

# Cognitive Behavioral Therapy Supervision in a University-Based Training Clinic: A Case Study in Bridging the Gap Between Rigor and Relevance

**Robert P. Reiser, PhD**

*Palo Alto University, Palo Alto, California*

**Derek L. Milne, PhD**

*Newcastle University, Newcastle upon Tyne, United Kingdom*

Principles and procedures for supervising cognitive behavioral therapy (CBT) were broadly defined in 2 early seminal texts almost 15 years ago (Liese & Beck, 1997; Padesky, 1996) and updated more recently (Beck, Sarnat, & Barenstein, 2008; Newman, 2010). However, the actual practice of CBT supervision often shows poor fidelity to this model (Townend, Iannetta, & Freeston, 2002) with notable deficiencies in the use of direct observation, standardized observational rating systems, and experiential methods in supervision (Milne, 2008). The advent of more specific competency statements on CBT supervision has been a significant leap forward (Falender et al., 2004; Roth & Pilling, 2008) but poses some practical challenges to clinical supervisors in terms of transferring broad competency statements into actual supervisory practice. We address the need for more rigor in CBT supervision within a university training clinic setting and outline some promising ingredients for this specification drawing on competencies, metacognition, and experiential learning theory.

**Keywords:** training; supervision; competence; cognitive behavioral therapy

In-house teaching clinics have been described as the preferred model for providing clinical practicum experiences, optimally helping students acquire the basic knowledge, skills, and attitudes required to integrate academic preparation with clinical practice (Binder & Wechsler, 2010). In theory, this approach allows for very high levels of control over supervised experiences and clinical problems, which maximizes consistency between coursework and clinical training and provides the fullest possible integration between science and clinical practice. Therefore, one of the major challenges of basic practicum training is to bridge the gap between classroom didactics and real-world clinical practice. This mirrors the well-recognized science-practice gap in which the divergent traditions of “pure” clinical science (with its basis in the positivist tradition and emphasis on rigor: high levels of internal validity) can be sharply contrasted with the “roughness” (Schon, 1983) of clinical practice (i.e., relevance: high external validity). Schon (1983) describes

the “swampy lowland” of clinical practice where problems are often “confusing messes” incapable of technical solution, and contrasts this with the “high, hard ground” of research-based theory and technique, noting, ironically: “in the swamp are problems of greatest human concern” (p. 42).

In discussing how we attempt to bridge this rigor-relevance gap in relation to clinical supervision, we will next outline the clinic setting, then detail some promising approaches to being more rigorous about the CBT supervision model, before providing a series of examples (critical incidents) designed to illustrate how our approach can be applied within this setting. The Kurt and Barbara Gronowski Psychology Training Clinic at Palo Alto University is a community-based psychology training clinic that provides mental health services to low income, ethnically diverse, and primarily uninsured (58% of our current clients) adults, older adults, families, and children. Clients typically present with very complex quality of life problems, high levels of comorbidity, and a significant percentage of clients fall into the category of severe and persistent mental illness. The clinic provides an important access point to clients needing outpatient mental health care and has an explicit mission that incorporates responding to the uninsured by providing mental health services to low-income adults, older adults, families, and children with serious mental illnesses who are unable to access care through the local public or the private fee for service health care system.

All students at Palo Alto University are required to begin their initial clinical practicum experiences at the clinic after an initial year of classroom and didactic training. Consistent with the National Council of Schools and Programs of Professional Psychology (NCSPP) model, efforts are made to closely integrate classroom and academic learning activities with clinical training (Ducheny, 2009). A clinical interviewing course is a required prerequisite that introduces many specific clinic forms and procedures in the context of teaching students directed clinical interviewing skills. However, despite such efforts to prepare students, almost inevitably students experience a challenging transition, because real-world clients present themselves in ways that fit poorly into established categories, resist adherence to well-defined treatment protocols, and present “messy” interpersonal dynamics that seem to defy standards of treatment. In turn, supervisors in early practicum experiences are faced with the Scylla and Charybdis dilemma of trying to adhere to rigorous, well-validated CBT treatment protocols; or, of individualizing and adapting treatment to meet individual and cultural differences with few well-established landmarks, roadmaps, or scientific studies to validate their procedures.

This dilemma is eased by the existence of core components of clinical competencies, in terms of the knowledge, skills, and attitudes that have been defined and benchmarked for clinical psychology trainees in an effort to determine readiness for different phases of practice (APA Presidential Taskforce on Evidence-Based Practice [APA], 2006; Fouad et al., 2009; Peterson, Peterson, Abrams, Stricker, & Ducheny, 2009). These guidelines emphasize technical or scientific knowledge, the requisite skills, and the relevant attitudes required to transport such knowledge into real-world practice. In particular, it is helpful that these guidelines incorporate metacognitive knowledge—the capacity for self-knowledge, self-reflection, self-awareness, and openness to corrective feedback. This kind of knowledge affords a vital “bottom-up” process that should complement the “top-down” material, so that students can successfully convert knowledge into practice. Schon (1983) has identified the concept of “reflection-in-action” as a central concept that bridges the worlds of theoretical knowledge and clinical practice: “reflection-in-action may be rigorous in its own right, and links the art of practice in uncertainty and uniqueness to the scientist’s art of research” (p. 69).

How can supervisors best approach the development of these key metacognitive skills in their trainees? This would seem to be a critical area for research and development in developing empirically supported best practices. Within clinical supervision, we have only a limited empirically supported knowledge base from which to draw: Our general knowledge base remains rather rudimentary in terms of providing supervisors with well-established, empirically

supported procedures for training and supervising to help students demonstrate these clinical competencies. Although there have been initial attempts to define the competencies inherent in effective supervision in the United States (Falender et al., 2004), these broad competency statements have not been effectively translated into procedural knowledge that would assist supervisors in terms of providing a standardized or manualized approach to supervision. Much more recently in England, there has been a national effort to provide a more comprehensive roadmap as to supervision competencies and procedures within the Improving Access to Psychological Therapies (IAPT) initiative (Roth & Pilling, 2008). In a recent review of the empirical status of CBT supervision, Reiser and Milne (2012) noted that, despite the rich empirical heritage of CBT, supervision of CBT still lacks a strong empirical base and “has tended to be largely descriptive, emphasizing principles—relationship factors, collaboration, guided discovery, structure (Padesky, 1996)—rather than explicit procedures and a corresponding rigorously manualized approach” (Reiser & Milne, 2012).

In the absence of specific guidance on how best to develop these metacognitive skills in our psychology trainees within CBT supervision, we draw on the learning principles recently outlined in the supervision competencies developed in the United Kingdom as part of the IAPT initiative (Roth & Pilling, 2008), with special reference to the principle of experiential learning (Kolb, 1984). This approach is illustrated in a series of supervision case examples where we attempt to demonstrate how these principles can guide our supervision in terms of identifying specific processes and procedures designed to develop self-reflective or metacognitive knowledge.

We have noted elsewhere (Reiser & Milne, 2012) that the IAPT initiative has filled in some of the gaps in earlier competency statements on training and supervision (Falender et al., 2004) by combining a broadly representative expert consensus panel with an empirical review of training procedures drawn from major clinical trials. In addition, the IAPT approach clearly identifies its sources by citing specific references and identifying expert reference group members. This approach appears to be more detailed, more transparent, and more soundly derived (i.e., from an empirical review of what is known to be effective) than previous efforts incorporated in the Falender et al. (2004) competency statements.

We are particularly interested in the attempt made within the IAPT initiative to integrate a broader set of educational principles of adult learning into the training and supervision process. There is also a discussion of the experiential learning cycle and its role in assuring the optimal transfer of learning from supervision to therapy. Of particular note, in relation to metacognition, the IAPT work on supervision competencies also details a set of generic supervision competencies involving reflection. This gives us empirical guidance on approaching the problem of developing those critical metacognitive competencies in our psychology trainees: the enhanced capacity for self-reflection, “reflection-in-action,” and self-awareness (including immediate awareness of thoughts and feelings in the moment of the therapy session, as well as a broader construct of emerging awareness of professional identity). Bennett-Levy, Thwaites, Chaddock, and Davis (2009) make useful distinctions between four types of reflection, including reflective practice, reflective skill, the reflective system, and reflection as process. They have argued that the development of a reflective capability is central to training and learning about psychotherapy. This capacity appears to be of vital importance to learning and development, because it creates a corrective feedback loop that can inform supervisors about what requires attention, and can provide trainees with a self-correction mechanism. As Bennett-Levy, Thwaites, et al. (2009) have put it, reflection and reflective practice represent the “engine of lifelong learning.”

Reflection has dominated accounts of professional training (Milne, 2009) but should be construed as only one of the functions of high-fidelity CBT supervision. Theoretically, it represents a necessary phase within the experiential learning process, which for optimal effect needs to be

supplemented by conceptualizing, experimenting, and experiencing (Kolb, 1984). We will elaborate on this experiential learning model in the case examples that follow.

## CONNECTING THE HIGHER FIDELITY MODEL TO SUPERVISION PRACTICE: SOME ILLUSTRATIVE CASE EXAMPLES

In this section, we present a series of case examples of student trainees in a first-year practicum experience that is intended to illustrate the emergence of key developmental training issues as students confront their first clinical experiences. These case examples are drawn from the first author's experiences in his routine supervision. In commenting on them, we emphasize the role played by reflective practice and experiential learning in developing basic technical and meta-cognitive skills in our first-year trainees. In so doing, we believe that we illustrate how the gulf between rigor and relevance in CBT supervision can be bridged.

### CONCEPTUALIZING AND MANAGING INITIAL TRAINEE ANXIETY— THE “IMPOSTER SYNDROME”

A common, indeed prototypical, experience for first-year practicum students is the sense of being highly anxious, feeling overwhelmed, and requiring high levels of emotional support and concrete guidance from their supervisor. This sense of anxiety appears to reflect, in part, the transition from science to practice with the associated “roughness” and “messiness” of real-world client presentations. Real-world clients do not present their problems in a fashion that is comfortably consistent with classroom experiences (i.e., video recordings of actors role-playing clients; students role-playing clients; textbook examples and client vignettes). Trainees can have an acute sense of being “destabilized” and “deskilled” in their first practice efforts. This can be formulated as dynamic tension resulting from the gap that occurs between the acquisition of theoretical and conceptual knowledge (the declarative knowledge system) and the practical application of procedural knowledge (Bennett-Levy, 2006). Bennett-Levy has outlined a helpful conceptual model outlining a tripartite system of learning—the declarative knowledge system, characterized by propositions and factual knowledge; the procedural knowledge system, consisting of “how to” and “when to” rules; and the reflective knowledge system, including metacognition. As a rule, knowledge acquired in the classroom through preparation and largely didactic experiences translates poorly into the “how to” knowledge that is required when sitting in the clinic with real-world clients. Students ask repeatedly “What do I do?” and “What do I do next?” because their theoretical, conceptual, and technical knowledge does not readily transfer into procedural knowledge.

The dilemma faced by the supervisor is exacerbated by the recognition that optimal levels of anxiety play an important, if not vital, role in learning, as noted in the IAPT supervision competencies (Roth & Pilling, 2008). It follows that if supervisors are overly supportive (to the extent of being protective), they are likely to convey messages that are inconsistent with either optimal learning or optimal client care in the CBT treatment model. Therefore, we call for students to tolerate their discomfort in the therapeutic process, without rescuing their clients. On the other hand, if the supervisor provides insufficient emotional support or scaffolding, students are likely to find that their performance in supervision (as well as in providing treatment) is hampered by anxiety. In trying to strike a balance between these options, the supervisor must strive to determine what level of anxiety is optimal for each individual student, as noted in the IAPT supervision competency set (Roth & Pilling, 2008).

It is probably most useful to take an acceptance-based approach to anxiety in the therapy room, with the assumption that some level of anxiety is useful, having an orienting and alerting function that keeps therapists focused and attentive. This is consistent with the main thrust of many

of our CBT treatments of anxiety, where exposure to distressing feelings and avoidance of safety behaviors is integral to the treatment. Because much trainee anxiety is associated with confusion and “not knowing what to do” in the difficult and immediate moment where clients present challenging, complex, and difficult problems, the supervisor is often in the position of helping trainees to accept the anxiety inherent in this situation and to resist the urge for simple, immediate solutions (giving advice, reassurance, easy answers, etc). Let us note here that too much reassurance to students would ultimately promote bad modeling, in terms of trainee—client interactions.

### **Experiential Strategies to Manage Trainee Anxiety**

CBT supervision has a rich tradition of encouraging supervisors and trainees to examine beliefs that might serve as barriers to providing effective treatment through experiential exercises and self-practice (Bennett-Levy, 2006; Padesky, 1996). The supervisor can use opportunities early on to demonstrate tolerance of mistakes and a willingness to learn from mistakes (including their own). It can be particularly powerful to share the supervisor’s tape recordings (with appropriate consent) of their clients in both an individual and group supervision format to illustrate “less than perfect” therapy. In some cases, it may be useful for the supervisor to directly self-disclose, with the theme that (even after years of postdoctoral training) clients can present in very challenging and confusing ways that can engender anxiety even in expert therapists.

In one of the initial group supervision meetings with new trainees, the supervisor chose to disclose a self-reflection/self-practice (Bennett-Levy, 2006) thought record exercise on his responses when he discovered that one of his clients had left her CBT homework in the restroom. Some of his maladaptive thoughts included the following: “This means I am not doing a good enough job with this client” (Belief level = 80%); “This patient is not taking me/therapy seriously” (Belief level = 80%); “This means that I have not been an effective therapist” (Belief level = 80%); “I am not a good enough therapist” (Belief level = 60%). The supervisor then discussed cognitive restructuring methods and asked students to identify and respond to similar thoughts that they might have had surrounding their sense of competence.

In this vignette, the supervisor demonstrates the use of self-reflection and “reflection in action” to identify his own anxieties concerning a client. The supervisor models tolerance for anxiety, nonjudgmental acceptance of anxiety, and demonstrates anxiety management strategies and the role of reflective practice for cognitive therapists in training. This serves to normalize the experience of anxiety and lowers the perceived gap between the “expert” therapist and the trainee. We can conceptualize this within the context of Kolb’s (1984) learning cycles of experiencing, reflecting, conceptualizing, and experimenting as follows. The supervisor was able to reflect on uncomfortable emotions that came up, associated with his client’s behavior (experiencing, reflecting). This led to an effort to explicitly conceptualize the problem underlying distressing and uncomfortable feelings (conceptualizing) and, ideally, in the last stage to engage in an experiment to see how processing these uncomfortable thoughts and feelings could lead to a more helpful reconceptualization of experiences with the client.

### **ADDRESSING TRAINEE ANXIETY ASSOCIATED WITH CULTURE AND POWER- PRESTIGE IMBALANCES IN THE SUPERVISORY RELATIONSHIP**

A second tactic to address anxiety in initial meetings with trainees is to engage in a reflective discussion that highlights the unequal nature of the supervisory relationship in terms of power and prestige. Unfortunately, the inherent inequality in the supervisory relationship containing formative, evaluative, and restorative elements can be greatly magnified by class or cultural factors. To address this head-on, the supervisor must be willing to have an explicit, transparent discussion

of culture—specifically how cultural differences between the supervisor and trainee can serve as barriers to learning or opportunities for personal growth.

In initial meetings, discussions with an Asian American immigrant trainee included a review of cultural differences and her sense of willingness to accept challenges in supervision versus the level of support she felt she needed. She also noted that her cultural heritage involved high levels of respect for elders and teachers and a sense that it might be impolite to ask questions, reveal private emotions (might be viewed as weakness), or unnecessarily “bother” her supervisors. The trainee and the supervisor noted how this cultural predisposition might prevent the student from fully participating in supervision and feeling free to disclose difficult emotions associated with being in supervision—normative experiences as a therapist in training. They agreed to monitor and pay attention to this as a potential impediment to training, which included an explicit metacognitive component (i.e., attending to thoughts about how to behave in supervision).

In introducing the supervisory model and framework, it is helpful to immediately emphasize the collaborative nature of supervision and the supervisor’s willingness to accept feedback from the trainee. This can serve to mitigate anxiety through directly addressing perceived power imbalances in the supervisory relationship. Ideally, the supervisor both requests verbal feedback in each session and provides an instrument for the student to provide written quantitative and qualitative feedback *after* every supervision session using a formal supervisee’s feedback and evaluation instrument. For this purpose we have used Rating of Experiential Learning and Components of Teaching & Supervision (REACTS; Milne et al., 2011; Wilson, 2007). REACTS is a brief 11-item, paper-and-pencil rating of supervision by the supervisee that may be completed in 5 minutes—typically after the supervision session. REACTS mainly focuses on the “formative” aspect of supervision (i.e., educative function), by listing Kolb’s (1984) learning modes (i.e., experiencing, reflecting, conceptualizing, and experimenting). It also prompts for qualitative open-ended feedback under a “helpful aspects of supervision” item, and this has proved to be particularly informative and useful.

For the CBT therapist, the value of accepting feedback from clients as a way of optimizing treatment is deeply ingrained in the cognitive behavioral tradition and philosophy of care. As noted earlier, the structure of a CBT supervision session systematically parallels the structure of a therapy session and includes a consistent element of feedback as part of the agenda. Recent IAPT guidelines on supervision competencies have emphasized the value of feedback to the supervisor in optimizing supervision and creating a collaborative context for training (Roth & Pilling, 2008). This principle of two-way feedback is also embedded within the IAPT competency statements (Roth & Pilling, 2008). By insisting on a parallel process of accepting feedback in supervision, the supervisor can model appropriately and nondefensively how to receive feedback from students. More importantly by acting on feedback to optimize supervision, a powerful experiential message is conveyed to the trainee about our underlying values and philosophy and training model. Not surprisingly, students are initially very reluctant to provide any negative feedback and will be wary of subtle or gross forms of potential retaliation on the part of the supervisor. Any hints of negative feedback from the student must be soundly reinforced and, in several cases, this supervisor has sent e-mails to students after initial negative feedback thanking them for their courage and honesty. Simply accepting feedback is not sufficient and the supervisor must demonstrate a concrete willingness to process feedback, specifically to improve the trainee’s supervision experience. In this case, the old maxim “seeing is believing” applies. Students will be very skeptical of any verbal reassurances until the supervisor’s behavior clearly demonstrates their intent.

## **Use of Structure and Feedback in Supervision to Address Trainee Anxiety**

CBT supervision is systematically structured and organized in parallel to the structure of a CBT session because there is a clear framework, providing a check-in, agenda-setting, working through



the agenda, periodic capsule summaries, feedback, and homework (Liese & Beck, 1997; Padesky, 1996). This type of well-structured supervision session can help practicum trainees manage anxiety by developing and managing a clear, predictable, and controllable framework for supervision. This framework should include an early review of a specific supervision learning contract defining roles and expectations for both supervisor and supervisee and explicitly reviewing performance standards and competencies to be evaluated.

Consistent with the CBT model of structuring each therapy session, CBT supervision explicitly calls for an agenda-driven supervision session. This principle is embedded in the IAPT supervision competency statements both in terms of establishing a learning contract and in terms of setting a structure for supervision sessions (Roth & Pilling, 2008). This requirement makes additional demands on both the trainee and the supervisor in terms of preparation for supervision. In the first one or two sessions, it is useful to introduce the concept of a learning contract with a focus on mutually defining learning objectives throughout the course of supervision and within each supervision session (Milne, 2009). The principle of using an explicit written learning contract in supervision is well supported in the literature (Milne, 2009; Roth & Pilling, 2008).

In initial discussions, the supervisor should explicitly inquire about the trainees' previous learning experiences that might be comparable and their sense of what has been an optimal level of support versus challenge. Although this may be a first-time clinical supervision experience, it is likely that past experiences of adapting to challenging or new situations can serve as excellent analogues for entering into an initial clinical practicum. Often, students can reflect on their responses to these other learning situations and this can orient them to useful strategies for coping with the sense of newness and awkwardness associated with beginning clinical work. This discussion should be followed up in every subsequent session by soliciting explicit feedback about the level of support versus challenge in the session, thereby attempting to adjust and optimize this balance for each student. The supervisor will inevitably make mistakes that can be rectified by reflection, attending to the trainee's emotional experiences in supervision, and thoughtful processing with the student:

Over the first quarter, this Asian American trainee was always diligent, hardworking, task-oriented, and well-prepared in her approach to supervision sessions. However, the supervisor had a somewhat intangible feeling that the trainee was working below her potential and seemed hesitant to take initiative. After a low rating (scoring 2 out of 5) on her REACTS feedback form for support: "I felt supported by my supervisor's use of 'core' relationship conditions (e.g., feeling accepted, receiving recognition and support)," we discussed her feedback in the next session and she disclosed that she often felt very anxious both *before* and *after* the supervision session. She stated that she often tried to work harder and "do a better job" to compensate, but this strategy was not working and that she felt "stuck" in always working harder and feeling more anxious. She felt that this undisclosed anxiety was hampering her performance in supervision and the supervisor reflected with her that he too was feeling like he was working too hard and apologized for overlooking the importance of the emotional context of supervision. We discussed rebalancing her supervision with higher levels of emotional processing and support and more attention to feelings in the moment both in supervision and in her therapy experiences and agreed to carefully monitor our progress. The trainee was asked to write a reflective essay on her experience discussing anxiety, culture, and the role of emotions in supervision and psychotherapy. Subsequently, her clinical work improved dramatically in terms of her willingness to improvise and take risks in trying out new therapy methods, with particularly good results with one of her clients.

This case example can be viewed through the lens of the experiential learning cycle (Kolb, 1984) where iterative cycles of experiencing, reflecting, conceptualizing, and experimenting helped contribute to a trainee's learning process and further development. In this case example, both supervisor and trainee were having problematic experiences ("working too hard," "feeling anxious") that interfered with conducting supervision and psychotherapy. After reviewing the

trainee's feedback and with mutual metacognitive reflection, supervisor and supervisee's identified high standards, cultural differences (in the meaning and expression of emotions), and perfectionism as impediments to the student's additional development. This led to a reconceptualization of how supervision should be focused: less task-oriented, more emotion-oriented, and a subsequent experiment in adjusting the tone of supervision to offer more support and less implicit "demands" for performance. The result was a substantial improvement in the tenor of supervision sessions, which directly transferred to substantial clinical improvements in a client that had made little progress previously.

## PROMOTING SELF-REFLECTION, SELF-AWARENESS IN THE MOMENT

Early discussions of CBT supervision strongly emphasized the importance of experiential learning and guided discovery/self-reflection (Padesky, 1996). However, surveys of actual practice and reviews of competency statements (Townend, Iannetta, & Freeston, 2002; Townend, Iannetta, Freeston, & Harvey, 2007) have emphasized the gap between recommended practice and actual practices and noted continuing poor fidelity in the real-world practice of supervisors, especially in the area of promoting and deepening experiential learning. In a recent review, Reiser and Milne (2012) identified a continuing trend in which CBT supervisors make limited use of direct observation through audio, video, or live observation and rely on discussions of case formulation and case conceptualization, thereby limiting the potential for experiential learning through enactive methods. IAPT supervision competency statements have also emphasized the importance of employing experiential methods within supervision and assuring that learning is an iterative process involving repeated cycles of observation, direct feedback, and rehearsal.

Without the use of direct observation as a substantial component of each supervision session, direct experiential processing of information is limited. For example, although trainees often pull for ready answers and quick technical solutions to address immediate client problems, simply providing continuing concrete answers can be quite counterproductive. By contrast, urging the trainee to reflect on feelings that come up while watching her video can help develop deeper reflection and experiential learning, with the potential for more refined solutions:

During supervision, one trainee began to feel increasingly frustrated that she was not helping one of her clients "enough." She pressed the supervisor to provide more ideas about next steps and possible interventions that might be helpful. As the supervisor and trainee watched a portion of the video where the client appeared quite distressed, the supervisor stopped the tape and asked the trainee to reflect on how she was feeling in the moment. After some reflection, the student noted a strong pull to try to reassure the client and provide some direct assurance and advice. As this metacognition was explored, it became clearer that providing immediate reassurance or "fixing the client" might not be a helpful intervention, and the trainee agreed to take a more emotion-focused approach, in terms of further processing the client's distress.

This approach could not have been used without an ability to directly observe the supervisee's behavior (importance of direct observation) as a jumping-off point for reflecting on the actual experiences within the therapy session. By reflecting on the trainee's direct experience (an uncomfortable sense of pressure to "fix the client") and the supervisor's experience (an uncomfortable pressure to help "fix the client"), both trainee and supervisor became aware of some of the countertransference pulls elicited by the client (and in supervision) and were able to reflect on more helpful strategies together. This tendency to reflect (as opposed to reacting rapidly to resolve the client's distress) then became a continuing point of departure



for discussions in further supervision sessions, and the student continued to experiment with more reflective strategies.

## **Transition From Concrete Problem-Solving to Case Conceptualization and Theory-Driven Treatment**

One of the most difficult initial transitions in early training involves helping the trainee move from a concrete approach to treatment (characterized by needing immediate repeated help in identifying specific concrete procedures and techniques: e.g., “What do I do next?”) to developing a more conceptual, theory-driven understanding of treatment. CBT has emphasized the use of individual case conceptualization to address the problem of how to consistently drive treatment, based on case formulation (Persons, 1989). Repeatedly giving the trainee concrete help ultimately undermines helping him or her develop a more conceptual understanding of the case and results in a very technical, mechanistic approach. The use of guided discovery and Socratic questions can help scaffold the trainee toward a more conceptual understanding of the case where he or she is “free” to experiment and design interventions consistent with the treatment conceptualization and plan.

A student toward the end of her first quarter of practicum found herself repeatedly “stuck” about what to do next with one of her clients after she had completed developing a problem list and collaborative goals with a young Asian American man who was complaining of poor concentration, procrastination, “feeling unproductive,” and negative rumination associated with problems running his start-up business. The supervisor had asked her to have the client to fill out an Activity Log monitoring the client’s procrastination, inactivity, and productivity. Over several supervision sessions, she repeatedly asked about how she should structure the next session and wanted step-by-step procedures outlined. Initially, the supervisor responded by outlining specific procedures to be used but then felt increasingly uncomfortable and stepped back and reviewed a “Learning Outcomes List” with the trainee (Milne, 2009). Together they collaboratively reframed the issue from a problem of concrete planning (e.g., “What to do next”) to the problem of case conceptualization. By using Socratic questions (e.g., “How do you understand the patient’s problems of avoidance, negative rumination, and procrastination? How can we apply the principles of behavioral activation to these problems? How can we use the Activity Log as a helpful intervention for this client?”), the supervisor worked toward a higher level conceptualization of the case and the client’s problems. The trainee, after initially feeling confused, then had a very dramatic “Aha” experience which she reported on her REACTS feedback form as follows: “The whole session tied together broad conceptualizing of my client, his case formulation and treatment goals and objectives. I feel like I’m viewing supervision and my therapy work from a different angle.”

We can think about this learning episode as an important transitional bridge between conceptual (or theoretical) knowledge and procedural knowledge. The student had recently completed a course in CBT which had introduced conceptual, theoretical, and basic strategies regarding behavioral activation, but this declarative conceptual knowledge had not been transformed into procedural knowledge. We can conceptualize this episode within the context of Kolb’s (1984) learning cycles of experiencing, reflecting, conceptualizing, and experimenting. The trainee experienced this as a sense of needing to be very problem- and task-focused in supervision and making sure she got just the right answers about how to proceed. Initially, the supervisor experienced a slightly uncomfortable feeling of a pressure to keep concretely planning what to do next in each supervision session. The continuing concrete focus on specific technical procedures never seemed to engage with a larger picture of the client and the continuing problem of “what to do next” resurfaced in each supervision session (experiencing cycle). Interestingly, this portion of the episode was marked by lower scores on several of the REACTS feedback items for supervisee’s learning (including the following: “I was able to recognize relevant feelings becoming more self-aware”; “My understanding

of my work improved”; “The supervisor helped me to try things out and to try and solve problems/practice skills”). By using an approach that encouraged the trainee to reflect on the supervision problem of what to do next at a less concrete level, the supervisor was able to reframe the problem as a lack of a comprehensive case formulation approach that could drive treatment (experiencing and reflecting cycle). In this way, both student and supervisor were able to move from a concrete “how to do it” approach to a more metacognitive understanding of the case and the supervision process (conceptualizing cycle). The final stage would be to assist the trainee in experimenting with interventions consistent with a behavioral activation theory and to apply a methodology to determine if these could be helpful to the client by addressing the core problems of procrastination, negative rumination, poor concentration, and feeling unproductive (experimenting cycle). Feedback on the learning-related items on the REACTS form improved markedly after this session.

## DISCUSSION

In this article, we have tried to address problems concerning the weak conceptual rigor of the CBT supervision model within theoretical accounts (Beck, Sarnat, & Barenstein, 2008; Liese & Beck, 1997; Newman, 2010; Padesky, 1996) and the further complication of low-fidelity applications of this model within empirical research (Milne, 2008; Townend et al., 2002). These gaps and limitations present impediments to the use of CBT supervision within training clinics, what we termed a rigor-relevance gap, following Schon (1983). In turn, this can create challenges for clinic supervisors and their first-year practicum students: CBT supervisors need to bridge this gap somehow, not least to help their students to make a transition from didactic and classroom-based learning to real-world clinical practice. To bridge the gap within our own clinic, we have adopted a developmentally informed model that highlights the role of experiential learning (Kolb, 1984) and metacognitive-reflection, as embedded in early descriptions of CBT supervision (Padesky, 1996). This model was enhanced by more recent and sophisticated accounts of reflection (Bennett-Levy et al., 2009), supplemented by key CBT supervision competencies (Roth & Pilling, 2008). With the help of some representative case examples, we tried to illustrate how these elements could be combined within routine supervision practice. Summarizing this discussion, it is apparent that competent supervisory practice entails the same use of self-reflection and a metacognitive mapping of the supervision process that directly parallels the reflective processes that we are hoping to develop within our supervisees.

Although we believe that this approach can contribute to developing the rigor and relevance of CBT supervision in the form of a case study, we are heartened by other developments which can aid the “work in progress.” In addition to the comprehensive statement of CBT supervision competencies (Roth & Pilling, 2008), there are now benchmarks for expected learning (Fouad et al., 2009) and CBT supervision guidelines (Milne & Dunkerley, 2010). We believe that the next major challenge is a formal conceptualization of the CBT supervision model, something that we see as necessitating a fully manualized approach, as per cognitive therapy itself. This would entail an instrument that could reliably quantify the behavioral aspects of supervision, alongside the supervisee’s learning process. Several surveys of the supervision literature have called for exactly this type of observational instrument (Falender & Shafranske, 2010; Watkins, 1998). Initial steps in this direction have been taken in the development of SAGE, an instrument designed as an observational measure of supervisor behavior and supervisee learning. Initial studies of reliability and validity are promising (Milne, Reiser, Cliffe, & Raine, 2011) but must be followed up with a larger generalizability study of the measure.

Consistent with the empirical thrust of CBT, there is also a clear need to apply instruments such as SAGE and REACTS within rigorous evaluations of the kind of supervision approach described earlier. We have outlined portions of what might be a best practice approach to CBT

supervision, but our discussion is obviously incomplete and lacks compelling empirical support. Instruments like SAGE could serve to specify the model and show how it might be applied in naturalistic clinical contexts, further closing the rigor-relevance divide. To allow for fine-grained research on effectiveness, we believe that the fidelity framework shows great promise (Borrelli et al., 2005) because it explicitly teases apart the related steps between a model and its effectiveness, as illustrated in a recent evaluation of supervisor training (Culloty, Milne, & Sheikh, 2010).

In conclusion, there appear to be some promising methods to improve the rigor and implementation of CBT supervision, which should be further evaluated as part of a concerted effort to develop high-fidelity CBT supervision.

## REFERENCES

- APA Presidential Taskforce on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271–285.
- Beck, J., Sarnat, J. E., & Barenstein, V. (2008). Psychotherapy-based approaches to supervision. In C. Falender & E. Shafranske (Eds.), *Casebook for clinical supervision—A competency-based approach*. Washington, DC: American Psychological Association.
- Bennett-Levy, J. (2006). Therapist skills: A cognitive model of their acquisition and refinement. *Behavioural & Cognitive Psychotherapy*, 34, 57–78.
- Bennett-Levy, J., Thwaites, R., Chaddock, A., & Davis, M. (2009). Reflective practice in cognitive behavioural therapy: The engine of lifelong learning. In R. Dallos & J. Stedmon (Eds.), *Reflective practice in psychotherapy and counselling* (pp. 115–135). Berkshire, United Kingdom: McGraw-Hill.
- Binder, J. L., & Wechsler, F. S. (2010). The intervention competency. In M. B. Kenkel & R. L. Peterson (Eds.), *Competency-based education for professional psychology* (pp. 105–123). Washington, DC: American Psychological Association.
- Borrelli, B., Sepinwall, D., Ernst, D., Bellg, A. J., Czajkowski, S., Breger, R., . . . Orwig, D. (2005). A new tool to assess treatment fidelity and evaluation of treatment fidelity across 10 years of health behavior research. *Journal of Consulting and Clinical Psychology*, 73, 852–860.
- Culloty, T., Milne, D. L., & Sheikh, A. I. (2010). Evaluating the training of clinical supervisors: A pilot study using the fidelity framework. *The Cognitive Behaviour Therapist*, 3, 132–144.
- Ducheny, K. (2009). Clinical training in professional psychology programs. In M. B. Kenkel & R. L. Peterson (Eds.), *Competency-based education for professional psychology*. Washington, DC: American Psychological Association.
- Falender, C. A., Cornish, J. A. E., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., . . . Grus, C. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology*, 60, 771–785.
- Falender, C. A., & Shafranske, E. P. (2010). Psychotherapy-based supervision models in an emerging competency-based era: A commentary. *Psychotherapy Theory, Research, Practice, Training*, 47(1), 45–50.
- Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M., & Crossman, R. E. (2009). Competency benchmarks: A model for the understanding and measuring of competence in professional psychology across training levels. *Training and Education in Professional Psychology*, 3, S5–S26.
- Kolb, D. A. (1984). *Experiential learning*. Englewood Cliffs, NJ: Prentice Hall.
- Liese, B. S., & Beck, J. S. (1997). Cognitive therapy supervision. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 114–133). Chichester, United Kingdom: Wiley.
- Milne, D. L. (2008). CBT supervision: From reflexivity to specialisation. *Behavioural and Cognitive Psychotherapy*, 36, 779–786.
- Milne, D. L. (2009). *Evidence-based clinical supervision*. Chichester: British Psychological Society Blackwell.
- Milne, D. L., & Dunkerley, C. (2010). Towards evidence-based clinical supervision: The development and evaluation of four CBT guidelines. *The Cognitive Behaviour Therapist*, 3, 43–57.

- Milne, D. L., Reiser, R., Cliffe, T., & Raine, R. (2011). SAGE: Preliminary evaluation of an instrument for observing competence in CBT supervision. *The Cognitive Behaviour Therapist*, 4, 123–138.
- Milne, D.L, Reiser, R.P., Cliffe, T., Boon, A., Raine, R., & Scarratt, P. (2011). A qualitative comparison of cognitive-behavioral and evidence-based clinical supervision. *The Cognitive Behaviour Therapist*, 4, 152–166.
- Newman, C.F. (2010). Competency in conducting cognitive-behavioral therapy: foundational, functional, and supervisory aspects. *Professional Psychology: Research and Practice*, 47, 1, 12–19.
- Padesky, C. A. (1996). Developing cognitive therapist competency: Teaching and supervision models. In P. M. Salkovskis (Ed.), *Frontiers of cognitive therapy*. London, United Kingdom: Guilford Press.
- Persons, J.B. (1989). *Cognitive Therapy in Practice: A Case Formulation Approach*. New York: W.W. Norton.
- Peterson, R. L., Peterson, D. R., Abrams, J. C., Stricker, G., & Ducheny, K. (2009). The National Council of Schools and Programs of Professional Psychology: Educational Model 2009. In M. B. Kenkel & R. L. Peterson (Eds.), *Competency-based education for professional psychology* (pp. 209–221). Washington, DC: American Psychological Association.
- Reiser, R., & Milne, D. L. (2012). Supervising cognitive-behavioral psychotherapy: Pressing needs, impressing possibilities. *Journal of Contemporary Psychotherapy*. Advance on-line publication. <http://dx.doi.org/10.1007/s10879-011-9200-6>
- Roth, A., & Pilling, S. (2008). *A competency framework for the supervision of psychological therapies*. Retrieved from [http://www.ucl.ac.uk/clinical-psychology/CORE/supervision\\_framework.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm)
- Schon, D. A. (1983). *The reflective practitioner: How professionals think in action*. London, United Kingdom: Basic Books.
- Townend, M., Iannetta, L., & Freeston, M. H. (2002). Clinical supervision in practice: A survey of UK cognitive behavioural psychotherapists accredited by the BABCP. *Behavioural and Cognitive Psychotherapy*, 30, 485–500.
- Townend, M., Iannetta, L., Freeston, M. H., & Harvey, J. (2007, July). Supervision practices of UK cognitive behavioural psychotherapists 2001 and 2006. *World Congress of Behavioural and Cognitive Therapies*, Barcelona.
- Watkins, C. E., Jr. (1998). Psychotherapy supervision in the 21st century. Some pressing needs and impressing possibilities. *Journal of Psychotherapy Practice & Research*, 7, 93–101.
- Wilson, M. (2007). *Can experiences of supervision be quantified? REACTS: A new tool for measuring supervisee's perceived satisfaction with clinical supervision*. Unpublished thesis, Psychology Department, Newcastle University, NE1 7RU.

Correspondence regarding this article should be directed to Robert Reiser, PhD, Palo Alto University, Palo Alto, CA 94304. E-mail: [rreiser@paloalto.edu](mailto:rreiser@paloalto.edu)