

Supervisee Information

Holly is a 47 year-old licensed clinical social worker in private practice. She worked in Human Resources and made a career change to social work after she was diagnosed and treated for breast cancer in June 2002. Holly felt inspired by the mutual aid and cathartic benefit she experienced from attending support groups, and changed careers so that she could combine her cancer journey with therapeutic knowledge to offer effective counseling to clients. After completing her MSW, Holly worked in oncology providing psychotherapy to patients, survivors, caregivers, families, spouses and friends. She described that the therapeutic approach in cancer care was largely unstructured and open-ended. Clients were encouraged to vent their anger and sadness; to view therapy as a space to express the full range of their thoughts and emotions without having to worry about the impact on their friends and family. While there was some emphasis on developing coping 'self-talk' and problem-solving, the main focus of therapy was for the client to have a sounding board. Holly was introduced to some of the strategies used in CBT. She was taught techniques for treating depression (e.g., activity scheduling) but not formal case conceptualization. After working in oncology for a few years, Holly became independently licensed and took the leap into private practice. She now works with adults in individual psychotherapy who present with anxiety and depression. Holly realized that she needed to learn more about CBT in order to provide competent service to the range of clients who were coming to her for help. She subsequently read the seminal book, "*Cognitive Therapy: Basics and Beyond*" (Beck, 2011a) and attended a 3-day workshop on depression and suicide at the *Beck Institute*.

Supervision Information

Holly's impetus for seeking CBT supervision was for help preparing for certification by the *Academy of Cognitive Therapy*. Holly read on my website that supervisees are encouraged to submit tape-recordings of therapy sessions to be rated on the *Cognitive Therapy Rating Scale (CTRS)*, and she liked the idea of getting feedback before submitting her final tape to the *Academy*. Initially, Holly had trouble articulating what she wanted my help with in supervision. She observed, "some clients don't seem to grasp the concepts, but I'm not sure why." Since Holly had not studied conceptualization and treatment of anxiety disorders, we agreed to focus supervision on building her skills to help clients conquer anxiety. The plan: individual supervision, 60 minutes in duration, held on a weekly basis for ten sessions.

Formulation, Target Setting and Conceptualization

Strengths: Holly possesses several qualities necessary to be a good cognitive therapist. Firstly, she demonstrates a collaborative spirit (inviting the client to actively participate in setting the agenda). When a client expressed feeling anxious about attending a party, she asked, "Would you like to try a thought record on this problem?" which shows she is attuned to the client's level of comfort and encourages teamwork. Also, when doing the thought record, she checks in frequently ("is this okay?") to ensure the client is comfortable and feeling helped. As opposed to trying to persuade or lecture the client, Holly uses Socratic questions and a non-judgmental manner. She recognizes the client's strengths, brings these strengths into her awareness, and uses these strengths in treatment planning ("Can you think of ways you might use these strengths to help with these issues?"). Holly's verbal and non-verbal behaviors convey warmth, concern, patience,

and a sense of humor--several qualities that make up interpersonal effectiveness. Holly often references key experiences that her client has shared in a previous session, which shows the client that Holly listens and cares. She also maintains good rapport as shown by shared laughter during sessions and making validating remarks like, "This was hard for you." Holly understands the importance of homework. She assigns homework every week and follows up on it.

Weaknesses: Holly struggles with maintaining control of session flow (pacing) and using time efficiently. She frequently allows the client to ramble without gently interrupting, this leads to sessions that become aimless or move too slowly. In the CTRS manual, Young & Beck (1980) state that cognitive therapy sessions are enhanced by having a strong, well-structured opening and closing.

Another weakness is Holly does not take an active role in teaching skills and being directive. At the beginning of sessions, she asks the client, "What problems would you like help with today?" but does not add problems to the agenda that would be important to discuss based on her conceptualization of the client or propose skills the client needs to learn. In goal-oriented, skills-based treatment like CBT, therapists must be directive. Moreover, in the beginning of treatment, clients often don't know *what* to work on or how they will get better, so therapist guidance is critical (Newman, 2013).

Another problem area for Holly concerns feedback. She does not ask questions to determine what the client has learned from a session (e.g., "What was the most helpful thing you learned in today's session?" or "would you summarize what we just discussed?"). Also while she is generally attuned to the client's reactions and asks if the client found the session *helpful*, she does not ask enough questions to find out *what specifically* helped the client and why. For example, she will use the closed-ended question, "Was the session helpful?" which might elicit a "yes" response, but does not reveal the source of the client's satisfaction.

Lastly, because Holly has only studied CBT for depression, she conceptualizes the difficulties of some clients inappropriately. For example, when a socially anxious client did not complete a homework assignment--to say hello to a stranger during the week—Holly assumed the client had sabotaging thoughts like, "it won't help, nothing will change," which follows the formulation for depression, not anxiety. Had Holly known the cognitive model for anxiety, she would have probed for the client's fear-based cognitions or images to understand what got in the way of successful homework completion (Beck, et al., 2005). Also, Holly might have considered that the assignment was too overwhelming or that the client needed skills training.

Conceptualization of weaknesses or problems:

To summarize, Holly demonstrates weaknesses in the following areas: (1) pacing & structuring sessions, (2) teaching and being directive, (3) eliciting feedback and assigning appropriate homework, & (4) working effectively with anxiety disorders. Just as it is essential for therapists to conceptualize their clients, CBT supervisors must also conceptualize their supervisees and explore cognitive schema (Pretorius, 2006). Below is my formulation to explain why Holly experienced problems in applying CBT.

I wondered if problems with pacing (interrupting and structuring sessions) stemmed from difficulty being assertive or tolerating discomfort. Perhaps Holly imagined a negative consequence of interrupting ("I will feel uncomfortable")? Or maybe she had a distressing image of how the client would respond? Based on the literature, I knew that a good cognitive therapy supervisor treats his conceptualization of the supervisee's problems as merely hypotheses until they are confirmed by the supervisee (Padesky, 1996). I Socratically tested my hypothesis that poor pacing was connected to Holly's insecurity as follows: During a supervision meeting, I played Holly a segment of her session that illustrated poor pacing while asking, "What was going through your mind at this time?" I learned that Holly felt neutral, not distressed, because she was thinking, "the client needs space to discuss whatever is on her mind." Trainees often believe (at least initially) that structure is disruptive to client insight and a good therapy relationship (Beck, 2009). Holly's belief that clients get better by venting in an unstructured way makes sense because she personally experienced a mood-shift after attending cancer support groups, which were also unstructured. Holly's assumption, "If the client is allowed to vent, she will be helped," was the culprit for poor pacing--not worries about feeling uncomfortable or having to assert herself, as I had originally hypothesized.

I learned that Holly was non-directive because she misunderstood the cognitive therapist's role. She had confused the concept of being directive with being rigid or non-collaborative, as demonstrated by her belief, "If I am directive, then I'm not being collaborative; since cognitive therapists are collaborative, being directive is wrong." Contrary to Holly's belief, Newman (2013, p.174) says, "competent CBT therapists know how to deliver treatment in a way that is authoritative yet non-*authoritarian*." Another part of the direction problem was that Holly simply lacked experience carrying out skills-based treatment from start to finish. In order to facilitate therapy efficiently the therapist must plan for each session and across sessions (Beck, 2011a). Holly needed to learn tools to plan treatment and monitor progress—e.g., completing a cognitive conceptualization diagram on the client from the first session or selecting strategies carefully based on the conceptualization to help the client reach stated goals (Beck, 2011b).

Holly's difficulty with conceptualizing anxiety disorders and implementing the appropriate techniques makes sense because she had attended only one CBT workshop prior to supervision, which was on depression. Learning cognitive therapy now is harder than it has ever been (Padesky, 1996). In the late 1970s there was a single treatment model existed for a single disorder, depression. Today there are specific cognitive therapy conceptualizations and treatment protocols for many syndromes described in the DSM.

Homework was sometimes inappropriate because Holly did not understand the cognitive model for that disorder. Moreover, she did not have experience completing cognitive therapy exercises on herself so she could not fully appreciate the challenges that may arise. She found that the clients described in CBT manuals dutifully carry out homework unless they express overt resistance, so when clients accepted her assignment without an argument, Holly assumed compliance would follow.

Supervision goals: Holly entered supervision without specific goals and had trouble pinpointing what areas of practice needed attention. The first assignment I gave Holly was to read the CTRS manual and rank her comfort level (low, medium, high) with each element (Sudak, 2013). Reading

the CTRS manual helped Holly self-reflect and develop insight into her goals. I was also able to ascertain her learning needs by listening to her taped therapy sessions and rating them on the 11 CTRS items. Finally, asking Holly a series of questions about her previous clinical experience and how she would respond to various challenges ("What would you do if...?") clarified her strengths and weaknesses (Milne, 2009). In our second meeting, I shared my impression of the skills Holly needed help with and she agreed. We established the following goals: Learn why and how to: 1. Structure sessions, 2. Demonstrate a collaborative WHILE ALSO directive manner, and 3. Be able to teach clients the cognitive model for anxiety and implement appropriate techniques with skill.

Plan and Course of Supervision

Supervision was carried out based on the recommendations in the literature. I explained from our first meeting that both CBT and its supervision are goal-directed, structured, collaborative, active, and time-limited (Beck, 2009). In addition, supervision sessions would be structured in the same way that therapy sessions are conducted (e.g., setting an agenda, practicing skills in session, etc.) (Beck, 2009). I provided an overview of the various learning methods we could use (e.g., case discussion, watching video, role-play, etc.) and asked how she learns best. We aimed to use 2-3 learning methods each week since using a range of methods is the best way to facilitate learning (Milne, 2009). We planned that each week Holly would submit a tape-recorded therapy session for review. I would listen to Holly's entire tape, rate it on the CTRS, and select 1-3 skills to teach. Also, we would both create an agenda for supervision in advance of the meeting.

Procedures/methods used in supervision:

The overarching teaching method for supervision included: a brief lecture & demonstration of the skill, followed by role-play to experience and practice the skill in "real time", and finishing up with a homework assignment to deepen learning and skills-acquisition.

Lectures & Didactic Supervision

Brief lectures and case examples from my own practice were used often. My teaching style was a blend of direct instruction ("Here's how you create an exposure hierarchy with a client") and guided discovery ("How do you think your client might answer the following: What might get in the way of completing the exposure task?" and "how can you modify the exposure instead of leaving the situation entirely?"). These exchanges helped Holly learn first-hand how one can be directive and active while maintaining collaboration. To address her problems with using session time optimally, I explained that the cognitive therapist creates a plan for each session. I shared a sampling of questions I routinely ask myself before each session ("What skills does the client need to learn today?").

An example of didactic supervision follows: During termination, Holly used questions appropriately to elicit and respond to the client's distressing automatic thoughts about ending therapy ("I'm going to have a relapse"); however, she neglected to provide the client with important information about realistic expectations and prognosis. I first praised Holly on her skillful method of helping the client recognize cognitive distortions and replace them with balanced alternatives. Then I provided an overview of the facts clients need to know when ending

therapy (lapses are to be expected; recurrences are not signs of dependency on treatment, but serve as an opportunity for the client to re-enact her CBT skills.) I also explained that long-term maintenance of gains is assisted by having a plan of action. In other words, rather than just ending therapy when the client has shown consistent stable progress, CBT therapists help their clients prepare for termination by anticipating future stressors that might lead to a setback and creating a relapse prevention plan (Beck, 2011a).

Role-Play

Practice with real people in clinical or role-play situations is the best way to acquire technical or interpersonal skills (Milne, 2009); therefore, role-plays were used in nearly every supervision session. For example, after reviewing the teaching points on termination (above), we used role-play to practice communicating these ideas to the client in an engaging manner. Since beginning therapists learn best from very structured, time-limited, and goal-oriented practice exercises (Padesky, 1996), role-plays were designed to be brief demonstrations of a particular therapeutic principle (e.g., 5 minutes of cognitive restructuring).

Self-Practice & Learning Experiments

Padesky (1996, p. 288) has written: "To fully understand the process of therapy, there is no substitute for using cognitive therapy methods on oneself." Indeed, Holly discovered that using cognitive therapy in session and during the week led to improved recall of the skills and better appreciation for how a client might think and feel when doing CBT exercises. Creating an exposure hierarchy for one of her fears and carrying out exposure practices, for example, helped Holly better understand the rationale for exposure, have a deeper appreciation for its utility, and empathize with clients who struggled with adherence. Holly also found it helpful to complete TRs from the client's point of view. For example, hypothesizing the automatic thoughts of a client she experienced as "difficult" helped her become curious about her client rather than judgmental.

Rather than didactically teaching "truths" I would summarize empirical findings, elicit Holly's reactions, and encourage the creation of learning experiments to see if these findings apply to her. Indeed, Alford and Beck (1997) caution that it should not be assumed that all therapists will immediately and fully accept training content, and therapy principles ("therapy works better when structured") should not be presented as blind facts but as testable hypotheses.

Here are the steps used to adopt an empirical stance about therapy principles (Padesky, 1996), along with an example that Holly used in supervision. (1) formulate the hypothesis (interrupting my clients will help them get more out of sessions), (2) conduct multiple experiments (tactfully interrupt several clients), (3) note the outcome of these experiments (two clients acknowledged they were rambling and thanked me, one seemed confused and upset), (4) analyze these outcomes carefully (the client who had a negative reaction had not been socialized to the structure of CT), (5) implement further experiments (apologize, explain to the client why I interrupted, and elicit her automatic thoughts about being interrupted), (6) review the outcomes of these experiments (this third client was accepting of interruptions and we compromised that the first 10 minutes of each session could be designated for 'venting time' when needed) and (7) draw conclusions

(interrupting clients helps us get more done in session. I will continue to interrupt clients and explain my rationale, and we can schedule 'venting time' when requested).

Assigned Readings & Videos

Holly was assigned reading and videos throughout supervision that were custom tailored to show how the range of anxiety disorders are treated. Typically, we first identified a specific problem (social phobia) and an evidence-based technique to apply (graded exposure with response prevention). Next, I would assign a book or video to show her how the technique can be introduced to the client—e.g., Holly watched a video demonstrating how a cognitive therapist explains the concept of exposure therapy and uses collaborative empiricism to make the conversation personally relevant and engaging to the client (Wright, 2005). Next I drew upon methods to show how the technique is executed—e.g., while she played the therapist and I played the client, we read transcripts showing how the cognitive therapist identifies the idiosyncratic factors that correspond to the client's fear and build a hierarchy (Beck, 2005). Lastly, we touched on typical barriers to implementing the skill and how they are handled-- e.g., assigned Holly read the 'trouble-shooting' sections from a consumer workbook on exposure therapy (Antony, 2004). Holly especially appreciated my recommendation to read consumer-oriented materials since they provide explanations of cognitive therapy ideas written in simple language. By referring to self-help workbooks, Holly was able to model her own verbal explanation to clients on these written samples, thereby giving her skills to be more conversational and engaging and ultimately build her confidence in executing the technique.

Observation of supervisee's work

Holly submitted a taped session each week which I scored on the CTRS. Also, she submitted cognitive therapy assignments on her clients (completed conceptualization diagrams) and herself (behavioral experiments) which we discussed during supervision.

Supervisory relationship:

Holly was a delight to supervise. She is hard worker, open to feedback, and completes recommended assignments with gusto. Holly was candid that she felt initially anxious about sharing tape-recordings of her sessions. A supervisee's anxiety about recording therapy sessions is a sign that the supervisee is feeling vulnerable to criticism and the supervisee's concerns should be made explicit, examined for cognitive distortions, and corrected (Pretorius, 2006).

Using the downward arrow technique we identified Holly's key concern: "My work won't be good enough; I will be criticized." I took Holly's concerns seriously and addressed them in several ways. During our supervisory meetings I: 1. explained the advantages that supervisees experience from taping sessions (Friedberg & Taylor, 1994), 2. Reassured her that my intention was to create a supportive and safe space, 3. Normalized that many trainees (including myself!) initially felt nervous about having tapes reviewed, and 4. Elicited her feedback both during and at the end of every session. Additionally, I sought consultation from my supervisor and got his feedback on tape-recordings of my supervision sessions with Holly. Also, to ensure I provided balanced

feedback while reviewing a tape I would ask myself, "What did Holly do well?" and purposefully highlight a minimum of 2 strengths during supervision.

To level the playing field, I invited Holly to listen to one of my therapy tapes. She was instructed to identify potential missteps and share her thoughts about how she would handle the session differently. Listening to my tape dramatically reduced Holly's self-consciousness and the power imbalance that is inherent in the supervisor-supervisee relationship. Another technique to build collaboration was through role-play where I played a therapist demonstrating a skill in a deliberately incorrect way and Holly practiced pointing out the flaws and showing me how to improve the skill. Finally, I proposed that Holly *also* rate herself on the CTRS for the recorded session. Rather than being a passive learner who views the supervisor as 'expert,' the invitation to listen to her tapes and rate them from a detached position encouraged Holly to self-reflect and participate actively.

Outcome and follow-up

At the end of our ten weeks of supervision, Holly had demonstrated improvements across skill areas and achieved passing scores on the CTRS consecutively for the final three supervisions. Her first tape scored a 31 on the CTRS whereas her final three tapes scored an average of 48. Holly reached her goals and was ready to submit her tape and case write-up for certification by the *Academy*. She decided to continue working together with me in supervision to hone her skills working with core beliefs and get consultation on challenging cases. Much of the time, clients present with more than one difficulty, requiring the therapist to combine or adapt generic conceptual models (Bennet-Levy, 2003). Therefore, Holly will learn to use evidence-based methods to develop individualized case conceptualizations and treatment plans when clients do not respond to standard interventions (Beck, 2011b). Also, we will continue between-session assignments that cultivate self-awareness. According to Bennett-Levy (2006), the principle strategy that takes a therapist from being average to expert is reflection. With practice at reflection-on-action, Holly will become progressively able to reflect-in-action.

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