervision model. Implications for future research are discussed, along with recommendations for CBT supervisors and training programs.

## ACKNOWLEDGMENTS

There are several people I am very grateful to for making this project possible and supporting me in my professional journey. First and foremost, I would like to especially thank my dissertation committee, Dr. Tom Hildebrandt and Dr. Dan Fishman. I would like to express my genuine gratitude to Dr. Tom Hildebrandt for encouraging me to pursue this topic and providing helpful guidance along the way. He was also my first supervisor in cognitive-behavioral therapy and inspired me to pursue being a CBT therapist. I would also like to thank Dr. Dan Fishman for introducing me to his pragmatic approach to psychology and for providing helpful guidance and feedback on this project. Additionally, I would like to thank Dr. Nancy Boyd-Franklin for her wisdom and encouragement throughout this project.

I would also like to thank my excellent supervisors and mentors along the way at Rutgers's Graduate School of Professional Psychology, including Dr. Brenna Bry and Dr. Shalonda Kelly, both of whom provided supervision on difficult CBT cases and were invested in my development as a professional. I would also like to thank the administrative staff at GSAPP—particularly Sylvia—who is incredibly committed and responsive to students.

I owe my deepest gratitude to my husband, Nikita Lytkin, whose unwavering love and support carried me through the challenges of completing this professional journey. I will forever be grateful for his constant encouragement and for believing in me.

Lastly, I would like to thank all the supervisors who participated in this study for their openness in sharing their supervision practices with me and for their commitment to the training of psychologists.

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## CHAPTER I

### INTRODUCTION

There is a pressing need to develop the field of cognitive-behavioral therapy (CBT) supervision (Reiser & Milne, 2012). This is particularly keen in light of the important role that supervision plays in the training of psychologists and the strong empirical foundation of CBT. In fact, supervision plays a central role in the training of psychologists, and is one of the primary ways in which they learn how to conduct therapy (Barnett, Cornish, Goodyear & Lichtenberg, 2007; Romans, Boswell, Carlozzi & Ferguson, 1995). There is also evidence to suggest that CBT supervision plays a key role in improving adherence to CBT and reducing therapist drift (Sholomskas et al., 2005).

Current models and recommendations for CBT supervision are based on a psychotherapy-based approach to supervision. That is, they assume that supervision in CBT is similar to the therapy in important ways. Beck's model of CBT supervision is considered to be one of the most highly influential and authoritative texts on CBT supervision (Reiser & Milne, 2012; Townend, Iannetta & Freeston, 2002). Beck proposes several features that are common in CBT therapy and supervision, including the structure of the session, the use of CBT techniques within the session, the development of a collaborative supervisor-supervisee relationship, and the implementation of cognitive techniques to respond to therapist's automatic thoughts (Beck, 2008; Liese & Beck, 1997).

However, there is a scarcity of research on this psychotherapy-based model of CBT supervision as well as a dearth of research on the supervision practices of CBT supervisors in the field. Moreover, despite the relevancy of CBT supervision to the

training of psychologists, there is still limited qualitative and quantitative research on CBT supervision overall. This current situation is paradoxical given that CBT is considered to be one of the most empirically driven and effective forms of psychotherapy to date (Butler, Chapman, Forman & Beck, 2006). Not surprisingly, several researchers have concluded that the field of CBT supervision is still at an “infantile state of development” (Reiser & Milne, 2012, pg. 169).

Thus, this study examined the conceptualization of CBT supervision from the perspective of doctoral-level CBT supervisors using a qualitative methodological approach. Firstly, this study aimed to address the dearth of research on CBT supervision by exploring the supervision practices of doctoral-level psychologists who supervised in a CBT framework in the United States. Secondly, this study assessed the extent to which doctoral-level CBT supervisors follow Beck’s supervision model in order to provide recommendations for the field of CBT supervision. Two research questions guided data collection and analysis:

- 1) How do CBT supervisors conceptualize the supervision process in terms of the following dimensions: a) the structure of CBT supervision, b) attending to supervisees’ emotions, thoughts, and behaviors, c) relationship factors, d) evaluating themselves and their supervisees.
- 2) To what extent do CBT supervisors in the real world follow Beck’s recommended model of CBT supervision?

To this end, 10 experienced CBT supervisors voluntarily participated in this study. They completed a 60-minute semi-structured interview, which was based on a review of the literature and Beck’s recommendations for CBT supervision. A content

analysis approach was employed to extract themes among the CBT supervisors. In addition, three case examples of supervisors were chosen and presented as exemplary approaches to CBT supervision. Overall, this exploratory study responded to the two guiding research questions and in doing so, contributed to the body of knowledge on best practices and recommendations for CBT supervision.

## CHAPTER II

### REVIEW OF THE LITERATURE

#### **Overview of Cognitive-Behavioral Therapy (CBT)**

Cognitive-Behavior Therapy (CBT) is considered to be one of the most well researched and extensively studied forms of psychotherapy treatment (Butler, Chapman, Forman, & Beck, 2006). In fact, there are over 325 published outcome studies on cognitive-behavioral interventions for a wide range of disorders and clinical populations (Butler et al., 2006). In a review of all rigorous, high quality meta-analyses of CBT, Butler et al. found CBT to be highly effective with large effect sizes for multiple disorders including: adult and adolescent unipolar depression, generalized anxiety disorder, panic disorder with and without agoraphobia, social phobia, PTSD, and childhood depression and anxiety disorders. CBT was also shown to be moderately effective (moderate effect sizes) for marital distress, anger, childhood somatic disorders, and chronic pain. Moreover, the effects of CBT have been shown to be sustained over time for a wide range of disorders (e.g. depression, GAD, panic, social phobia, OCD, sexual offending, schizophrenia, and childhood internalizing disorders; Butler et al., 2006). In addition, compared to psychopharmacology, CBT has superior long-term effectiveness with half the rates of relapse of medications for depression and panic disorder (Butler et al., 2006).

### **Importance of Supervision in CBT**

However, despite all the research demonstrating effectiveness and efficacy of CBT as well as the development of manualized treatments for diverse disorders and age groups, very little research has been carried out on CBT supervision. This is paradoxical given how integral supervision is in cognitive-behavioral therapy. Firstly, supervision is currently one of the primary and essential ways in which psychologists learn how to conduct psychotherapy. For example, researchers on supervision have noted that supervision is a “central component in the training of graduate students in clinical, counseling, and school psychology” (pg. 407, Romans, Boswell, Carlozzi, & Ferguson, 1995). Supervision is also considered to be essential to each psychologist’s training and development into a competent professional (Barnett, Cornish, Goodyear, & Lichtenberg, 2007). In addition to the essential role that supervision plays in the training of psychotherapists, psychologists spend a significant amount of time engaging in psychotherapy supervision. Clinical supervision continues to be one of the top five activities in which psychologists spend their time (Norcross, Hedges, & Castle, 2002 cited in Falender & Shafranske, 2007). In fact, a national survey of APA’s division on clinical psychology showed that full-time faculty (including cognitive-behavioral faculty) spend an average of seven hours per week providing individual and group supervision to graduate students (Tyler, Sloan, & King, 2000).

### **Role of Supervision in Dissemination and Implementation of CBT**

Moreover, one can argue that supervision plays a key role in the dissemination and implementation of cognitive-behavioral treatments by reducing therapist drift. In fact, researchers suggest that a major goal of cognitive-behavioral supervision is to reduce

therapist drift and ensure that therapists are operating within the CBT model (Liese & Beck, 1997). In a recent report on the dissemination and implementation of evidence-based practices, McHugh & Barlow (2010) argue that there is no “clear consensus” or evidence base for the most effective way to carry out dissemination and implementation of evidence-based psychological practices despite an urgent need to do so. One important barrier to effective dissemination and implementation efforts, includes training clinicians to competently administer treatments that are quite complex as well as therapists drifting outside the psychotherapy model (McHugh & Barlow, 2010). They believe that competence training involving some form of supervision should play a key role since workshops and didactic training are insufficient at ensuring therapist adherence or bringing about lasting changes in therapeutic practices (McHugh & Barlow, 2010).

Although there is limited research regarding the most effective means for dissemination of cognitive-behavioral therapy interventions, research suggests that supervision may play a key role in dissemination of CBT (Sholomaskas et al., 2005). For example, in a study of 78 clinicians who were assigned to one of three training conditions (CBT manual only, manual plus access to training website, and review of manual and didactic seminar followed by supervised training), therapists in the seminar plus supervision condition received significantly higher ratings in terms of their adherence to CBT and their ability to implement CBT interventions (Sholomaskas et al., 2005). In addition, in McHugh and Barlow’s (2010) review of leading dissemination and implementation programs in the United States and Britain (including Dialectical Behavior Therapy, The National Traumatic Stress Network, and the Veteran’s Health Administration) each of these programs included supervision as a key competent of

training. The duration of supervision for each of these programs was also extensive, and ranged from nine months to ongoing supervision (McHugh & Barlow, 2010). Thus, while there is limited evidence on “best practices” for dissemination and implementation of EBPT’s at this point, supervision appears to play a key role by improving adherence to the CBT model and reducing the possibility of therapist drift.

### **Models of Cognitive-Behavioral Supervision: Psychotherapy-Based Model**

Despite the clear importance of supervision in CBT, there has been a scarcity of articles written about CBT supervision. Several authors have noted this gap in the field and have attempted to create models and recommendations for cognitive-behavioral psychotherapy supervision (Liese & Beck, 1997; Pretorius, 2006). This section will discuss models and recommendations for cognitive-behavioral supervision specifically as opposed to providing an overview of supervision models as a whole.

Current models and recommendations for cognitive-behavioral supervision are based on a psychotherapy-based approach to supervision. That is, they assume that supervision in cognitive-behavioral therapy resembles the therapy in important ways. Several authors have also argued that instead of developing a comprehensive theory of supervision, it is important to approach supervision from the unique standpoint of each of the therapeutic models given that overall guidelines for supervision are not specific enough for CBT, and since each “psychotherapeutic approach has different assumptions about therapy” (Rosenbaum & Ronen, 1998). Other advantages of psychotherapy based approaches to supervision is that they provide a structure and coherent approach to supervision that is based on an existing theoretical orientation (CBT) and that specific

therapeutic techniques can be tailored and used to increase therapists' skill level (Beck, Sarnat, Barentstein, 2008).

### **Beck's Framework for CBT Supervision**

In 1997, Liese and Beck developed a framework for cognitive therapy supervision that is considered to be a highly influential and frequently cited model of CBT supervision (Townend, Iannetta, & Freeston, 2002). Judith Beck later elaborated on this model on with an additional article in 2008. According to Liese and Beck (1997), cognitive therapy supervision has three important purposes: (1) "to teach cognitive theory and techniques;" (2) to correct inaccurate beliefs about cognitive therapy (e.g. CBT dismisses emotions, interpersonal factors); (3) to reduce the likelihood that therapists will drift away from the model over time (pg. 131). They stress the importance of supervisors teaching therapists to evaluate their own cognitions and to use cognitive techniques on themselves. Liese and Beck (1997) recommend the following structure for supervision sessions that is based on the structure of CBT therapy:

1. check in
  2. agenda setting
  3. bridge from previous supervision session
  4. inquiry about previously supervised therapy case
  5. review of homework since previous supervision session
  6. prioritization and discussion of agenda items
  7. assignment of new homework
  8. supervisor's capsule summaries (also throughout session)
  9. elicit feedback from therapist (also throughout session)
- (Adopted from Liese & Beck, 1997; pg. 121)*

According to Beck (2008), the supervisor begins each supervision session with a check-in with the supervisee in order to "re-establish the alliance" (pg. 60). The check-in often involves, "How are you? How was your week?" and is similar to a mood check with a client (Beck, pg. 60). Secondly, the supervisor sets the agenda in a similar manner



to setting the agenda with the patient. For example, the supervisor can ask, “So if it’s okay, we’ll review what you did for homework and I’ll give you feedback on the session I listened to. Is there anything else you want to put on the agenda?” (pg. 60). Thirdly, the supervisor makes a bridge between supervision sessions by reviewing what the therapist did for homework and what she learned from it. This is similar to homework review with a patient (Beck, 2008). Next, the supervisor asks the therapist to “prioritize the agenda,” which involves selecting an initial problem/topic to discuss (pg. 60). During this discussion, the supervisor teaches the therapist skills, including direct instruction, guided discovery, and role-playing to demonstrate techniques (Beck 2008; Liese & Beck, 1997). The supervisor then provides the supervisee with a relevant homework assignment (e.g., reading, case conceptualization, implementing new technique with a patient). Lastly, supervisors summarize and elicit feedback from therapists (e.g., asking the therapist to summarize what she learned to make sure she is listening; Beck, 2008).

Beck (2008) also proposes and elaborates on five features that are common in both cognitive therapy and supervision that form the basis of her model on cognitive-therapy supervision. She argues that supervision in cognitive therapy is unique in that “many of the many of the foundational principles and techniques used in psychotherapy are directly implemented in supervisory practice” (Beck, 2008, pg. 69). Below are the five main features of supervision that she proposes:

- *Developing the relationship with supervisee:* establishing a solid collaborative relationship; balance of positive and negative feedback.
- *Planning the session on the basis of conceptualization:* “supervisors help conceptualize clients according to cognitive model.”
- *Structuring the session:* based on Liese and Beck, 1997 structure cited above.
- *Collaborating on setting homework:* supervisees are assigned to use cognitive therapy techniques on themselves.

- *Use of standard cognitive techniques within session:* this includes role-playing, responding to automatic thoughts and beliefs, direct instruction. (Adopted from Beck, 2008; pg. 59-60).

In terms of the supervisor-supervisee relationship, Beck emphasizes the importance of developing a solid relationship so that supervisees can feel safe and trust the supervisor (Beck, 2008). She also discusses the importance of “collaborative teamwork,” which involves working together to achieve goals. Moreover, supervisors are encouraged to strike a balance between reinforcing positive behavior and correcting maladaptive behavior/thoughts (Beck, 2008).

Lastly, regarding evaluating supervisees, Beck (2008) believes that evaluating therapy tapes is a core component of supervision that is unique from the therapy. She recommends that supervisors listen to entire therapy tapes and use the Cognitive Therapy Rating Scale (CTRS) to evaluate the therapy session and highlight problems. She believes that without listening to tapes supervisors often cannot identify problems and offer effective guidance (Beck, 2008). In addition, Beck recommends that supervisors ask themselves questions (e.g., “What were the supervisee’s weaknesses?”) when listening to therapy tapes in order to plan for the next supervision session (pg. 64).

Thus, according to Liese & Beck (1997) and Beck (2008), supervision in CBT follows a general structure that mirrors the therapy, there is a focus on developing a collaborative relationship, using standard cognitive techniques within the session, assignment of homework between sessions, and evaluating therapy tapes with the use of rating scales.

### **Support for Psychotherapy Based Model of CBT Supervision**

Several authors have proposed “best practices” and recommendations for CBT supervision that appear consistent with Beck’s psychotherapy-based model of CBT supervision (Pretorius, 2006; Rosenbaum & Ronen, 1998). These author’s proposals are consistent with the above model with some minor additions and language differences. For example, Pretorius reviews the literature on “best practices” of CBT supervision, and highlights the following framework which is consistent with psychotherapy-based models of supervision: (1) general principles and goals of CBT (2) format of individual supervision sessions; (3) course and stages of CBT supervision; (4) attending to supervisees’ cognitions and affects; (5) importance of the relationship; (6) recording and rating therapy tapes (Pretorius, 2006).

Similarly, Rosenbaum & Ronen’s (1998) approach to CBT supervision is consistent with Beck (2008) and Liese & Beck’s (1997) model of supervision. For example, they argue that CBT supervision is similar to CBT therapy, supervision is a collaborative “meaning making process,” is systematic and goal directed, and involves the use of homework assignments to practice skills and techniques (Rosenbaum & Ronen, 1998, pg. 222). They highlight that CBT is a “philosophy of life; a way of living,” and that therapists should be encouraged to think as CBT therapists (pg. 224). In a similar manner, Beck emphasizes the importance of assigning cognitive techniques to supervisee’s for homework and encouraging them to practice skills and techniques outside of supervision (Beck, 2008).

However, these authors also discuss some additional aspects of CBT supervision, including attending to supervisee’s emotions and encouraging autonomy in CBT

supervision. For example, Pretorius discusses the importance of exploring supervisee's emotions in addition to Beck's recommendation to explore cognitive beliefs that interfere with therapy. This way, supervisors will also help therapists to identify emotions and generate alternative perspectives (Pretorius, 2006). In fact, several researchers have supported and encouraged the incorporation of emotions into CBT supervision (Lombardo, Milne, & Proctor, 2009). Researchers have argued that focusing on supervisee's emotions may increase their effectiveness as therapists (e.g., contributing to more emphatic responses with patients), and may also allow the supervisee to "assess an additional source of clinical data" regarding the effects of the client's behaviors on others (Batten and Santanello, 2009, pg. 148).

Moreover, Rosenbaum and Ronen (1998) believe that the goal of CBT supervision is to empower the supervisee so that he can develop into an "independent thinking therapist who is highly resourceful and confident in applying CBT to client's problems" (pg. 228). For example, instead of providing supervisee's with direct answers to questions, the supervisor encourages the supervisee to explore the relevant literature or asks them a series of questions, such as "What is the first thing you can do to help the client resolve his or her problem?" (pg. 228). Although not explicitly discussed, empowering supervisee's is not inconsistent with Beck's model. For example, Beck encourages supervisees to summarize what they learned in supervision and asks for feedback (Beck, 2008). Other authors have also highlighted the importance of encouraging independence and limiting dependence of supervisees in CBT supervision (Pretorius, 2006). Overall, despite some additional recommendations (e.g. addition of

emotions in supervision, empowerment of supervisee's), several authors have supported Beck's model of CBT supervision (Pretorius, 2006; Rosenbaum & Ronen, 1998).

### **Empirical Support for Psychotherapy-Based Model of CBT Supervision**

Is there any empirical support for a psychotherapy-based model of CBT supervision? Although very little research has been carried out to test this model, two studies offer some preliminary support for Beck's supervision model. For example, Milne, Pilkington, Gracie, and James (2003) employed a qualitative methodology to study the transfer of skills from therapy to supervision using analysis of supervision and therapy tapes from one client's treatment. Ten therapy and supervision tapes were transcribed, and grounded theory methodology was used to extract themes from the audiotapes. The 14 themes that emerged were consistent with Beck's (2008) model of supervision and showed that many of the skills and principles of CBT therapy were similar to CBT supervision. For example, both CBT supervision and therapy focused on conceptualization, evaluating thoughts, agenda setting, socialization to the model, and the use of standard CBT techniques in session (e.g. role-play and homework; Milne et al., 2003).

Additionally, in a qualitative and quantitative survey of 170 cognitive-behavioral supervisors in the UK, Townend, Iannetta, & Freeston (2002) found that cognitive-behavioral supervisors frequently cited Liese & Beck's (1997) model as influential upon their supervision practices. In addition, findings showed that supervision in CBT had many similarities with CBT therapy (e.g. agenda setting). Findings were also consistent with psychotherapy-based models in several ways. For example, consistent with the Beck (2008) model, case formulation was the most frequently used in supervision (Townend et

al., 2002). In addition, agenda setting and examination of supervisees' own cognitive processes were used "sometimes" or "often" by 50% of respondents (Townend et al., 2002). On the other hand, supervision appeared to be less structured than CBT therapy and supervisors did not often review tapes of therapy sessions (Townend et al., 2002). Overall, these two studies provide us with some preliminary evidence for Beck (2008) and Liese & Beck (1997) models of cognitive-behavioral supervision, and show support for the assertion that CBT supervision parallels CBT therapy.

### **Scarcity of Research and Limitations of Existing Research on CBT Supervision**

Many authors have noted the scarcity of research on CBT supervision despite its complexity and importance (Liese & Beck, 1997; Milne, 2008; Reiser & Milne, 2012; Townend, 2008; Townend et al., 2002). In fact, in a review of the CBT supervision literature conducted on PsychInfo, this author only found a few published studies that collected data on CBT supervision using either a quantitative or qualitative methodology. Secondly, these studies have some important limitations that prevent their results from being generalized to the CBT supervision field as a whole. For example, the Milne et al. (2003) study mentioned above relied on data from only one supervisor who was an author on the study. On the other hand, while Townsend et al. surveyed a larger sample of CBT supervisors, they grouped supervisors from multiple professions in one sample (e.g. mental health nurses and occupational therapists), left out important data on supervisors (e.g. how long they have been supervising for), did not analyze their qualitative results using a methodology, and mostly provided an overview of supervision practices that did not include an in-depth analysis of CBT supervision from the perspective of the

supervisors they surveyed (e.g. they did not capture how supervision was less structured than CBT therapy).

Additionally, in a review that examined the effectiveness of CBT supervision, Milne & James (2000) relied on studies from the intellectual disability field that have much simpler interventions than most CBT interventions, and had missing information about the supervisors they studied as they had predicted (e.g. missing information about education, experience, job title and competence of supervisors was common). More recently, a fourth study attempted to develop a framework for CBT supervision for mental health nursing by interviewing 16 CBT course directors in the UK, and analyzing the results using grounded theory methodology (Townend, 2008). Although the author reported 8 themes that emerged based on the interviews, findings were not related to current CBT supervision frameworks, and results were reported in a vague manner.

Thus, in addition to a scarcity of research, the studies that have been carried out have important limitations, including missing important information about the supervisors surveyed/interviewed, not analyzing qualitative results, not applying their results to the literature on CBT supervision, and employing an analysis of supervision from one supervisor-therapist dyad. In addition, none of these studies mentioned included in-depth analyses of supervision practices nor did they survey doctoral-level psychologists specifically.

Some important questions remain to be studied including: What are the supervision practices of doctoral-level CBT supervisors? Do CBT supervisors carry out supervision in a manner consistent with Beck's model of CBT supervision? Are there any important extensions to this classic model of CBT supervision? Thus, this study

examined the conceptualization of CBT supervision from the standpoint of doctoral-level psychologists who supervise in a CBT framework. Secondly, this study addressed the extent to which CBT supervision in the real world is consistent with recommended models. This is an important initial step before developing more comprehensive models of CBT supervision and beginning quantitative research on CBT supervision.



## CHAPTER III

### METHODOLOGY

This study employed a qualitative research methodology to understand the supervision practices of 10 CBT supervisors along various dimensions. This chapter will outline the rationale for using a qualitative research methodology, review the data analysis methodology, and describe the characteristics of the participants, the interview questions, and the procedures. The chapter will end with a discussion of the steps that were taken to reduce research bias from the study's design.

#### **Qualitative Approach Introduction**

Overall, qualitative methodologies may be useful over quantitative methodologies in several circumstances. Firstly, qualitative approaches are used when there is little research on a topic or when research is limited due to being biased or partial (Morse & Richards, 2002). Secondly, when the purpose of the study is to gather information about a topic that is complex and nuanced, a qualitative methodology is appropriate (Morse & Richards, 2002). Third, if one is trying to understand and make sense of participants' experiences, the meaning they attach to it, and understand their perceptions in a detailed manner, a qualitative approach is most useful (Morse & Richards, 2002). Thus, given that there is very limited research in the field on cognitive-behavioral supervision (e.g. there are only a few studies with qualitative or quantitative data on CBT supervision), and due to supervision being very complex and nuanced (Milne et al., 2003), a qualitative approach was the most appropriate and useful for this study. A qualitative approach was also advantageous in this study since the goal was to provide an in-depth analysis of the participant's approaches to supervision.

## **Data Analysis**

The data was analyzed according to Fishman (1999) and Patton (2002).

The purpose of the analysis was to identify themes in the CBT supervision process of experienced CBT supervisors by using a content analysis approach. Subsequently, three case examples were selected to further illustrate several approaches to supervision. The first component of the analysis (Chapter IV) reflects a horizontal approach, as each of the five main dimensions (structure of CBT supervision; attending to emotions, thoughts, behaviors; relationship factors; evaluation; self-evaluation) was analyzed for common and different responses across the 10 participants. The second component of the analysis (Chapter V) follows a vertical pattern, whereby three supervisors were selected and their supervision styles were captured along these same dimensions.

## **Participants**

### **Selection Criteria.**

Participants were required to possess a doctoral degree in psychology and be licensed as psychologists. Secondly, they were required to provide supervision primarily in a cognitive-behavioral framework for a minimum of three years. They were also required to supervise doctoral students in clinical/counseling psychology, and provide supervision in an individual format (could also provide group supervision in addition to individual supervision). Lastly, in order for the sample to reflect “state of the art practice” participants were required to be employed at CBT institutes, CBT group practices, or CBT centers that were affiliated with medical schools.

**Recruitment.**

The participants were contacted via email through reputable CBT institutes and professional organizations that had publicly accessible websites (e.g. The Association for Behavioral and Cognitive Therapies (ABCT), American Institute for Cognitive Therapy, Beck Institute for Cognitive Therapy). A few participants were also recruited through referrals from other participants. The purpose and method of the study was explained to participants over the phone.

**Demographics.**

A total of 10 CBT supervisors voluntarily participated in this study. Eleven participants were recruited for this study, but one supervisor did not meet eligibility criteria for this study (e.g., supervised for less than three years). A complete list of participant demographics and characteristics can be found in Table 1 and Table 2. The participants were 40% female and 60% male. Ninety percent of the sample was Caucasian (one supervisor identified as multiracial). As expected based on inclusion criteria in this study, all the participants were employed in either a CBT institute (50%), CBT Group/Private Practice (40%) or CBT Clinic (10%). Several participants had additional employment settings (mostly academia/research).

In terms of their supervision practices, the interviewees had been supervising for a median of 10 years at the time of the interview and were spending a median of 8 hours per week engaging in supervision. They supervised a median number of 7 therapists. Only 30% of the sample had any training in supervision, but most were engaged in supervision/peer consultation groups (80% of the sample). The majority of the sample

also indicated that they had achieved Diplomate/Fellow certification with the Academy of Cognitive Therapy (70%).

Regarding their theoretical orientation as therapists (see Table 2), 100% identified themselves as primarily cognitive-behavioral and were supervising in a CBT framework. The majority of the sample considered themselves more behavioral than cognitive (70% were more behavioral than cognitive or predominately behavioral). All the participants incorporated third wave CBT techniques into their therapy (e.g., mindfulness, acceptance, Acceptance and Commitment therapy).

The intention of this study was to gather a sample of very experienced CBT supervisors who are employed at reputable CBT centers, institutes and practices in order to reflect “state of the art practice” in CBT supervision. This aim was achieved since supervisors were employed at reputable CBT organizations, were very experienced as supervisors (median of 10 years of experience), and supervised many students (median of 7 students). Thus, this study did not intend to interview a representative sample of CBT supervisors.

## **Measures**

*Initial Data* (See Appendix C): This questionnaire required that participants fill out information about their age, level of education, years of experience supervising, training in supervision, type of supervision they provide, theoretical orientation, number of people they supervise, how many hours per week they spend supervising, whether they engage in their own supervision or peer consultation, and methods of supervision they employ.

*Semi-structured Interview* (See Appendix D): This interview is comprised of 17 open-ended questions based on a thorough literature review of the field of cognitive-behavioral supervision and discussions with advisors and professors. The questions are directed towards getting at unique aspects of cognitive-behavioral therapy supervision as opposed to the supervision field as a whole. The majority of the questions are based on Liese and Beck (1997) and Beck (2008) conceptualization of cognitive-therapy supervision, which includes a recommended structure for CBT supervision, developing a collaborative relationship with the supervisees, using standard CBT techniques in supervision, attending to supervisees' automatic thoughts, evaluating and rating audiotapes of psychotherapy sessions. In addition, several questions were added from Pretorius (2006) recommended practice for CBT supervision, including questions about the goals and principles of CBT supervision as well as attending to supervisee's emotions in supervision sessions. Thus, the semi-structured interview consisted of the following 5 dimensions: a) structure of cognitive-behavioral supervision, b) attending to supervisees' emotions, cognitions, and behaviors, c) relationship factors in supervision, d) evaluating supervisees, e) self-evaluation. Moreover, since the second aim of this study was to capture whether supervisors were following Beck's recommended model of CBT supervision, several probes were added to relevant questions so that supervisors could elaborate on how their supervision practices are different from this recommended model and provide examples. Lastly, supervisors were provided with a handout of this model (name of researcher was redacted) and given the opportunity to reflect on their similarities and differences with this model (see Appendix D; Beck, 2008; Liese & Beck 1997).

## **Procedure**

Interviews were conducted in the participant's offices at work based on their preferences. Every participant was provided with the option of conducting the interview in a private office at the GSAPP, Psychological Services Clinic at Rutgers University. Two of the interviews were conducted by phone due to schedule restrictions. Before beginning the interviews, the interview format was described to participants. Secondly, participants read and signed the consent form that includes a written description of the study (Appendix B). They were presented with a copy of the consent form. Any questions or concerns were addressed before signing the consent form. Third, participants completed an initial 5-minute data form that included demographic questions as well as questions related to their supervision practices and theoretical orientation (Appendix C). Fourth, participants were interviewed using a semi-structured interview developed by the researcher that covers important dimensions of CBT supervision (Appendix D, see description of semi-structured interview under measures). The interviews lasted between 60 to 90 minutes over one meeting time. Interviewees were given the option to withdraw at any point during the study. All the participants complete the study protocol. There were no adverse effects reported by any participant during or after the interview.

A case number was assigned to each participant, which was used to identify the interview. All interviews were then transcribed by the principal investigator. All identifying information (e.g., names, employment location) was removed from the transcripts. Consent forms were kept in a locked filing cabinet separate from the interview data. Tape recordings, consent forms, transcriptions of interviews, or other data

collected from participants will be maintained in a locked filing cabinet for three years after completion of the study. The principal investigator will destroy all research material after three years.

### **Quality of Knowledge Procedures**

Fishman (1999) discusses the importance of the researcher clarifying his/her biases and values and also taking steps to reduce researcher bias. Rather than attempting to erase all possible biases, the researcher clarifies and shares his/her values and biases with the reader. In this section, this author will be discussing her values and biases with the reader and also outlining how these biases were reduced in the study design.

I, the principal investigator, am a graduate student in clinical psychology, a supervisee, and a cognitive-behavioral therapist. I share a similar profession, identity and theoretical orientation with the participants in this study who were all CBT supervisors and licensed psychologists. My career goals also include supervising and training psychologists, and I have had many several years of supervision in a CBT framework.

In order to reduce researcher bias, the interview questions I selected were based on a literature review of the field of CBT supervision. I also received feedback on the interview questions from several readers, which allowed me to modify the questions in a more neutral way. Some of the readers were not connected to the study while others were connected to the study. Secondly, I chose to use a semi-structured interview format to minimize bias from entering the dialogue with the participants. The interview questions were therefore written in advance and I followed a planned script, which allowed me to remain more neutral during the interview. Moreover, the interview was piloted on two

CBT supervisors so that this author could get feedback on the interview process and deliver the questions in a non-judgmental and non-evaluative manner.



## CHAPTER IV

### RESULTS

#### **Structure of CBT Supervision**

All of the supervisors (10/10) mentioned that they use a flexible supervision style that mirrors cognitive-behavioral therapy. Typically, each supervision sessions begins with a brief 5 to 10 minute check-in (e.g., “How was your week?” similar to a mood check) and agenda setting (e.g., “What should we prioritize today?”). The majority of the supervision session is then spent on case updates and problem solving, which will vary depending on the needs of the supervisee, the number of cases, and level of experiences. Supervisors employ many CBT strategies to help with the problem-solving phase, particularly Socratic questioning, CBT case conceptualization and role-playing. At the end of supervision, there is a 5-minute “wrap up” that typically includes feedback, plans and goal setting for the next session. See Table 3 for a complete list of CBT techniques/strategies that supervisors used in supervision on a regular basis.

Moreover, supervisors consistently emphasized that their approach to supervision was flexible and depended on the needs of the supervisee and clinical needs of the patients (e.g., crisis issues) even though they followed a CBT model overall. For example, James reflected on the flexibility of his approach:

I would suggest that it’s a very open structure--based on what the perceived needs are for their clinical work and what they bring to the session. But it’s collaborative and there is an agenda setting in the beginning of the supervision session just like in traditional Beckian CBT. It’s modeled on a hello how are you? What is our agenda? How can we best use our time? Lets look at these points,

let's summarize, and let's get feedback. So it's a general CBT thing but within that it can get pretty flexible.

Consistent with employing a flexible approach, 70% of the supervisors discussed adjusting supervision to account for the therapist's level of experience. Overall, they emphasized that beginning level therapists require more didactic instruction, basic conceptualization and guidance on all individual cases while advanced CBT therapists require more trouble shooting and fine-tuning of techniques. Both Doug and Kelly reflected on this theme below respectively:

So we get some [students] with analytic backgrounds but want to learn CBT so for them its much more didactic in the beginning. With them I'll say read this and let's discuss how it's going. We see where they are in terms of conceptualizing first—can they think about case in CBT terms. Junior people need this foundation. More experienced people...I may start off just by assessing where they are and asking general questions. But if they are on board and know theory well, the push is to know some of the more advanced techniques like Socratic questioning. I may challenge them to do a session only using Socratic questioning no statements-- could they get through it...why or why not?

Basically, it varies depending on the level of the student I'm working with. If they are fairly competent in CBT then I am more likely to troubleshoot.... the less people know the more didactic it is. The more they know the more trouble shooting problems areas, case conceptualization it is. I'm also going to go through

every client with someone less trained. And I don't feel that need with people more trained or more competent with skills.

When asked about the rationale for their supervision structure, 7 out of 10 supervisors described that their supervision structure is similar to how they conduct therapy and that the structure was also modeled to them by previous supervisors. Alex described how his style developed by combining experiences with previous supervisors and his natural style as a therapist:

Mostly from my work as a therapist I follow a similar pattern as I do with therapy clients. Using my experiences as a therapist and using my experiences with supervisors that I liked—I then kind of put those together. It seemed like a natural way for me to be with people.

Moreover, the supervision structure reported by the supervisors above was similar to the supervision structure suggested by Beck (2008) and Liese and Beck (1997) with a few variations (see Table 4 for a comparison between Beck's recommended structure for supervision and the typical structure that supervisors reported in this study). Similar to the Beck model of supervision, supervisors in this study also began supervision with a check-in and then set the agenda. However, they did not report "creating a bridge from the previous supervision session." After setting the agenda and prioritizing, they generally discussed updates on cases and spent the majority of the supervision time problem-solving issues (e.g., problems implementing a CBT technique or getting the patient to complete an assignment for homework). Supervisors also did not formally

review homework and then assign new homework at the end of the session based on Beck's recommended structure. Supervisors emphasized that they do not formally assign homework with the exception of reading, despite doing so as CBT therapists. Many of the supervisors expressed that their role was to provide practical skills and did not want to further burden students with additional assignments. Kelly reflected on her reluctance to assign homework:

They have classes and other places where they are learning this and I am filling in the blanks in a practical nature. I do not want to weigh student down with a lot of work because I think they have plenty of work already. It's not that there is something wrong with giving homework. That is just not how I happen to approach my supervision.

In summary, the supervisors reported and described that the structure of their supervision sessions mirrored a CBT therapy session overall (e.g., check-in, agenda setting, problem solving, and wrap-up at the end). They generally adhered to the recommended structure outlined by Beck's model with several variations. The most notable difference was that supervisors in this study did not formally assign and review homework as part of every supervision session with the exception of providing suggestions for reading or asking supervisees to conceptualize cases. They emphasized that their role was to provide practical skill training and noted that students were already busy with homework. Additionally, supervisors reported that their supervision structure was very flexible and emphasized that they adjust supervision depending on the therapist's level of experience and training (e.g., beginning-level therapists require more

didactic instruction, focus on case conceptualization, and guidance/review of all individual cases).

### **Attending to Supervisees' Emotions, Thoughts, and Behaviors**

The majority of the supervisors (8/10) emphasized that attending to supervisees' emotions, thoughts, and behaviors is important in supervision. Many of the supervisors felt that attending to these factors was very important since they can interfere and impact the work that they are doing in therapy. Peter reflected on this by stating:

I can't imagine doing CBT supervision without using some CBT methodology as part of my discussion with the supervisee themselves in term of how they are thinking about other issues outside of therapy if it should come up, or their own anxiety about the therapy session or sense of themselves as therapists.

Two of the supervisors that did not believe attending to emotions, thoughts, or behaviors were important/essential in supervision, qualified this by stating that they are important if they interfere with effectiveness as a therapist. For example, Kelly stated:

I think they can be very important and other times not. If there are cognitions that are affecting students' ability to treat the case, such as anxiety, worries that the patient can be mad or storm out, or worries about being able to say something. So I often think restructuring that or getting them to look at that can be helpful. Do I think its imperative in CBT supervision? No. Every time? No.

As noted above, supervisors reported that attending to emotions is important/essential in CBT supervision, particularly if they interfere with providing

effective therapy. The main emotions that supervisors discussed were shame, guilt, anger, and fear. Keith reflected on how his student's emotions can impact therapy:

The emotional reaction that you have reflects on behavior. So I think a person who is doing exposure with a panic patient and is afraid that the patient may faint. That is a difficult situation and the person may need his or her own cognitive restructuring to deal with it to follow through. If someone is annoyed at a patient and responding this way---that would be a problem.

Supervisors discussed attending to emotion through modeling possible emotional reactions, exploration, providing validation, as well as through the use of cognitive therapy techniques (e.g., cognitive restructuring), in a similar manner to how they would deal with cognitive distortions. Alex discussed how he explores and validates emotional reactions by stating,

I ask fairly direct questions and either reflect, “wow that sounds frustrating” and see if I get anything back or “are you feeling frustrated/angry about that person because if I were there, I would too.”

Majority of the sample echoed that they address dysfunctional thoughts in supervision by using CBT techniques, including identifying exaggerations/distortions, exploring worst and best case scenario, and discussing coping techniques. Keith described this process with a supervisee:

I address this in a similar way to what I do in cognitive therapy. Looking at the nature of those thoughts/fears, identifying exaggerations/distortions, and also

identifying realistic aspects of those fears, and realizing that this is chance you have to take. For example, maybe the person will not come back to therapy anymore if you are confrontational—that is realistic. But I would argue that you are not going anywhere with them so it may be worth the change. I also get the supervisee's sense that they will be able to cope with this even if it occurs and there may be some exaggerations to this as well.

Supervisors felt that behaviors were at least equally important to address in supervision, although they were described as infrequent in CBT supervision overall and there was no consensus on how to effectively address them. Supervisors discussed dressing inappropriately (e.g. jeans), distracting behaviors (e.g., nail biting, watching the clock during sessions), lack of eye contact, talking too much, and jumping into problem solving as the most common behavioral issues that they see in supervision. Several of the supervisors emphasized that they address these behavioral issues through exploring with the supervisee and using gentle Socratic questioning without putting the supervisee on the spot. Kelly provided an example of this process:

When someone comes in wearing jeans. That is not okay. I do not just say that is not okay. I say, “how does that make the client feel and how do they interpret you?” I have certainly approached all those things and they are really important, but they are kind of ingrained. There is a person who is very reticent and looks down a lot. Or apologizes a lot themselves, I'll directly address that. Or I may just say, do you think you were sitting like you are sitting right now, what message

does that send to the client? What message do you want to send? How can we change that?

Despite echoing that these types of behaviors mentioned above are important to address in CBT supervision, three supervisors discussed the sensitive nature of bringing up these behavioral issues. Doug reflected on this by providing an example with a supervisee:

I introduced to them if they were aware of the habit. The person was aware but was embarrassed that I called them out on it. It became a teaching moment for us both because I tried to be gentle about it but not gentle enough so we ended up having a discussion about it, but the [supervisee] ultimately felt that it was too much like, “what are you doing about this thing?”

Moreover, despite agreeing that it’s important to attend to supervisees’ emotions, thoughts, and behaviors, 40% of the supervisors described doing so in a more informal way than with patients and will generally not assign homework. Alex described assigning a book chapter to therapists if they have some dysfunctional cognitions, and also questioning them informally and gently:

I definitely have an ear open to how things are being talked about. I would never have a therapist keep track of automatic thoughts and dispute them. Instead, in the moment, they may say something and I’ll ask them to repeat it and listen to what they said, and how it’s impacting what is going on. So I’m not formally doing it.



Lastly, three supervisors emphasized the importance of keeping firm boundaries and making sure they keep supervision distinct from therapy when attending to emotions, thoughts, and behaviors. Monica described the importance of not making supervision into a therapy session when discussing how she attends to behaviors:

I'll sort of ask about it or I'll say that commentary of, "I notice that you are looking away or I'm noticing you seem tense today." What I try to guard against is going into an overly personal place. I don't want to create something that feels overly personal. Its not analysis.

Overall, the supervisors believed that attending to supervisees' emotions, thoughts, and behaviors are very important in CBT supervision, particularly since they can interfere with effective treatment. Supervisors generally used a variety of techniques to attend to these issues, including some general therapy techniques (e.g., exploring, questioning, validating, normalizing), as well as CBT specific techniques (e.g., cognitive restructuring). Several supervisors, however, emphasized that they carried this out in a somewhat more informal manner (e.g., do not assign thought records) compared to with a patient, and a few supervisors emphasized that they were careful and cautious when doing so since they wanted to make sure supervision did not feel like therapy.

### **Relationship Factors in Supervision**

Eighty percent of the interviewed emphasized creating a collaborative, collegial and non-hierarchical relationship with their supervisee. They understood the power differential inherent in supervision, and aimed to create an environment that felt collegial

and safe. Alex and Doug described their collegial and collaborative approach to supervision respectively:

I'm not trying to create a separation between myself and my supervisee even though there is an obvious difference. I really want it to be a collaborative process. I try to model the idea that we are going to be peers so that there is less of a hierarchy, and I try to level the playing field.

Like with a patient, I try to make it serious but fun. We want to be a team. I don't care to be the one that knows more. We may all come in with different levels of experience in different areas so it should be set up to be safe, team based, informative, but collaborative and fun. That is what I strive for.

Supervisors described a variety of ways in which they attempted to create a collegial and collaborative environment, including through the use of gentle Socratic questioning, create a collegial space for supervision, using ice breakers at the onset, asking supervisees for permission to go in a certain direction in supervision. However, one theme that was consistent among 70% of the supervisors was the emphasis on empowering supervisees' by encouraging autonomy. These supervisors also discussed meeting supervisees' needs by allowing them to choose the direction and pace of the supervision session. For example, Doug conveyed this theme by stating,

I empower them to dictate the pace and what they do. It is up to them. I am usually not going to be the one to say what we are going to talk about. I won't tell them to do this, but instead, "what do you think we should try?"

Jane also emphasized this sense of increasing autonomy through the use of Socratic questioning:

When we listen to tape, I wait for her to say what she thinks is going on and what she thinks she could have done differently. I try to point out her strengths and have her think about it first and explore. I try to use Socratic questioning in terms of drawing out what she is already thinking and asking her. So sometimes I have to control myself from getting into a too didactic role but really making a point to ask her first what she thinks is going on.

Moreover, 8 out of 10 supervisors interviewed were very aware of the anxiety inherent in the supervisor-supervisee relationship and made a conscious effort to reduce anxiety by encouraging learning in a more informal and less pressured way. This was particularly seen through the use of Socratic questioning and role-playing cases in a non-intimidating and supportive manner. For example, James described using Socratic questioning in a warm and encouraging way as opposed to putting students on the spot by stating:

I like using Socratic questioning in a way that is intentionally emphatic and connected rather than Socratic questioning where you are in a movie about law school. You can ask someone a question in a way that they know you are giving them an opportunity to discover it themselves or you can ask them a question so that they feel under the gun. If that was a useful form of exposure, I would want to put people under the gun and have them perform better as therapists. But I

don't think so. The warm encouraging, asking for permission, reflective listening [works].

Doug conveyed this same theme of reducing anxiety and making supervision less intimidating for therapists by describing how he conducts role-playing:

I try to foster a creative environment so that they can have fun and learn. We try to use role-plays but not in a 'do it for me' type of way. Its more informal a lot of the time. It will just be, let's jump into role-play, and suddenly I'm them for a bit. I usually role-play the therapist first without putting them on the spot. If they are stuck, I'm not going to make them squirm and we'll reverse back and forth so that I can help them out.

Moreover, 70% of the supervisors interviewed used self-disclosure as a technique that helps to normalize their supervisees' struggles with patients as well as anxieties related to the being a therapist. Keith expressed:

I try to set the tone right in the beginning and let them know that I run into the same problems as they do even though I'm a lot more experienced. I make it seem that it is more of a rule than an exception that you run into problems. I tell them that I've had the same type of problem with a patient if it's true, and that sometimes it's resolved and sometimes not. That normalizes the idea that it's not bad that that the person does not respond to treatment.

Despite emphasizing the importance of self-disclosure to normalize anxiety and the process of therapy, 4 out of 10 of the supervisors added that they also aim to have professional boundaries with supervisees, and that it is important to differentiate between supervision and therapy. Doug expressed:

I also do not want to make supervision like therapy. There are other supervisors who may blur the lines more by talking about the processes in the process and talking about stuff in the therapist's life. I'm vigilant about boundaries and keeping the two separate. Obviously, I'll ask if someone is distressed and it's a tough case or if they seem visibly distressed, but I try my best to allow there to be a separate place for these two things.

In summary, the supervisors interviewed emphasized creating a collaborative, collegial, and non-hierarchical relationship in supervision. They did so in a variety of ways, the most common of which was empowering supervisees and encouraging autonomy. For example, supervisors discussed that they allow the supervisee to set the agenda and choose which patients he wants to focus on. They also encouraged autonomy through the use of Socratic questioning (e.g., encouraging the supervisee to think independently and draw out his/her thinking). Interviewees were also very sensitive to the power dynamics in supervision as well as therapist anxiety. Thus, they made a conscious effort to reduce anxiety through the use of "gentle" Socratic questioning, and role-playing in a supportive manner (e.g., not putting them on the spot, modeling the therapist role initially). Lastly, supervisors emphasized the importance of using self-

disclosure about their difficulties with patients as a technique to normalize anxiety and therapeutic challenges that supervisees' inevitably encounter.

### **Evaluation of Supervisees**

All the supervisors interviewed followed the program/school structure they are given for evaluating students. This typically consists of competency rating forms (likert scales) that include CBT specific skills (e.g., agenda setting, presenting rationale) and also more general therapy skills (e.g., ability to form alliance with patient, level of attunement). These evaluations are provided to the student twice per year (typically middle and end of supervision).

Furthermore, 60% of the supervisors emphasized that they take a multifaceted approach when evaluating supervisees. For example, they rely on audiotape review, session notes, self-report, CBT specific competencies as well as general therapy skills. Jane emphasized looking at multiple sources of data by stating:

Every week I sign off on her progress notes so I'm working on different sources of data and also looking at the tapes aside from her self-report. Tapes show so much if I only used her self-report, I would miss out on what is actually happening.

The emphasis on evaluating supervisees by paying attention to CBT competencies and general psychotherapy skills was explained by James below:

I look at CBT skills, but also general therapy skills. The ability to be responsive, match affect, be empathic, have clinical wisdom, divide attention between client's processes and own, be mindful, and show up and really do good work in session.

All of the supervisors emphasized that audiotape review was important to the evaluation process. However, the vast majority (8/10) were unable to listen to the entire therapy session. They were also unable to consistently listen to sessions due to time barriers and a lack of compensation for their time outside the supervision hour. James stated:

I would not have time to listen to [tapes] outside. I tried in and it seemed onerous. Because its 6-7 hours of volunteer supervision per week and then you are in your car driving and listening. It felt like I wasn't being fair to myself...there has to be a limit or your are over committing.

When supervisors were able to listen to audiotapes of sessions, they generally had the supervisee cue it up to a part of the session where he/she was struggling. From there, they generally used Socratic questioning, role-plays, and direct instruction to problem solve and identify alternative ways of responding. The majority of supervisors (70% of the sample) evaluated therapy tapes by paying attention to specific CBT competencies (e.g. how they explained the rationale of the treatment, explicit guidance on techniques) as well as general therapy skills, particularly rapport and relationship factors. Several also mentioned that they try to imagine how they would respond to the patient if they were the therapist. Monica reflected on this by stating:

I think I was always listening for where is the agenda, that was always a stickler point for me. Does the session have threads that are continued throughout or does it feel disjointed and bouncing around? Is there an agenda, body, and wrap up.

I'm listening and asking myself, how does rapport seem? Are they connecting? Are they misunderstanding? Is therapist/patient not listening? Is the therapist providing explicit interventions (e.g. today we are going to do exposure, look at homework we are covering). I'm always listening for specific guidance.

When supervisors were asked about whether they use the Cognitive Therapy Rating Scale (CTRS) when they are evaluating tapes, 9/10 reported that they are unable to use the CTRS since it takes several hours to listen to the session and complete it. A few supervisors also stated that they do not use the CTRS since they are unsure of its effectiveness or relevance in their particular setting. James stated:

It usually is not called for with the population we are seeing here. We are usually seeing private multi-problem clients with complicated diagnoses and longer-term case conceptualization. It's not part of the structure here so I don't use it...Let's just say that there are many dimensions to good therapy outside the CTRS.

Lastly, it is important to note that three supervisors discussed that supervisees were reluctant to bring up problems/mistakes in the sessions due to fear of evaluation. Keith discussed this below:

Students are less likely to disclose problems because they are concerned about my evaluation. They want to learn, but at the same time they don't want to look like if two cases don't respond and neither case is getting better and the client is dropping out or whatever. ..The only thing is on some level the students are likely



to get a letter of recommendation so there is always the implicit idea that they want to come across in a positive light.

In summary, the supervisors interviewed emphasized that they take a multifaceted approach to evaluating supervisees (e.g., rely on audiotape review, self-report, session notes). Supervisors evaluated therapy tapes by focusing on specific CBT competencies (e.g., agenda setting, how the student provided rationale for the treatment) as well as general therapy skills (e.g., ability to establish rapport/alliance with the patient). However, even though supervisors emphasized the importance of audiotape review, the vast majority did not review entire audiotapes of therapy sessions outside of supervision due to time constraints and lack of compensation outside of supervision. In a similar manner, supervisors did not use the Cognitive Therapy Rating Scale or another instrument when they evaluated the student's therapy sessions due to time constraints.

### **Self-Evaluation**

When asked about how they evaluate themselves in terms of their own competence, expertise and ethics, 70% supervisors interviewed emphasized that they engage in consultation with colleagues when they are faced with difficult cases or cases that fall outside their area of expertise. A few of the supervisors also noted that they attend regular supervision groups (e.g., peer supervision), attend workshops, and do extra readings when faced with patient issues they are outside their area of specialization. James emphasized all of these aspects by stating:

I have never left supervision in a sense. I engage in ongoing supervision. I am in case conference once per week, I go to regular workshops, I formally meet with

senior therapists for supervision at times, I go to lunch with colleagues a couple of times per week, and we have our peer supervision once per week. So through that process, and also needing to learn and write, I am forced to face what is working and not working in my clinical work and supervision.

When discussing how they evaluate themselves as supervisors, 60% of the supervisors stated that they do not practice or supervise outside their areas of expertise, and noted that they have a niche practice or work in a specialized CBT clinic so they do not usually take referrals from patients outside this area. Keith reflected on this by stating:

If an eating disorder case came in, I would be more likely to refer out or do extra reading. For that reason, I talk to everyone in the clinic, and make sure [cases] are within anxiety and depression. This is not just a general clinic with problems that I may be less familiar with. I restrict my practice to my area of anxiety and depression as well.

In addition to consulting with colleagues and not practicing within their area of expertise, 70% of the supervisors reported that they evaluated themselves based on formal and informal feedback from supervisees. They received formal feedback generally twice per year (based on school's requirements and forms), but also emphasized that they elicit ongoing feedback throughout supervision sessions. Peter discussed eliciting feedback during supervision sessions:

[During supervision] I ask how does that sound? Does this feel okay? Do you feel comfortable with this? Do you have any concerns about this? If there is a particular problem [with a patient] and you addressed it, very often in the next session I'll say, "How do you think I handled that? Is there something that you preferred that I said or said in a different way in terms of that?" Again, parallel process in terms of the way I would do it in therapy.

Despite attempting to elicit ongoing feedback from supervisees, three supervisors discussed feeling uncertain about their performance as supervisors due to the difficulties in getting honest or negative feedback from supervisees. These supervisors felt that there were barriers to getting honest feedback due to the power differential and supervisee's anxieties related to being evaluated. Pam stated:

I ask for [feedback] throughout the year and when I give them their feedback. But they do not give negative feedback. I do not think they would feel comfortable doing so. I think it is always hard to give negative feedback-especially when there is a power differential. And I'm evaluating them so even when the evaluations are done I ask those questions—but I always take it with a grain of salt that there is no negative feedback—there must be something.

Overall, the majority of the supervisors evaluated themselves by emphasizing that they do not practice outside their areas of expertise, work in a specialized CBT clinic/niche area, and also consult with colleagues when faced with difficult cases. Supervisors also evaluated themselves by encouraging and asking for feedback from

supervisees in both formal and informal ways (e.g., check-in during the session and also relying on written feedback twice per year). Lastly, a few supervisors reported that they were unsure if supervisees' were able to give honest or negative feedback due to the power differential inherent in supervision.

## CHAPTER V

### CASE EXAMPLES

This chapter will highlight the supervision style of three of the CBT supervisors interviewed in this study. Although there was significant homogeneity in supervision practices among the supervisors in this study, these cases were selected to further illustrate each supervisor's unique style and approach. All names and other identifying information (including employment agencies) have been changed or removed to protect each supervisor's identity.

#### **Case Example 1: Monica**

Monica is a 36-year-old licensed psychologist who is employed full-time at a CBT program in a hospital setting. She primarily provides psychotherapy to patients and supervision of doctoral students. She has over 15 years of experience as a therapist and has been supervising doctoral students for 10 years. She identifies CBT as her primary theoretical orientation, and considers herself more behavioral than cognitive. She also sometimes incorporates mindfulness and acceptance techniques into her therapy sessions. Monica estimated that she spent 12-15 hour of her week engaging in supervision (7 hours of group and 7 hours of individual supervision). She supervised 7-8 doctoral students on average. Monica received training in supervision on internship (consisting of a 2 week course and observed her supervisor). She also attends a peer supervision group on a weekly basis.

## **Structure of CBT Supervision**

Monica discussed the structure of a typical individual supervision session whereby she supervises 4-5 therapy cases. She begins supervision with a brief check-in, which she believes is an “opportunity to see how the therapist is doing and also check-in on how many clients came in that week.” She explained that the check-in “mirrors the therapy session in that it’s a bit like a mood check or a homework check.” She would then set the agenda and prioritize the agenda items. Monica had a particular structure for agenda setting that was explicitly modeled to the students at the onset of supervision. Urgent issues or problems are always prioritized (e.g., homicidal and suicidal issues with patients, serious medical problems and other crises). She would then review case descriptions and updates for each patient with a particular format, including information about the patient’s functioning, case conceptualization, review of interventions and progress. Monica stated, “I made it a point to hear about all the cases, even if it was only a sentence or two.”

The majority of the supervision session would be spent on case updates and problem solving any problems or concerns. Consistent with the majority of the supervisors interviewed, Monica employs CBT strategies to help supervisees’ with stuck points, including Socratic questioning, cognitive restructuring and role-playing. Monica enjoys using role-playing and stated, “I would be the therapist first and the student the patient and then we would reverse it because I find that students are less anxious when the supervisor goes first.” Monica believes that Socratic questioning is “one of the best ways of teaching and training.” While discussing difficult cases/issues, she often asks the therapist, “I wonder if there is another way to approach that problem? Did anything else

cross your mind in that moment.” Monica noted that this is a great way to get the “therapist talking” and to allow her to feel that she is in the “position of the expert” since the supervisor is not in the session.

Lastly, Monica reported that her supervision sessions end with a brief (3-5 minute) wrap up. This includes goals for the week, informally assigning homework, providing feedback and praise to the therapist, and also sometimes providing the opportunity for feedback about the supervision (if time permits). Additionally, unlike most of the supervisors interviewed, Monica listens to at least one full therapy session for each supervisee each week and emails the student a full page of feedback before supervision. Below is the overall structure of a typical individual supervision session:

1. **Check-in:** (“Opportunity to see how the therapist was doing; similar to a mood check.” )
2. **Agenda Setting and Prioritization of Agenda Items** (bulk of supervision)
  - a. Urgent issues or problems are prioritized (suicidal/homicidal issues and crises).
  - b. Case descriptions and updates for each case ( can be 1-5 minute updates for each)
    - i. Current functioning
    - ii. CBT case conceptualization
    - iii. Review of main interventions and progress
    - iv. Trouble shooting (frequent use of role-playing, Socratic questioning).
3. **Wrap-Up:**
  - a. Goals for the following session
  - b. Assigning homework (reading, case conceptualization after first session)
  - c. Provide feedback and praise to the therapist (“You are doing really well with this, I would like you to try more of X”)
  - d. Provide feedback on supervision if time permits: (“Any thoughts on the supervision today?” )

Monica’s supervision structure is very similar to the Beck model. She emphasized that CBT supervision “should and could model therapy sessions, especially since the

notion of socialization and social learning is the backbone of CBT.” For instance, she begins each supervision with a check-in, agenda setting and prioritization of the agenda items. Monica, however, has a more explicit structure for how to prioritize cases by focusing on the urgent ones first and also reviews each case weekly with updates (Beck does not go into detail on this in her structure). As recommended by Beck, Monica also uses standard CBT techniques in the session, such as role-playing, and also relies on CBT case conceptualization.

In a point of departure from the Beck model, Monica does not “bridge from the previous supervision session and then “review homework from the previous session.” Instead, Monica focuses more on reviewing all the cases from the week and getting updates on each case, which then leads to problem solving where there is a stuck point for a specific case. This affords her enough time to focus on where the “trouble spots” are in each supervision. Additionally, she does not formally use “supervisor capsule summaries” at the end of each supervision. However, she noted that she takes notes during supervision and “lists a few things that need to be followed up on or were themes” similar to a “walking out the door reminder.” Lastly, unlike most of the supervisors interviewed for this study, Monica relies on assigning homework at the end of each supervision session, which is consistent with Beck’s model. She noted that homework assignment is less formal than with a patient and that she attempts to “make it fun” because she knows that supervisees are incredibly busy. She explained, “I will say, there is a new technique I’ve read about, why don’t you look it up and come back and tell me about it.”



### **Attending to Emotions, Thoughts, and Behaviors**

Overall, Monica echoed that it is important to attend to supervisees' emotions, thoughts, and behaviors, particularly if they are impacting the therapy. However, she explained that she does so in a more informal manner than with a patient and is "careful about going into an overly personal space." Regarding thoughts, Monica emphasized that she attends to the therapist's automatic thoughts in a more informal way than with patients, but noted that "all the tools are there." She explained, "I use the white board and write down, Ms. Smith can't seem to do X, Y, Z." She then asks the supervisee, "where is the evidence? Is there another way to say it? Could there be another way to think about it?"

Monica believes that attending to behaviors is important in supervision because they are "what you reinforce in the session." She added that she attends to verbal and non-verbal reinforcers from the therapist in the session, including "how they follow-up on a patient's comments and how they spend their time." In addition, Monica occasionally comments on certain therapist behaviors in the session by asking, "I notice that you are looking away or I'm noticing that you seem tense today," and then waiting to hear if the therapist elaborates. Nonetheless, she emphasized that she does not want to "create something that feels overly personal. It's not analysis." She added, "I try to keep it even handed and not overly evaluative."

Lastly, Monica attends to the therapist's emotions in supervision, particularly if they are impacting the treatment or in cases where treatment is very distressing (PTSD cases). When supervising PTSD cases, Monica does not like to "assume they are having emotions." Instead, she normalizes the experience and sees if she gets a response from

them by asking, “a lot of therapists who do this type of work have described this experience. Has this happened to you?” In cases where the therapist seems frustrated or angry with a patient, again she does not want to “assume emotion,” and instead inquires, “The patient has not shown up 3 days in a row, tell me what it’s been like for you.” She also asks her supervisees for permission to look at her frustration with a patient. She illustrated, “Are you okay if we look at your frustration with the patient as a chance to do cognitive restructuring or radical acceptance?” Monica emphasized that she asks permission in this way because “[she] would like for supervision to be more collegial.”

### **Relationship Factors in Supervision**

Similar to the other supervisors in this study, Monica emphasized that she attempts to establish a collaborative and non-hierarchical relationship with her supervisees. For instance, Monica enjoys using “ice breakers” in order to learn about her supervisees more personally. She explained, “we talk about ourselves, our favorite CBT/DBT theorist. we talk about our styles—not as therapists but as people.” She also establishes a “collegial workspace for supervision,” which consists of a conference table whereby she can sit across from her supervisees and take notes. Additionally, Monica facilitates a collegial relationship by using “evidence based praise.” She explained, “If there is a specific part of the audiotape that I liked. I would make a little bit of a big deal with it. On the white board I would write great job with cognitive restructuring, fantastic, exclamation point.”

Lastly, Monica was one of only two supervisors interviewed who formally established goals and expectations from the onset and elaborated on the role of supervisee and supervisor during an orientation to supervision. Monica explicitly reviews her model

of supervision with expectations. She explained, “I review the forms we use for evaluation, how our time is used in supervision, that I listen to one audiotape per week and give them written feedback.”

### **Evaluation of Supervisee and Self-Evaluation**

Monica emphasized that she uses a multifaceted approach when evaluating her supervisees, including relying on patient feedback forms (e.g., working alliance questionnaire), weekly audiotape review, and role-playing in supervision to assess skill level. She relies heavily on audiotape review and would send her supervisees feedback one to two days prior to supervision. She provides written feedback that is specific (“I would like to see you try this technique here”) and balanced by focusing on both strengths and weaknesses (“You did this really beautifully. Consider trying more of this”). Moreover, Monica evaluates audiotapes of therapy sessions by focusing on general therapy skills (rapport) and CBT specific competencies. She explained, “I am always listening for whether there is an agenda, body, and wrap up? I’m listening and asking myself, how does rapport seem? Is the therapist/patient not listening? Is the therapist providing explicitly interventions?” Lastly, consistent with the other supervisors interviewed in this study, Monica does not use the Cognitive Therapy Rating Scale or another instrument to evaluate tapes. She does believe that it is important to have a consistent way of evaluating supervisees. However, due to time barriers it is more efficient for her to focus on providing written feedback as she is listening to the tapes.

In terms of evaluating herself as a supervisor, Monica found it extremely helpful to attend a peer consultation group that would meet every few week to discuss supervision issues. She stated, “That was a huge part of how I thought about my work

and evaluated myself over time. It was great to have colleagues weigh in.” Monica also relies on feedback she gets from supervisees. She informally asks supervisees for “feedback about our supervision work together and my style as a supervisor.” She also gets formal feedback from supervisees at the end of the year that includes likert scales and a narrative. Even though this feedback scale was submitted anonymously as part of the program (she was supervising 8-10 supervisees at points), Monica was unsure whether supervisees were completely comfortable giving honest feedback. She noted, “It would be interesting to ask them how comfortable they felt and add this [question] to their anonymous feedback form.”

### **Case Example 2: Jane**

Jane is a 40-year-old licensed psychologist who is employed at a cognitive-behavioral therapy (CBT) institute and also holds a research position in an academic medical center. She has been practicing for over 10 years and has been supervising for 3.5 years. In her graduate doctoral program, she received psychotherapy training in CBT, psychodynamic therapy, and structural family therapy. She identifies CBT as her primary theoretical orientation, although she frequently incorporates mindfulness and dialectical behavior therapy interventions as a therapist. At the time of the interview, Jane was supervising one student individually as an adjunct CBT supervisor, and this student only had one patient. She also teaches a CBT lab course and provides supervision in a group format there. Jane did not formally receive training in supervision. She described her individual supervision format when the therapist has one patient in the subsequent section below.

## Structure of CBT Supervision

Jane spontaneously stated that she uses a “similar approach to CBT therapy in the way [she] structures her supervision sessions.” She begins supervision with a brief check-in (e.g., how was your week? Did you see your patient?), then an agenda setting (“I ask her if there is anything urgent we need to set on the agenda first”). Jane then spends the majority of the supervision session on reviewing audiotape of the previous session (focusing on where the supervisee needs feedback), and then assisting her with areas where she is struggling using CBT techniques, like role-playing or Socratic questioning. For example, the supervisee frequently struggles with being more directive with her patient when it comes to self-monitoring her health problems or completing her homework. Furthermore, during her last supervision session, the patient was not adhering to self-monitoring. Jane explored with her supervisee what is interfering with her being more confrontational about this since it is a long-standing behavior (e.g., feeling anxious that the patient will leave treatment). Jane then suggested that they role-play how she can present the self-monitoring issue to the patient as an exposure. Jane varies the role-play between her playing the therapist and her patient playing the client and then switching roles. She does this so that the supervisee can also take the role of the patient and imagine what is going on for her.

When Jane was asked about how her supervision sessions end, she explained that she focuses on eliciting whether the supervisee has a plan by the end of supervision (e.g., “What are you going to do next with the client?”). She also asks her supervisee if she has any questions and asks her to summarize the pertinent aspects of what they reviewed in supervision to see if she conveyed things effectively. Jane added that she asks for

feedback from her supervisee if time permits. She offered, “I ask her if there was something that didn’t work so well today, but I do not do that every time due to time [barriers].”

Jane reflected on how her supervision is similar and different from the Beck model. She noted that her structure is very similar. She also uses a check-in, agenda setting, and prioritizes and discusses items on the agenda (with audiotape review). However, she does not formally assign and review homework or use “supervisor capsule summaries.” Jane instead focuses on eliciting from the therapist what she learned and what her plan is for the patient at the end of supervision (see above paragraph). Jane also noted that she is unable to review the entire audiotape of each session (based on Beck’s recommendations) due to time issues and practical challenges, particularly since she is an adjunct supervisor and does not have access to the tape prior to the session. Jane noted that this interview was helping her realize that she can modify her approach to supervision sessions. She sees the benefit of reviewing tapes prior to supervision and also providing some homework to the supervisee (particularly having him/her listen to the tape prior to supervision).

### **Attending to Supervisee’s Emotions, Thoughts, and Behaviors**

Jane believes that addressing supervisees’ emotions is essential to CBT supervision. She helps her supervisee manage emotions such as fear and shame that are impacting the therapeutic process. Her supervisee frequently worries about the patient dropping out of therapy, and this fear prevents her from being more directive with the patient. Jane validates this reality (“that this is tough and difficult to learn”), examines her automatic thoughts, and explores the worst-case scenario with her. Jane offered, “We

have gone through all the different scenarios if the patient were to discontinue.” Jane was also quick to point out that she uses techniques outside the Beck CBT model, such as exploratory psychodynamic therapy and mindfulness/relaxation to help her supervisee manage emotions, such as anxiety. She reflected, “I explore for her what its like for her and what’s coming up for her emotionally when she sits with the patient.”

Moreover, Jane believes that it is very important to address behaviors that are impacting the therapeutic process (e.g., talking too much as a therapist). Jane has taught her supervisee mindfulness techniques (body scan) and autogenic relaxation (relaxation with a hypnosis element to it) to help her talk less frequently in therapy, monitor her anxiety, and not take on such a didactic role with her patient. She has encouraged her supervisee to do a mini body scan during the therapy session in order to check-in with each of her body parts and slow herself down during the session.

### **Relationship Factors in Supervision**

Jane finds supervision to be rewarding, especially since her supervisee is motivated, smart and hardworking. Jane described her style as collaborative and stated, “There is definitely a sense of collaboration that you really are detectives together and trying to gather information together and revise understanding of the case and yourself as a therapist.” She also attempts to foster a collaborative environment by providing her supervisee with balanced feedback---focusing on her strengths first and then mentioning areas for improvement. For example, she notes that her supervisor is very smart and eloquent and at the same time offers feedback letting her know that she would benefit from slowing down in session and waiting for the patient to respond. Jane also focuses on encouraging independent thinking and autonomy in her supervisee via Socratic

Questioning and “drawing out what she is already thinking and asking her first.”

Additionally, Jane finds it very helpful to use self-disclosure about her previous struggles as a therapist in order to “normalize and make her feel more confident.” She shares with her supervisee examples of previous mistakes with patients.

Lastly, Jane inquired about her supervisees’ goals in the beginning of supervision, and then she followed-up with her at the end of the semester about progress she has made towards these goals. Jane explained that she did not formally establish goals/expectations using a formal written document based on Beck’s recommendations. However, she was very open to the idea of writing down goals and sharing the document with her supervisee in the future and is thinking about doing so.

### **Evaluation of Supervisee and Self-Evaluation**

Jane emphasized the importance of relying on multiple sources of data in order to evaluate her supervisees, including listening to audiotapes of session, self-report, and written notes. When asked about whether she uses the Cognitive Therapy Rating Scale (CTRS), Jane noted that she has been unable to use it due to time barriers (1 hour per week of supervision) and practical limitations since she is an adjunct supervisor. Jane noted that she would be very open to using the CTRS if her circumstances changed.

Jane measures her own competence as a supervisor by the extent to which her supervisee feels comfortable contradicting her, offering her own opinion and standing up for her own interventions. She also offered that she does not practice outside her area of competence (e.g., anxiety and depression). For example, she has been helping her supervisee in a more unfamiliar area of health psychology so she decided to do extra reading and consult with a colleague who is an expert in this area. Jane attends team



meetings on a weekly basis with colleagues, but was looking for a more formal peer supervision group at the time of the interview.

### **Case Example 3: Alex**

Alex is a 41-year-old licensed psychologist who works full-time in a CBT clinic that is part of a medical setting. He provides psychotherapy, supervision of practicum students/residents, and also engages in research. He has over 10 years of experience as a therapist and has been supervising for three years. He identifies CBT as his primary theoretical orientation, and noted that he is more behavioral than cognitive. He also frequently incorporates mindfulness interventions with his patients. At the time of the interview, Alex was supervising 10 therapists (mostly doctoral students) and spending 15 hours per week on supervision related activities.

### **Structure of CBT Supervision**

Alex offered the following structure for an individual supervision session (each doctoral student carries 4-6 cases):

1. *Check-in*: “Casual conversation, what’s been going on, are they okay in general?”
2. *Agenda Setting*: “Ask about cases they have and then we start with questions/concerns about those cases.”
3. *Problem solving* (most of supervision time is spent here):
  - a. Usually pick 2-3 cases where they have questions/concerns
  - b. Employ conceptualization from a behavioral model in each session
  - c. Frequently employ modeling and direct instruction to demonstrate how to say something to a patient or how to conduct a behavioral exposure (e.g., “Here is what you want to say to the patient”).
  - d. Sometimes using audiotape review in session and brainstorming around “stuck points” using Socratic questioning
4. *Updates on other cases* (e.g., patients who are not coming in and updates on cases that are going well)
5. *Feedback*: Elicit feedback from therapist and throughout supervision (“Does this make sense to you?”)
6. *Wrap-up*: Let supervisee know that 5 minutes is left; plan for next session

Alex emphasized that that this structure is based on a CBT model overall, but noted that it is flexible and is adjusted to the level of the trainee. With beginning-level therapists, he spends considerably more time “talking about the basics of the CBT model” and “discussing rationale and conceptualization.” On the other hand, in his supervision sessions with a well-trained CBT clinician they are “fine-tuning exposure treatment and spend little time talking about the structure of CBT.” When reflecting on how his supervision style developed, Alex noted that his style is a “natural way for [him] to be with people.” He added that he combined his “experience as a therapist with the experiences with the supervisors that [he] liked.”

When discussing how his supervision style compares to Beck’s model, he noted that overall he is “more relational and less structured” than her model. Although he also begins his supervision sessions with a brief check-in and agenda setting, he does not formally “bridge from the previous supervision session.” He explained that the bridge from the previous session usually comes up naturally in supervision without prompting (e.g., I get reminded of it as we’ll talk more and then I may just ask, ‘how did such and such go’). Consistent with the majority of the supervisors interviewed, Alex does not formally assign and review homework. He offered that his supervisees always have tasks to do to prepare for each patient, and noted that he sometimes assigns readings to them (e.g., readings on behavioral interventions). Alex does not frequently summarize during supervision because he does not do this as a therapist either, although he acknowledged that summarizing can be helpful. Instead, Alex focuses more on whether the supervisee understood what he has communicated and whether she has any questions. He commented, “I always elicit feedback by asking, ‘is this making sense to you?’”

### **Attending to Supervisee's Emotions, Thoughts, and Behaviors**

When asked about whether attending to emotions is essential to CBT supervision, Alex reflected on this by stating, “You have to be able to talk about feeling frustrated, upset, or feeling negative towards a client.” Alex attempts to create a comfortable space for his supervisees’ to be able to talk about their emotions. He normalizes emotional reactions and asks them directly how they are feeling, “Are you feeling frustrated about that person because if I were there I would too.” In regards to trauma-focused therapy, he commented, “With prolonged exposure, you are hearing terrible things and a supervisee can be very upset.” In these supervision sessions, he always checks in with his student and asks, “So how it is to be in the room with the patient and listen to [trauma]?”

Alex also frequently attends to supervisees’ behaviors in sessions, particularly how they deliver treatment rationales, problem solving too quickly or not being assertive enough. He listens to audiotapes of the sessions with the supervisee to address these behaviors. He noted that one supervisee was having difficulty being assertive and interrupting a patient. He initially explored this behavior pattern with her by asking, “What about it is difficult?” and then discussing her feeling of anxiety and guilt. He then worked with her on problem solving by listening to segments of the audiotape together, pausing it at specific moments, and asking her, “What can you say right now?” After generating ideas with her, he would also use modeling and direct instruction. He added, “That’s where I would come in and say, “Here is what you would be able to say.”

On the other hand, Alex does not believe it is essential to attend to supervisees’ automatic thoughts and will not have a therapist keep track of her automatic thoughts. As an alternative, he will call attention to a belief that is not helpful or is impacting the

therapeutic process. For example, he will ask the supervisee to repeat a belief and then ask him whether he thinks it is impacting the therapy without formally asking him to fill out a thought record.

### **Relationship Factors in Supervision**

Alex emphasized that he is very relational as a person and therapist and believes it is very important to “develop an alliance with supervisees.” He does not develop an alliance by discussing roles in an explicit manner, but rather in terms of “getting to know them as people.” Alex believes that it would be helpful to formally discuss expectations/goals from the onset with supervisees; however, he believes that this does not come naturally for him. He also emphasized that he attempts to create a collaborative, non-hierarchical setting by focusing on their needs and added, “Agenda setting is entirely up to them. For the most part, I’m willing to go where they want to be.” Furthermore, Alex offered that he creates a safe environment in supervision so that supervisees are comfortable bring up problems. He fosters this environment by normalizing the struggles they are having and using self-disclosure to normalize the process of therapy. He reflected, “I will definitely use myself as an example in terms of how I struggled with something in a similar way as a therapist.” He added, “Today, I was telling my supervisee, this is something you are doing and recognizing, and something that I still have to pay attention to all the time.”

### **Evaluation of Supervisees and Self-Evaluation**

When reflecting on how he evaluates students, Alex noted that he is “not a good evaluator” and that it does not “come naturally for [him] to use formal rating forms.” Instead, he relies on the structure that the students brings in from his/her program. He

also emphasized that he uses his internal assessment of, “Is this person learning or does he have the same questions week and week and we aren’t making any progress?” Similar to the vast majority of the supervisors interviewed, Alex does not use the Cognitive Therapy Rating Scale when evaluating tapes for the same reason as noted above. As an alternative, he notes several common therapy factors and CBT specific competencies when evaluating supervisees’ tapes of the session. He offered, “I look at the components of the rationale, was the patient involved in the process, degree of collaboration, alliance, how clear instructions are given, is the therapist applying the exposure model and following it correctly?”

Alex was unsure about whether he is a “good supervisor” since he is unsure about what makes an effective supervisor. He also added, “There is a point you cross where you become a supervisor but are unsure why. I sometimes wonder how I got to this position now because it happened so quickly and there was no formal coursework.” Alex, however, ensures that he is competent as a supervisor by only supervising within his area of expertise. He consults if a patient comes in that is outside his area of expertise, but noted that he works in a very specialized clinic.

## CHAPTER VI

### DISCUSSION

This chapter focuses on the most significant findings that arose based on the analysis of data collected from interviews with cognitive-behavioral therapy (CBT) supervisors. These findings include the structure of CBT supervision, the importance of attending to the supervisees' emotions in CBT supervision, the formation of a collaborative and collegial relationship with supervisees, and the evaluation of supervisees. This chapter also focuses on how these findings are consistent or inconsistent with the Beck model of CBT supervision (Beck, 2008; Liese & Beck, 1997). Secondly, implications for future research, particularly the role of emotions in CBT supervision and the potential for increasing autonomy as an important aspect of CBT supervision are highlighted. Lastly, several important implications and recommendations for CBT supervisors and CBT training programs are discussed.

### **Main Findings**

#### **Structure of CBT Supervision**

One important finding in this study is that all the participating supervisors described the use of a supervision structure that mirrored CBT sessions. (Refer to Table 4 for a typical structure reported by participants). The majority of the supervisors even described the structure of a supervision session as similar to the way they conducted CBT with a patient. A typical supervision session among supervisors in this sample began with a brief check-in (e.g., How was your week?) and then an agenda setting (e.g., What should we focus on/prioritize today?). The majority of the supervision session was then

spent on problem solving where the student was experiencing difficulties (e.g., problems related to patient having difficulty complying with the treatment; problems administering interventions; interpersonal difficulties in the session). During the problem-solving phase, supervisors in this study employed CBT techniques in supervision, particularly Socratic Questioning and role-playing. Audiotape review was sometimes used during problem solving as well. Supervision then ended with a “Wrap up,” which typically consists of plans and goals for the next session as well as eliciting feedback from the supervisee (e.g., How does this sound to you?).

This finding corroborates the existing literature on CBT supervision and is consistent with the Psychotherapy-Based Model of CBT Supervision outlined by Liese and Beck (1997) and Beck (2008). Beck describes the beginning of supervision as a check-in with the supervisee in a similar manner to a mood check with a client (Beck, 2008). She recommends that supervisors then set an initial agenda for the supervision and relates this to how therapists in CBT set agendas with clients by asking, “What problem or problems do you most want my help in solving today?” (Beck, 2008, pg. 60). In addition, Beck recommends the use of CBT techniques in the session in a similar manner to the therapy. For example, at various times, supervisors may use direct instruction (e.g., “Here’s how to do activity scheduling with a client”) and role-play (e.g., “How about if you play yourself, and I’ll play your client, so you can practice teaching me about the cognitive model?” Beck, 2008, pg. 63). This is consistent with the self-report of supervisors in this study who employed several CBT techniques during the problem-solving phase, including role-playing with the therapist and direct instruction.

This psychotherapy-based approach to supervision has several advantages since it provides a coherent structure to supervision that is based on the therapy itself (Beck, Sarnat & Barenstein, 2008). It also has the advantage of modeling specific CBT techniques to the therapists by using them during supervision. Nonetheless, it is important to note that although the overall structure is similar to the Beck model of CBT supervision, the supervisors in this study reported several variations to the model (see Table 4 for a comparison between Beck's structure and the typical structure reported by participants). Common elements found in this study included a check-in, agenda setting, and then a prioritizing of agenda items with a focus on problem solving cases here. However, supervisors in this study did not formally mention making a "bridge between sessions" after setting the agenda, which involves reviewing what the therapist did for homework the previous session and what she has learned from it (Beck, 2008).

Consistent with this finding, the supervisors in this study did not formally assign and review homework at each supervision session as recommended by the Beck model. Instead, the supervisors in this study focused their time on problem solving cases because they believed that this was an important area to focus on when there was limited time. They also emphasized that it was not their role to assign and review homework, but rather teach practical skills. Although they regularly suggested reading or practicing new skills at the end of supervision, they did not view this as homework per se and did not follow-up with the supervisee afterwards. There appears to be some inconsistency between these findings and the literature on CBT supervision, which emphasizes the benefits of assigning and reviewing homework to supervisees at each supervision session (Beck, 2008). Rosenbaum and Ronen (1998) assert that homework assignments are important in



CBT supervision because they train the “supervisee to think and act like a cognitive-behavior therapist” (pg. 224). Beck (2008) adds that homework is an important part of CBT supervision since it allows supervisees to explain techniques to clients, see how difficult it is to complete homework assignments, and can help with better self-care (e.g., self-monitoring etc.).

Lastly, the majority of the supervisors in this study did not formally summarize at the end of every supervision session (e.g., summarize the most important points from the supervision session). Beck (2008) does not formally describe how to summarize in supervision, but provides one example whereby she asked the therapist to summarize what she thought was important to remember from this week. Instead of formally summarizing, supervisors in this study focused on setting goals and plans for the next week with the therapist (“What are you going to do next time?”). This may be complementary to summarizing though, but has the advantage of getting input from the therapist and encouraging autonomy.

### **Attending to Supervisee’s Thoughts, Emotions, and Behaviors**

Most of the supervisors in this study emphasized the importance of attending to supervisees’ emotions, thoughts, and behaviors in CBT supervision, particularly since they could interfere with effective treatment. The supervisors discussed common concerns of supervisees, including anxiety about themselves as therapists and worries that the patient will leave treatment. This finding appears to be consistent with the literature on CBT supervision. Beck (2008) notes the importance of attending to dysfunctional thoughts in supervision and even recommends that the therapist use a Dysfunctional Thought Record to respond to her dysfunctional cognitions related to the client. This is

consistent with supervisors in this study who addressed the therapist's dysfunctional thoughts by employing cognitive techniques in supervision (e.g., cognitive restructuring), but did so in a more informal manner than with a patient and did not assign a Dysfunctional Thought Record. Monica, for example, only attended to her supervisee's automatic thoughts when they were interfering with the treatment. She provided an example whereby the supervisee believed that the patient could not do something. In this situation, she wrote columns on the board and examined the supervisees' thoughts in a collaborative manner (e.g., by examining the evidence and asking the supervisee whether there were other alternative ways of thinking about the situation).

Moreover, as an alternative to Beck's model, the majority of the supervisors in this study emphasized that they attended to supervisees' emotions in supervision, particularly if they interfered with the therapy process. They described attending to emotions (e.g., fear and shame) by increasing supervisees' emotional awareness, normalizing their emotional reactions, and exploring them. For example, Alex increased his supervisees' emotional awareness by reflecting, "Wow, that sounds frustrating," and waiting to hear if he responds back or alternatively asking him directly if he feels frustrated/angry while normalizing this reaction (e.g., "Do you feel frustrated/angry, because if I were in this situation, I would feel this way"). Monica also attempts to increase her supervisees' emotional awareness, but without naming a particular emotional response (e.g. "Your patient has not shown up for three days in a row, tell me what it's been like for you?").

In fact, several researchers have argued for the importance of incorporating emotions into CBT supervision (Lombardo, Milne & Proctor, 2009; Pretorius, 2006).

Researchers have emphasized the benefits of exploring emotions in supervision, including increasing the effectiveness of therapy by enhancing the therapist's level of empathy. They have also argued that allowing therapists to discuss shame/anxiety related to making mistakes can enhance their skill level as therapists (Batten & Santanello, 2009). Preliminary models for addressing emotions have been proposed that focus on increasing emotional awareness (e.g., helping the supervisee recognize emotional reactions), and then linking this information to the therapeutic context by using this data to help the therapist respond to the patient in the session (Batten & Santanello, 2009). This focus on increasing emotional awareness in supervisees' is consistent with techniques that supervisors in this study were using to address emotional reactions (described above in Alex example). However, there is currently no data on how to effectively address supervisees' emotional reactions. Therefore, this would be an important avenue for future research.

### **Relationship Factors in Supervision**

A common theme stressed by the supervisors in this study was the importance of creating a collaborative and collegial relationship with their supervisees. They emphasized that supervision should be "team based" and non-hierarchical. One of the most consistent ways in which supervisors in this study created a collaborative and collegial relationship was by increasing autonomy and empowering supervisees. For example, Jane discussed the importance of not telling her supervisee what to do or say to the patient, but instead asking her first what she was thinking and drawing out her thinking. Alex used this same approach, but also allowed the supervisee to choose the

direction and pace of the session (e.g., agenda setting is up to them), and was willing to focus on what the supervisee believed was important.

The literature corroborates this finding on the importance of establishing a collaborative relationship with supervisees (Beck, 2008; Pretorius, 2006). However, Beck does not explicitly discuss the importance of encouraging autonomy as part of her supervision model, but rather focuses on “collaborative teamwork” in terms of working together to achieve goals (Beck, 2008). In support of findings in this study, other authors have emphasized the importance of empowering supervisees to act independently as well as limiting autonomy without discussing how to do so (Pretorius, 2006; Rosenbaum & Ronen, 1998). This study may therefore provide an important extension to Beck’s supervision model by highlighting the importance of increasing autonomy as part of CBT supervision with some specific suggestions for how this can be carried out (e.g., Socratic Questioning). To this researcher’s knowledge, there is no data on how to increase autonomy in CBT supervision so this is another important area for future research.

### **Evaluation of Supervisees**

One surprising and key finding in this study was that the majority of the supervisors did not listen to the complete audiotapes of sessions before supervision, and most did not use the Cognitive Therapy Rating Scale (CTRS) or any other instrument to evaluate their students’ therapy sessions. Supervisors reported that they were unable to listen to the entire therapy tape and use instruments to evaluate the tapes due to time barriers, lack of compensation for time outside the supervision hour, and other practical barriers (e.g., being in a separate location from the student’s program and not being able to access tapes before supervision). Many of the supervisors specifically mentioned that it

would take them several hours to listen to the audiotape of the entire session and use the CTRS. One survey on the supervision practices of CBT supervisors in the United Kingdom found similar constraints in the use of audiotape review and rating scales, both of which were rarely used by supervisors (Townend et al., 2002).

This finding is inconsistent with Beck's model of CBT supervision, as well as general recommendations for CBT supervisors, which highlight the importance of reviewing entire tape recorded session prior to supervision and using standardized instruments, such as the CTRS, to evaluate supervisees (Beck, 2008; Liese & Beck, 1997; Newman, 2010). Audiotape review is important since supervisees may not be able to accurately identify problems in the session (Liese & Beck, 1997). Listening to tapes also has the advantage of allowing the supervisor to provide very specific feedback to the supervisee (Newman, 2010).

It is important to note, however, that supervisors in this study emphasized that audiotape review was an important aspect in their evaluation process. Many supervisors expressed that they would like to be able to engage in more audiotape review, but were unable to do so due to time barriers. In addition, the majority of the supervisors listened to segments of the audiotape in supervision (where the therapist was struggling), but did not report doing so on a weekly basis.

### **Limitations**

This qualitative study had several important limitations. Firstly, the data gathered and interviews were based on cognitive-behavioral supervisors' self-report of the process of supervision and how they conceptualize supervision. Since the data are based on self-report, they may be affected by bias or social desirability factors. Secondly, the

interviews were approximately 60 minutes and captured many dimensions of CBT supervision in order to provide broad recommendations and findings on CBT supervision. Thus, this study was not intended to be an in-depth analysis of CBT supervision practices. Secondly, the sample was recruited through a networking approach and targeting CBT institutes and CBT group practices in a specific region of the country. There was no control group or randomization of subjects for a basis of comparison. Thus, the results may have limited generalizability and are not intended to represent the practices of CBT supervisors as a whole. Lastly, it is important to note that the author of this study, Ayelet Kattan, is a graduate student and CBT supervisee. The author conducted all of the interviews, transcribed and analyzed the data. Although there were measures in place to limit bias (e.g., using a semi-structured interview format), the results of this study may be impacted by researcher bias. Despite these limitations, this study was intended to be exploratory, thus findings will be used to generate future research in the field and additional quantitative studies.

### **Implications for Future Research**

Overall, there is currently a scarcity of qualitative and quantitative research on CBT supervision. Thus, this research study adds to the body of literature by highlighting important dimensions of CBT supervision based on the self-report of experienced CBT supervisors. It also assesses the extent to which they follow Beck's recommended model for supervision and adds some potential extensions to this current model. Nonetheless, many opportunities for future research exist.

Firstly, the available literature on CBT supervision is primarily composed of untested recommendations and descriptive criteria (e.g., establishing a collaborative

relationship) rather than explicit procedures or competencies that CBT supervisors can implement (Reiser & Milne, 2012). An important next step would be to operationalize the main aspects of CBT supervision and create and validate a measure that can accurately capture important dimensions of CBT supervision. Eventually, this measure should be tested on large samples of CBT supervisors. Milne and colleagues have developed an instrument for evidence-based supervision and have recently begun preliminary testing on this instrument (Milne, Reiser, Cliffe, & Raine, 2011). However, there is no current instrument that measures CBT supervision specifically.

Additionally, findings from this qualitative study were based on the self-report of 10 CBT supervisors who were primarily employed in CBT institutes and CBT group practices. Future research on CBT supervision should rely on a larger samples of CBT supervisors and other research designs, such as quantitative or mixed methods. Future qualitative research designs could also use observational methods and review audiotapes of CBT supervision sessions to capture important dimensions of CBT supervision.

Lastly, this study found additional factors that may be important to incorporate into CBT supervision models, including the role of emotions in CBT supervision and encouraging autonomy in supervisees. Thus, an important direction for future research would be to gather qualitative and quantitative data on how to attend to supervisees' emotional reactions in CBT supervision, and which strategies are effective for doing so. In a similar manner, it would be imperative to gather additional data on how to effectively encourage autonomy in CBT supervision. For example, what strategies do supervisors use to increase autonomy in supervision? Which strategies are more or less effective?

### **Recommendations For CBT Supervisors**

1. *Recommended structure for CBT supervision:* Supervisors in this study were using a supervision structure that mirrored CBT therapy and were employing CBT strategies to assist students with learning new techniques throughout supervision (see Table 4). This is consistent with Beck's model of CBT supervision and has several advantages for supervisors and supervisees. This structure allows supervisors to model and demonstrate CBT techniques to supervisees, including role-playing and Socratic Questioning. It also provides an efficient structure for supervision by having an agenda setting and prioritizing what is important to focus on from the onset. Additionally, hands-on techniques, such as role-playing, are effective learning methods and can also encourage supervisees to use these techniques in session with their patients.
2. *Importance of Attending to Emotions in CBT Supervision:* This study highlighted the importance of attending to supervisees' emotions in supervision, particularly fear and shame, since they can impact their ability to provide effective treatment. Supervisors in this study employed several useful strategies for increasing emotional awareness in supervision, including reflecting, normalizing, and modeling emotional reactions. Creating a comfortable space for sharing emotions in supervision can also be helpful in increasing the supervisor-supervisee alliance.
3. *Establishing a Collegial and Collaborative Relationship:* Supervisors in this study emphasized the importance of establishing a solid relationship with their supervisees with an emphasis on being collaborative, non-hierarchical, and by increasing autonomy. Supervisors can use many helpful strategies for establishing a collegial and collaborative relationship, including through the use of Socratic questioning to help



encourage independent thinking and empower supervisees. It may also be helpful to encourage autonomy by asking the supervisee what he/she would like to focus on during the agenda setting in supervision. These strategies may help facilitate trust and encourage supervisees' in their development as professional psychologists.

4. *Evaluating Supervisees using Audiotape/Videotape Review:* CBT supervisors should listen to audiotape and videotapes of therapy sessions since this is a valuable way for them to gain objective information about what happens in therapy and provide specific feedback to supervisees. Even though supervisors in this study were unable to listen to entire therapy sessions outside of supervision, they still expressed that this approach was useful. One efficient alternative that the majority of the supervisors employed in this study, included listening to segments of the session during supervision and providing on the spot feedback to their supervisee. Another option is to listen to one complete audiotape each week from each supervisee prior to supervision. For example, two of the supervisors in this study listened to one weekly audiotape for each supervisee and wrote detailed feedback while they were listening to the tape. This feedback consisted of areas of strengths, areas for improvement, as well as alternative responses for several techniques that the supervisee used with the patient.

### **Recommendations for CBT Institutes and Training Programs**

1. *Facilitate Audiotape/Videotape Review in Supervision:* Given that the majority of supervisors were unable to listen to full audiotapes of sessions, CBT training centers and institutes need to facilitate and encourage audiotape/videotape review. It would be helpful for training centers to allow supervisors to count audiotape review as part of their overall supervision hours. It is also recommend that

training centers facilitate audiotape review through the use of technology (e.g., finding ways to send audiotape/videotapes of therapy session over a secure and internal server).

2. *Providing Training in Supervision:* Most of the supervisors in this study did not receive any formal training or coursework in supervision. It may be helpful for CBT Institutes to offer a brief supervision seminar or provide supervision of supervision for a brief period of time to new supervisors.
3. *Facilitate Regular Peer Supervision Groups:* It is important for supervisors to get additional support from their institutions through the use of peer supervision groups. Most of the supervisors in this study attended a peer supervision or consultation group. These groups can serve as an additional source of support for supervisors and a common place for them to share questions/concerns about their supervisees.

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## APPENDIX A

Table 1

*Demographic characteristics of the 10 participants*

Characteristic	Value
Age	
Median	39
Range	34-57
Gender	
Male	6 (60%)
Female	4 (40%)
Ethnicity	
Caucasian	9 (90%)
Biracial	1 (10%)
Employment setting <sup>a</sup>	
Academia	3 (30%)
Research	1 (10%)
Hospital	1 (10%)
CBT Clinic	1 (10%)
CBT Institute	5 (50%)
CBT Group practice	3 (30%)
CBT Private practice	1 (10%)
Type of doctoral degree	
Ph.D.	6 (60%)
Psy.D.	3 (30%)
Ed.D.	1 (10%)
Type of psychotherapy training	
CBT	10 (100%)
Psychodynamic	5 (50%)
Family systems	3 (30%)
Theoretical orientation	
CBT	10 (100%)
Diplomat/Fellow, Academy of Cognitive Therapy	7 (70%)
Type of supervision provided	
Individual	10 (100%)
Group	8 (80%)
Number of years of experience as a therapist	
Median	16
Range	11-30
Number of years of experience as a supervisor	
Median	10
Range	3-25
Number of therapist supervisees	
Median	7
Range	1-21

Table 1 (Continued)

*Demographic characteristics of the 10 participants*

Characteristic	Value
Hours spent in clinical work per week	
Median	30
Range	12-40
Hours spent on supervision per week	
Individual	
Median	7
Range	1-12
Group <sup>b</sup>	
Median	3
Range	1-7
Total (individual and group)	
Median	8
Range	1-15
Received training in supervision	
Yes	3 (30%)
No	7 (70%)
Currently engaged in own supervision or peer consultation group	
Yes	8 (80%)
No	2 (20%)

*Note.* <sup>a</sup> 50% of participants had more than one employment setting. <sup>b</sup> For those who do group supervision.

Table 2

*Therapeutic Techniques Employed by the Participants*

	Number of participants (percentage)
Theoretical orientation	
CBT	10 (100%)
Do you consider yourself more cognitive or behavioral?	
Predominantly cognitive	0 (0%)
More cognitive	1 (10%)
Equal	2 (20%)
More behavioral	5 (50%)
Predominantly behavioral	2 (20%)
To what extent do you incorporate techniques beyond traditional CBT (e.g., ACT)?	
Always	2 (20%)
Most of the time	1 (10%)
Sometimes	7 (70%)
Rarely	0 (0%)
Never	0 (0%)
Do you incorporate mindfulness techniques into your therapy?	
Always	2 (20%)
Most of the time	0 (0%)
Sometimes	5 (50%)
Rarely	2 (20%)
Never	1 (10%)



Table 3

*Strategies regularly employed in supervision*

Strategy	Yes (%)	No (%)
Audio/video tape review	70	30
Role-playing	80	20
Responding to automatic thoughts	70	30
Check in	100	0
Bridging from previous session	20	80
Use of training manuals	50	50
Assign homework	20	80
Review homework	10	90
Case conceptualization	90	10
Agenda setting	90	10
Feedback from supervisee	80	20
Feedback to supervisee	90	10
Video modeling/observation	0	100

*Note.* Total number of participants was 10.

Table 4

*Comparison of Structure of CBT Supervision: Beck Model vs. Study Participants*

Beck Supervision Model	Common Structure Reported by Participants
1. Check in	1. Check in
2. Agenda Setting	2. Agenda Setting
3. Bridge from previous supervision session --inquiry about a previously supervised therapy case --review of homework	3. Prioritization and discussion of agenda items (*Mostly problem solving difficult cases/problems)
4. Prioritization and discussion of agenda items	4. Updates on other cases
5. Assignment of new homework	5. Wrap-up --plans and goals for the next session (may include informal suggestions for homework) --elicit feedback from therapist
6. Supervisor's capsule summaries	
7. Elicit feedback from therapist	

*Note.* Left side of table adopted from Liese & Beck, 1997, pg. 121.

## APPENDIX B

### INFORMED CONSENT AGREEMENT

#### Conceptualizing Cognitive-Behavioral Supervision: An Exploratory Study of Supervising Psychologists

**You are invited to participate in a research study. Before you agree to participate in this study, you should know enough about it to make an informed decision. If you have any questions, ask the investigator. You should be satisfied with the answers before you agree to be in the study.**

#### **Purpose of the Study:**

This study explores cognitive-behavioral psychotherapy supervision from the perspective of supervising psychologists. This study aims to understand your thoughts and opinions about the goals of cognitive-behavioral supervision, how you structure supervision sessions, relationship issues involved in supervision, and about how you evaluate yourself and your supervisee. There is currently very little research on cognitive-behavioral supervision despite its importance in the training of psychologists. This study will be used to develop more comprehensive theories of cognitive-behavioral supervision and to improve training of psychologists. A doctoral student at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University is conducting this study as a fulfillment of dissertation and doctoral requirements. It is anticipated that 20 individuals will participate in this study.

#### Study Procedures:

You will be interviewed about your experiences, thoughts, and opinions in regards to how you conduct cognitive-behavioral supervision. You will first answer general demographic questions and questions about your training, including your ethnicity, years of experience as a supervisor, and employment setting. You will then be asked about your experiences and opinions in regards to the goals of cognitive-behavioral supervision, how you structure your supervision sessions, what cognitive-behavioral techniques you employ during supervision, your relationship with supervisees, and how you evaluate your supervisees. **The interview will take about one and one half hours over one meeting time.** Interviews will be audio taped to contribute to the authenticity of the study.

Risks: The interview focuses on your experience and thoughts as a psychotherapy supervisor. It is my hope that the interview will be a positive experience for you. However, recalling some professional experiences may be unpleasant for you and you may experience some discomfort when answering questions. If you experience emotional distress related to the study, please contact the researcher and discuss this with her, so that she can assist you and help provide you with referrals as necessary.

Benefits: Participation in this study may not benefit you directly. However, the knowledge that we obtain from your participation, and the participation of other volunteers, may help us create more comprehensive theories of cognitive-behavioral supervision, and improve training for cognitive-behavioral therapists. Sharing your experience as a psychotherapy supervisor may also be valuable to you.

**Confidentiality:** This research is **confidential**. The research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes your age, gender, job title, and years of experience supervising. Your name will only appear on consent forms and will be kept separate from research records. Please note that we will keep this information confidential by limiting individual's access to the research data and keeping it in a secure locked location.

The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. Your responses will be grouped with other participants' responses and analyzed collectively. I may also quote you directly or write about your supervision practices as a case example (e.g. How you structure a typical supervision session, Which cognitive-behavioral techniques you use in the session). If I quote you directly or write about your supervision practices as mentioned above, I will disguise your identity to protect your confidentiality by changing all identifying information including your age, gender, employment setting, job title and years of experience. All study data will be kept for 3 years. Please also refrain from mentioning any clients, supervisees, and supervisors by name during the interview to protect their identity.

Interviews will be transcribed by the principal investigator and audio recordings will be destroyed three years after the study. All audio recordings, transcripts of interviews, or other data collected from you will be maintained in a locked file cabinet and destroyed three years after the study. Audio recordings will be assigned a case number.

**Compensation:** There is no compensation for participation in this study.

**Contact:** I understand that I may contact the investigator or the investigator's dissertation chairperson at any time at the addresses, telephone numbers or emails listed below if I have any questions, concerns or comments regarding my participation in this study.

Ayelet Kattan (Principal Investigator)  
Investigator)  
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If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:  
Rutgers University, the State University of New Jersey  
Institutional Review Board for the Protection of Human Subjects  
Office of Research and Sponsored Programs  
3 Rutgers Plaza  
New Brunswick, NJ 08901-8559  
Tel: 732-932-0150 ext. 2104  
Email: [humansubjects@orsp.rutgers.edu](mailto:humansubjects@orsp.rutgers.edu)

**Rights as a Participant:** Participation in this study is VOLUNTARY; If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to

which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be removed from the data set and destroyed. You can also stop the interview at any time if you become uncomfortable and can choose not to answer specific questions. Also, if you refer other individuals for participation in this study, your name may be used as the referral source only with your permission

I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Investigator Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUDIOTAPE ADDENDUM TO CONSENT FORM**

You have already agreed to participate in a research study titled, Conceptualizing Cognitive-Behavioral Supervision: An Exploratory Study among Supervising Psychologists conducted by Ayelet Kattan. We are asking for your permission to allow us to audiotape (make a sound recording) as part of that research study. You do not have to agree to be recorded in order to participate in the main part of the study.

The recording(s) will be used for analysis by Ms. Kattan.

The recording(s) will be distinguished from one another by an identifying case number not your name.

The recording (s) will be stored on a password protected and encrypted digital recorder and transcribed by the principal investigator. They will be linked with a code to your identity not your name.

All audio recordings will be maintained in a password protected and encrypted digital recorder that will be locked in a filing cabinet and deleted at the study's completion. All transcripts of interviews will be maintained in a locked file cabinet and destroyed three years after the study.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Subject (Print ) \_\_\_\_\_

Subject Signature \_\_\_\_\_ Date \_\_\_\_\_

Principal Investigator Signature \_\_\_\_\_ Date \_\_\_\_\_

## APPENDIX C

### INITIAL DATA & DEMOGRAPHIC QUESTIONS

Participant #:

Date:

Age:

Gender:

Ethnicity:

Job Title:

Employment Setting:    Clinic                      Hospital                      Research                      Academia                      Private

Practice    Group Practice                      Counseling Center                      CBT Institute                      Other:

Total Number of Hours spent engaging in clinical work:

Type of Doctoral Degree:              PhD                      Psy.D.                      Ed.D.

Type of Psychotherapy Training:

What is your Theoretical Orientation:

Do you consider yourself more cognitive or behavioral?

1	2	3	4	5
I predominately use cognitive techniques	I place more emphasis on cognitive techniques	I use cognitive and behavioral techniques to an equal extent	I place more emphasis on behavioral techniques	I predominately use behavioral techniques

To what extent do you incorporate techniques beyond traditional CBT (e.g. mindfulness, acceptance)?

1	2	3	4	5
Always	Most of the time	Sometimes	Rarely	Never

Do you incorporate mindfulness (e.g. ACT) techniques into your therapy?

1	2	3	4	5
Always	Most of the time	Sometimes	Rarely	Never

Type of Supervision Provided:

Years of experience as a therapist:

Years of experience supervising:

# of Therapists you supervise:

# of hours spent on supervision per week (including paperwork): Individual \_\_\_\_\_ Group

\_\_\_\_\_

Did you receive training in supervision? Yes No

Do you currently engage in own supervision or peer consultation group? Yes No

Do you regularly employ the following strategies in CBT supervision (check any that apply):

Review of audiotape/videotapes:

Role-playing:

Responding to therapist  
automatic thoughts:

Check In:

Bridging from previous sessions:

Use of training manuals:

Review Homework:

Case Conceptualization:

Assign Homework to therapist:

Agenda Setting:

Feedback from supervisee:

Provide feedback to supervisee:

Video modeling/observation:



## APPENDIX D

### SEMI-STRUCTURED INTERVIEW

A lot of people have written about supervision and I'm really interested in what happens in the real world and in your experiences as a supervisor. Today I'm going to ask you about how you structure your supervision sessions, what you attend to in supervision, and how you evaluate yourself and your supervisee. Several of the questions may not apply to you since the interview is meant to be comprehensive. If you do something differently than what I'm presenting during your supervision sessions, I may ask for an example and for your rationale.

#### Structure, Goals, and Principles of CBT Supervision

1. Walk me through a typical/recent supervision session with examples from start to finish?
  - a. What do you spend the most time on?
  - b. Any Problems?
2. What is the rationale for this supervision structure?
3. In your opinion, what are the primary goals (core features) of CBT supervision?
4. Some authors have proposed that CBT supervision mirror CBT therapy in several ways (e.g. in terms of structuring the session, employing of CBT techniques such as role-playing, using case conceptualization as a guide, give examples) and other authors have a different point of view than this. Do you think that CBT supervision should mirror CBT therapy in this way (Provide handout on Model)
  - a. Do you conduct supervision in a similar way? If yes, How so?
  - b. How do you conduct supervision differently from this model?
  - c. What real world barriers prevent you from conducting supervision within this model?

**\*\*For relevant questions answered "NO" ask:**

- What alternatives do you use? Tell me more about what you do differently?
- What is your rationale for doing this?

- Can you give me an example of your approach?

Relational factors in supervision:

5. Do you foster a collaborative approach in supervision? If yes, how so?
6. How do you handle ruptures in the relationship with your supervisees?
7. Do you adjust supervision based on supervisee level of experience/training? If yes, how so?
8. Do you establish goals, expectations or contracts for supervision from the onset? If yes, how so?
9. In your opinion, what relational factors make CBT supervision effective?

**\*\*For relevant questions answered “NO” ask:**

- What alternatives do you use? Tell me more about what you do differently?
- What is your rationale for doing this?
- Can you give me an example of your approach?

Attending to Supervisees’ Emotions, Cognitions, Behaviors

Some of these questions may not all apply to you depending on how cognitive vs. behavioral you are:

10. Do you think that attending to supervisee cognitions or automatic thoughts are an essential ingredient of CBT supervision? If yes, under what circumstances?
  - a. If yes, how do you address supervisee’ automatic thoughts/cognitions (in a comfortable/safe way)?
  - b. What about attending to behaviors (e.g. eye contact, posture, looking away, speaking in a soft voice, dress)
  - c. Mindfulness techniques (give examples, metaphors)

11. Do you think that attending to supervisee emotions are an essential ingredient of CBT supervision? If yes, under what circumstances?

a. If yes, how do you address supervisee' emotions in a comfortable/safe way?

12. Do you address misconceptions regarding CBT and/or dysfunctional beliefs about treatment to your supervisees?

**\*\*For relevant questions answered "NO" ask:**

- What alternatives do you use? Tell me more about what you do differently?
- What is your rationale for doing this?
- Can you give me an example of your approach?

#### Evaluating Self and Other

13. What methods of evaluation of supervisees do you rely on?

14. Do you listen to audiotapes/videotapes of therapy sessions that your supervisees conducted?

a. If yes, how do you listen to therapy tapes (e.g. before supervision, play segments of partial tape, watch entire tape)?

b. If yes, what are the most important questions that you ask yourself in order to prepare for supervision?

c. Do you use any rating scales to assess supervisee?

15. How do you evaluate yourself as a supervisor in terms of your own competence, expertise, and ethics?

16. Do you receive feedback from supervisees? What form (if any)?

**\*\*For relevant questions answered "NO" ask:**

- What alternatives do you use? Tell me more about what you do differently?
- What is your rationale for doing this?
- Can you give me an example of your approach?

17. Is there anything that I did not ask that you think is important to tell me?

### Possible Model of CBT Supervision:

#### Session Structure

1. check in
  2. agenda setting
  3. bridge from previous supervision session
  4. inquiry about previously supervised therapy case
  5. review of homework since previous supervision session
  6. prioritization and discussion of agenda items
  7. assignment of new homework
  8. supervisor's capsule summaries (also throughout session)
  9. elicit feedback from therapist (also throughout session)
- *Developing the relationship with supervisee:* establishing a solid collaborative relationship; balance of correcting maladaptive behavior and reinforcing positive behavior;
  - *Planning the session on the basis of conceptualization:* “supervisors help conceptualize clients according to cognitive model.”
  - *Structuring the session:* cited above
  - *Collaborating on setting homework:* supervisees are assigned to use cognitive therapy techniques on themselves.
  - *Use of standard cognitive techniques within session:* This includes role-playing, responding to automatic thoughts and beliefs, direct instructions, etc.
  - *Evaluating Therapy Tapes*

(Adopted from Liese & Beck, 1997, pg. 121; Beck, 2008 pg. 59-60)