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Essential Dimensions/ Key Principles

THE IMPORTANCE OF THE SUPERVISORY RELATIONSHIP

The centrality of the therapeutic relationship (TR) is widely acknowledged and empirically supported in the field of psychotherapy (see Norcross & Lambert, 2011). However, it may be argued that the salience of the supervisory relationship (SR) is sometimes underestimated (Ladany, 2004). In fact, supervisors must be mindful of creating a safe environment for trainees—safe enough for them to speak freely about the difficulties they may encounter in treating certain clients. Such difficulties may include supervisees' gaps in knowledge about certain clinical problems and/or the proper corresponding interventions or their problematic emotional reactions to clients, such as anger, fear, boredom, and sexual attraction (Ladany, Friedlander, & Nelson, 2005; Ladany, Hill, Corbett, & Nutt, 1996).

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It is incumbent upon the supervisor to contribute to a climate in supervision that encourages trainees to speak candidly and thoughtfully about such matters without the fear of censure, condemnation, or harm to their status in their training/credentialing programs. A key element in formulating an objective evaluation of supervisees' progress in training is listening to or watching audiovisual recordings of therapy sessions conducted by the supervisees. A collaborative, benevolent SR can go a long way toward providing supervisees with both the implicit and the explicit encouragement to submit recordings of their work that may not always show them at their best but may allow the supervisors to give constructive feedback that will assist both the supervisee's and the client's progress. Overall, there is evidence that a positive SR is related to the quality of supervision and to the supervisees' satisfaction with supervision (see Livni, Crowe, & Gonsalvez, 2012).

How can supervisors create such a positive SR? It starts at the first meeting, with the supervisor inviting a discussion about the goals of supervision, and overtly saying things such as,

> It is my responsibility to help you provide your clients with the best care possible while simultaneously promoting your growth as a clinical professional. I intend to give you a lot of constructive feedback along the way so that you know where you stand, so that our work together is a meaningful learning experience for you, and so that you can make adjustments in your approach when necessary. I am very invested in your success in this program, and I am highly motivated to help you achieve your clinical learning goals.

During the course of supervision, it is useful for supervisors to positively reinforce supervisees who take risks in making difficult disclosures about their work with their clients. The following are examples of supervisors' comments that serve this purpose:

- "This new client on your caseload seems to have a history of exhibiting high-risk behaviors, missing sessions, and sometimes making excessive demands on his therapists that require limit setting. Moving forward, we—as a clinical team—are going to give this client the benefit of the

doubt in terms of conceptualizing his problems objectively and providing him with interventions that may truly help him. *I will be impressed by anything that you do with this fellow that can help him break old patterns and make progress in treatment. Similarly, I will be impressed if you are willing to tell me about the inherent difficulties, including negative cognitive or emotional reactions, you may have at times in working with this client.* If you show that sort of courage it will give me the best chance of working with you to come up with responses that will help both you and your client."

- "When you submit recordings of your sessions with your clients, I will listen to them in their entirety, and I intend to let you know where I think you were on track and also where you may have gone off track, but it will always be with the goal of helping you to help your client. If you can listen to the recording as well and give yourself some corrective feedback, that would be ideal, and I will respect your comments. I will also look at your corresponding clinical note to get a better understanding of your views about the session and what you intended to accomplish. In other words, *I will greatly appreciate you sharing your work samples with me, and I will welcome a constructive dialogue with you about any sticking points you may have in a given session.*"
- (*Upon seeing that the supervisee is somewhat distressed about a particular client*) "I give you credit for facing these problematic issues with this client and for bringing them up in supervision. The easiest thing in the world would be to omit this discussion, put this client last on our agenda, and get a perfunctory signature from me on your note. Instead, *you are highlighting the difficulties you are having with this client, and I commend you for that.* Let's do some problem solving, but first, how are you feeling right now? What do you think about what I just said?"
- (*Chuckling in a good-natured way*) "You don't have to apologize for using the word 'countertransference.' It's not *verboten* in cognitive–behavioral therapy, and in fact I could show you quite a bit of CBT literature that explicitly uses this term, although maybe in different ways than it was originally formulated. I am very open to hearing your views on the matter. What sort of thoughts and feelings did you notice

in yourself in working with this client? *I think it's great if you can self-reflect in this manner because it not only will provide us with useful data in supervision but it also will help you to monitor yourself constructively in session so that your behavior remains professional and clinically on target.*"

Whereas CBS is not free of occasional points of disagreement between supervisors and their trainees, the supervisor attempts to be collaborative in discussing and resolving the relevant issues. For example, a supervisor may recommend a particular intervention, whereas the supervisee may favor an alternative approach. Rather than getting into a "competition" about whose intervention is "right," the supervisor can nicely ask the supervisee to offer a rationale for his or her point of view and then to summarize it thoughtfully. Many times, the issue is not a matter of "either/or" as there may be ample reason to try more than one approach such that both the supervisor's and supervisee's hypotheses can be tested appropriately in the next session with the client. When supervisors have reason to believe that their supervisees may be hesitant to offer contrasting points of view, they (the supervisors) can nicely spell out that they welcome supervisees' comments that may not necessarily fall in lockstep with what the supervisors believe. Supervisors can encourage an open consideration of more than one hypothesis because the ultimate goal is to help the clients by following the data rather than by being wedded to one viewpoint or one method.

GOALS

There are two fundamental goals of clinical supervision in general and several subgoals that are pertinent to CBS per se. The primary goal of supervision is to provide clients with care that is properly and competently managed, in which both supervisor and supervisee measure the clients' progress and outcomes (Swift et al., 2015). The supervisor provides the trainee with ongoing feedback and direction so that treatment stays on course and adheres to professional guidelines and mandates, thus ensuring that clients receive at least a normative standard of care. The

secondary goal of supervision is to promote the professional development of the supervisees themselves by affording them hands-on clinical experience combined with supportive and corrective instruction. Over time, the supervisors take more of a backseat, asking more of the trainees (e.g., in terms of treatment planning and outcome evaluation), and moving them toward goals such as licensure, independent practice, and specialty areas. When trainees evince significant difficulties in meeting their clinical obligations, perhaps owing to a poor acquisition of basic competencies or perhaps because of compromised functioning, supervisors also have the responsibility of serving as gatekeepers for the profession and for the public. Rather than allowing such substandard trainees to have a perfunctory pass toward graduation, supervisors need to facilitate their trainees' receiving the remediation they need in order to earn the privilege of treating clients. We discuss this important issue again later in the volume.

Facilitating the supervisees' professional development includes teaching them and/or evaluating them on their foundational and functional competencies in conducting psychotherapy in general. These are two of the three categories (along with the developmental level) that make up the Cube Model of psychotherapy competency (Rodolfa et al., 2005), a conceptual framework with which we are most familiar and have found particularly useful. Foundational competencies broadly include the qualities we call "professionalism," such as respecting and understanding the scientific underpinnings of human functioning and mental health care; adhering to ethical standards; being interpersonally effective; valuing self-reflection and self-correction; being sensitive and responsive to cross-cultural issues; diligently keeping clinical records; and knowing how and when to appropriately consult with other professionals on matters pertinent to client care, among other variables.

Complementary to the foundational competencies are the functional competencies that have to do with the specific skills and knowledge base required to provide therapy to clients. In CBT, these include conducting a cognitive–behavioral (and perhaps a formal diagnostic) assessment; collecting clinical data to formulate a cognitive–behavioral case conceptualization and measure clients' progress; devising, implementing, and

evaluating the results of specific CBT interventions; and having the requisite knowledge and skills to provide clients with valid, helpful psychoeducational knowledge.

Of course, it is not solely the supervisor's job to introduce the trainees to the foundational and functional competencies of conducting therapy. Extensive course work is part and parcel of trainees' ascension to more advanced levels of professional development and corresponding competence. However, supervisors are important promulgators of this knowledge, by word and by deed. As an example, supervisors can make sure that their therapists-in-training are conversant in the rules and exceptions pertinent to maintaining the confidentiality of client information. Supervisor and trainee can do a role-play in which the supervisor plays the part of the client while the trainee recites his or her monologue about the limits of confidentiality. The supervisor can then offer feedback, perhaps helping the trainee to improve his or her style of delivery of this information so that it has more of a routine and benevolent feel and tone. Throughout the course of the supervisory relationship, the supervisor then "walks the walk" of preserving the client's confidentiality by taking care not to disclose client information in unsecured ways and settings, thus serving as an ethical role model.

The subgoals of CBS (consistent with enhancing functional competencies) include familiarizing the supervisees with the methods of CBT per se, explicating how these methods differ across clinical areas of concern and client populations. At times the clinical supervision is part of a research project in which the supervisors are charged with the task of guiding the therapists through a treatment protocol, making sure that the CBT is delivered with fidelity, and with a minimum of "drift" (see Newman & Beck, 2008; Waller, 2009). At other times the supervision is guided less by circumscribed manuals and more by general CBT principles tailored toward individually based case conceptualizations (e.g., Kuyken, Padesky, & Dudley, 2009) and treatment plans (e.g., Leahy, Holland, & McGinn, 2011). In either instance, effective CBT supervisors help their supervisees learn how to structure therapy sessions for time efficiency and become familiar with delivering a number of specific techniques that are central to CBT overall (e.g., self-monitoring, cognitive restructuring, behavioral

activity planning, exposures to avoided experiences, relaxation) as well as methods that are associated with specialty areas within CBT (e.g., mindfulness, guided imagery, values-driven behavioral prescriptions, emotional self-regulation, and self-soothing). In addition, supervisors work with their supervisees to create homework assignments that will help clients practice these methods in their everyday lives.

Thus, there is a pathway of teaching that leads from the supervisor to the clinical trainee and then to the clients themselves. Ultimately, as several studies have suggested, clients who learn and utilize the self-help skills of CBT in a competent way tend to get more out of treatment as a whole (Jarrett, Vittengl, Clark, & Thase, 2011; Strunk, DeRubeis, Chiu, & Alvarez, 2007), just as clients who engage in CBT homework assignments more regularly and with higher quality show better short-term and long-term gains from their participation in CBT (Burns & Spangler, 2000; Kazantzis, Whittington, & Dattilio, 2010; Rees, McEvoy, & Nathan, 2005). Clearly, when CBT supervisors succeed in teaching their clinical trainees to teach their clients—via the use of in-session methods and the use of homework assignments—the all-important goals of promoting better client outcomes and therapist competencies are facilitated.

Another important subgoal can be described as follows: supervisors train their supervisees to learn to think like CBT practitioners, most notably by studying and applying the principles of CBT case conceptualization (Beck, 2011; Eells, 2011; Kuyken et al., 2009; Needleman, 1999; Persons, 2008; Sturmey, 2009; Tarrier, 2006). This involves guiding trainees to become data collectors and hypothesis generators who, with care and interest, seek an increasingly better situational and phenomenological understanding of their clients' lives, taking into account the clients' biohistorical and familial-cultural contexts. It also involves thinking across disciplines, such as when a medical problem may be playing a role in the client's difficulties. Here, supervisees need to give consideration to the possibility that they may need to refer their clients for a medical examination (e.g., an endocrinology work-up), neuropsychological testing, or other forms of assessment pertinent to their health and overall functioning that may go beyond the scope of standard CBT.

The following sample dialogue between a supervisor and clinical trainee illustrates the process of teaching the trainee to think and conceptualize in CBT terms. The trainee at first states that the client's behavior "doesn't make sense," whereupon the supervisor encourages the trainee to generate hypotheses that may help explain the client's in-session reactions and shed light on how to intervene in an accurately empathic way.

Trainee: My client spends a lot of time in session bitterly complaining about not being appreciated, either in her personal life or at work. She gives me example after example about her friends taking her for granted and not giving back what she gives them. Almost every session she tells me that nobody gives her credit for her contributions at work and that she is constantly being overlooked despite her hard work. But here's a funny thing. A pattern has developed in our therapeutic relationship where I give her positive feedback—such as telling her that I admire her sense of responsibility at work or that I think she has been very resilient in the face of disappointments—and then she doesn't acknowledge what I've said at all. She changes the subject or just keeps complaining. She comes across as craving positive acknowledgment in her life, but when I try to give that to her, she seems to ignore it. It makes no sense.

Supervisor: Well, it's certainly a paradox. She purports to want something from people, then you give it to her, and she appears not to notice it. It's incongruous. But maybe in a way it "makes sense" in her world. Can you try to come up with a hypothesis or two that might explain this pattern? Mind you, I'm not saying that you have to know for sure. We don't have enough clinical data for that sort of accuracy or certainty yet. But this is a good opportunity for you to look for the "logic in the illogic." How might this all make sense?

Trainee: Well, the thought crossed my mind earlier that maybe she doesn't perceive the positive feedback for some reason. I was thinking that maybe she has some sort of mental filter that for some reason does not allow her to really hear or incorporate people's positive comments toward her. That might account for her really believing that nobody appreciates her and for her not seeming to notice the support I'm giving her.

Supervisor: What sort of "filter" or schema might we be talking about here?

Trainee: I guess this could be an example of an "unlovability" or "social exclusion" schema. I actually thought of that, but there's another problem. I tried addressing this issue directly with her. I made a process comment, which is something you and I have practiced through role-playing in supervision. I told her that I noticed that every time I felt something genuinely positive about her to the extent that I came out and told her directly, she changed the subject and never engaged with me. And do you know what she did? She changed the subject again! I couldn't even make a process comment with her. So I don't think she couldn't perceive the positive regard I was giving her. It seemed like a deliberate avoidance on her part. That's why I couldn't make sense of it.

Supervisor: Nice going with the process comment! That was one of the things I was going to suggest, but you beat me to it. Good work. But since she confounded your attempt to address the issue, we may have to come up with additional hypotheses. What else could be going on here?

Trainee: Maybe she mistrusts the positive comments. Maybe she thinks it's all insincere and that it's a way for people to manipulate her. But she hasn't said anything like that before, so I think this "mistrust" schema hypothesis could be a bit of a stretch. It's also possible that we're talking about a "vulnerability to harm" schema in that if she allows herself to believe that someone has positive regard for her she might become too attached, and she might be afraid of that. I'm just concerned that I'm getting a little too wild with my hypotheses here.

Supervisor: Well, if you can perceive my positive feedback and can allow yourself to trust it (*chuckles*), I have a lot of positive reactions to what you're saying. First of all, that's excellent brainstorming you're doing. Rather than just feeling helpless in the face of client reactions that at first glance seem not to make sense, you are indeed trying to understand the "logic in the illogic," and you are giving consideration to several hypotheses. Second, I have to give you extra credit for recognizing that there is a potential hazard in getting carried away with our armchair hypothesizing. We need to balance the benefits of brainstorming with the potential

drawbacks of straying too far from the data. So what can we do about that? How can we stay closer to the data while still keeping an open mind?

Trainee: I can go back and look at previous documentation on the case. I have an intake report from 3 months ago to which I can refer. I also have a copy of a summary submitted by her previous therapist from a few years ago and my own clinical notes from earlier in our work together. Maybe there are clues there that might lend support—or not—to some of the hypotheses about various schemas that we're coming up with.

Supervisor: Bingo! Look at the client's history. Part of this information can be found in the clinical documentation. Another part could be . . .

Trainee: . . . talking directly with the client about her experiences in the past when she was neglected, let down, or otherwise felt unappreciated. Or maybe when she felt manipulated by someone's sweet-talking her. Or maybe when she believed she got too close to someone and then couldn't bear it when she lost them. Or whatever. It's about looking at the history and talking directly to the client about the issues.

Supervisor: Absolutely. You can tell her that you would greatly value her input about her personal history and how it affects the present and that you would welcome her viewpoints about your clinical hypotheses. That's another great way to stay close to the data. I know that you said that you already tried to make a process comment with her to no avail, but maybe it will take several times and several variations to reach her with your sincere comments. How about if we try to role-play some ways that you could try to make more of such process comments to her? Who do you want to be first: the client or the therapist?

In the previous dialogue, the CBT supervisor encourages the trainee to brainstorm schema-focused conceptual hypotheses while agreeing that it is important to stay close to the facts of the case as known and as could be gained through further inquiry. Note that the supervisor offers a good deal of constructive, supportive feedback.

Another subgoal of supervision is helping trainees properly manage and administrate the termination or transfer of their work with clients.

The importance of a client's ending treatment on a constructive, positive note is analogous to the importance of someone's successfully graduating from school with confidence, hope, and credentials. Similarly, the necessity of smoothly transferring a graduating trainee's clients to a new therapist who can seamlessly continue to provide proper treatment is as relevant as a hospital patient's receiving consistent care from one shift of nurses to the next. Supervisors help orchestrate the manner in which the trainees accomplish the goal of a healthy termination or transfer first by keeping track of the status of each client (including client absences from treatment) and second by being aware of the supervisees' target dates for finishing their current period of training. The proper handling of therapy terminations and transfers has major clinical and ethical implications (Davis, 2008), so it is incumbent upon supervisors to make sure that no client "falls through the cracks" in the system.

Supervisors serve as procedural advisors to their supervisees about how to prepare clients for the end of their work together, both from a practical, administrative standpoint and from a clinical standpoint (e.g., sensitively dealing with clients who feel a profound sense of anticipatory loss, and/or anxiety, and/or anger). They also serve as ethical mentors, helping supervisees understand how to steer clear of the two dysfunctional extremes of termination—abrupt abandonment of the client on the one extreme and seeing clients for extended periods of time with no evidence of therapeutic benefit (or without attempting any adaptations to the treatment plan) at the other extreme. In sum, supervisors play a vital role in helping supervisees learn to create a positive resolution to their work with their clients.

Supervisors, by their words and deeds, communicate a set of values to their trainees (see Corrie & Lane, 2015; Falender & Shafranske, 2004), which is an oft-overlooked subgoal of supervision. Although many of these values are subsumed under the ethical principles that are formally codified and guide the field of mental health care, there are parallel values that are not often explicitly articulated but that warrant mention in their own right. The list that follows is neither exhaustive nor universal, and its contents may be modifiable depending on cultural context. However, it is useful to spell out the sorts of attitudes and beliefs that many CBT supervisors

try to inculcate in their trainees through modeling. The following items are adapted from Newman (2012):

- Time is precious. Therefore competent therapists strive to be time-effective both in session and over a course of treatment.
- Learning CBT well requires repetitions. If we apply the methods of CBT to ourselves routinely, thus providing ourselves with more practice, it will benefit our professional development as well as our personal well-being.
- Stay close to the twin priorities of teaching clients solid, durable self-help skills and boosting their morale and sense of hope.
- Hypothesis generation and testing are far preferable to self-assured dogmatism.
- Embrace the role of being an ever-learning student for your entire career.
- To gain the trust and collaboration of a client is a privilege not a right.
- To truly understand and empathize with clients, endeavor to see the world through their eyes.
- Words matter. They can hurt, and they can heal. Communicate with kindness and clarity.

Other writers have included such values as the importance of tolerating (indeed, embracing) ambiguity, rather than being disconcerted when real-life clinical practice does not imitate the textbooks, and looking at high affect in clients and oneself not as a distraction but as an opportunity for better understanding (see Friedberg, Gorman, & Beidel, 2009; Safran & Muran, 2001). Yes, supervisees need to have respect for the fundamentals of CBT practice, but they can benefit from discovering the art of "flexibility within fidelity" (Kendall, Gosch, Furr, & Sood, 2008; Newman, 2015).

TEACHING CBT METHODS

Discussing the care of ongoing clients provides fertile ground for the explication of any number of CBT practice methods. Although there are many excellent books on the topic of learning and utilizing CBT techniques that can be assigned to supervisees for homework (e.g., Beck, 2011;

Kuyken et al., 2009; Leahy, 2003; Ledley, Marx, & Heimberg, 2010; Newman, 2012; O'Donohue & Fisher, 2009), the supervisor is in an ideal position to assist the supervisee in learning, applying, and practicing CBT techniques. In other words, supervisors help instruct supervisees not only about what to do but also how to do it (Bennett-Levy, 2006; Friedberg et al., 2009), thus turning their supervisees' raw skills into refined skills (Newman, 2010).

Supervisors also play an important role in helping supervisees deal with typical obstacles in implementing techniques, such as how to assign homework and ask for feedback and yet end sessions on time, how to balance a directive approach with guided discovery, and how to respond when clients habitually say, "yes, but. . . ." As an illustration, the following dialogue shows a supervisor providing a recommendation about how the supervisee can improve the client's use of thought records.

Supervisor: I'm glad you made copies of your client's thought records so we could take a closer look at them. I notice that most of the client's comments under the "automatic thoughts" column are in the form of questions. For example, she writes, "Why is this happening to me?" and "What if I never figure out how to cope with my anxiety?"

Trainee: I noticed that, too. It makes it a little tricky to come up with rational responses.

Supervisor: Here's a suggestion. Ask the client to answer her own questions. For example, what are her hypotheses about "why these things always happen" to her and about what is going to happen in the future in terms of her skills in coping with anxiety? We want to draw out her implicit answers to her questions because those are actually her automatic thoughts.

Trainee: My guess is that if we try to hypothesize answers to her questions, we'll find a lot of hopeless and self-reproachful thoughts, such as, "I'm so weak and damaged I'll never get better."

Supervisor: Good guess! And you can see how important it would be to start working on coming up with alternative responses to those sorts of thoughts.

Trainee: I think we'll get a lot more mileage out of identifying automatic thoughts this way. Next session, if my client asks a rhetorical question that sounds distressed, I'm going to nicely ask her to try to answer her own question and create her own hypotheses, and we'll take it from there.

Supervisor: While we're talking about thought records, let me mention another tip. Your client tends to think in "all or none" terms, and therefore it would be great practice for her to generate some rational responses even if she does not believe in them 100%. Can you think of a rationale you can give her for this approach?

Trainee: I guess I could tell her that it's good practice to consider viewpoints other than her more customary depressive and anxious thoughts, even if she doesn't buy into them all the way.

Supervisor: Exactly right. Rational responding doesn't require clients to completely relinquish what they believe in favor of completely adopting new ideas. This is CBT, not reprogramming! Good CBT just asks people to stretch and flex their thinking—like "cognitive yoga"—to consider new ideas that might work better for their mood and functioning.

Trainee: And that means being able to brainstorm, right?

Supervisor: Right. It's about getting them out of their cognitive habits—their tunnel vision. If your client can generate new ways of thinking, it will be helpful, even if she only believes the rational responses at a low level at first, such as 20%.

Trainee: I can see how that will give her evidence against her idea that you either believe something or not, with nothing in between. This strategy will encourage her to write down some rational responses that she might have previously rejected because she didn't totally buy them.

Supervision: So, in the next session, ask the client to answer her own rhetorical questions to get at the actual automatic thoughts that are statements, and then ask her to brainstorm some rational responses along with listing the respective percentages that she believes them.

The didactic part of being a clinical supervisor entails not only teaching supervisees about how to implement the core methods of CBT but also giving general instructions that will help the supervisees to stay on task and be effective clinicians in general. The following is a nonexhaustive sample list of 10 of such nuggets that good CBT supervisors may impart to their trainees. Note that these comments may pertain to CBT in particular but may just as easily reflect best practices regardless of theoretical model.

1. "The sessions you conduct will automatically be better organized and more instructive to the clients if you have good 'bookends.' In other words, start and end your sessions in a strong way, which means that you orient your client to be ready to get to work at the top of the hour, and you summarize the work you have done at the end of the hour so as to maximize what the client takes from the session. For example, if we take a lesson from the Cognitive Therapy Rating Scale (Young & Beck, 1980), a strong opening means that you check on the client's mood, set an agenda, and inquire about the previous homework assignment. A strong finish means that you provide the client with a summary statement about the session, ask the client for feedback about the session, and collaboratively devise a new or continued homework assignment. If you can get into the positive habit of providing these sturdy bookends to your sessions, it will make the entire therapy session more time-effective, relevant, and memorable. Similarly, it is helpful to have strong bookends for the entire course of therapy. A strong first session introduces clients to the treatment model and illustrates how it is relevant to their concerns, shows them that you are a credible professional who is well-equipped and motivated to help them, boosts their sense of hope, and immediately presents them with some early skills and homework. A strong concluding session summarizes your work together, reinforces a maintenance plan, and promotes a sense of camaraderie in which you and your clients contemplate your positive connection and a job well done."
2. "As you begin to use your CBT conceptualization and intervention methods, you may find that it's difficult to relax and just be yourself. After all, when you're working so hard on method it's not so easy to

focus on manner. But don't worry because the more you practice, the more you will find that you can weave your best personal qualities into the interventions so that the therapeutic relationship is strong and you can feel more natural in doing your work. Don't feel that you have to subjugate your personality to the model. I'm confident that you will find that you can succeed in combining best practices in CBT with the best of your personal style. The result will be that you will enjoy the work more, and your clients will benefit greatly."

3. "Clients vary in how much they are willing to engage in the homework assignments. When they are not so keen to do the homework, don't give up. In other words, don't let the clients' lack of positive response extinguish your appropriate homework-giving behavior! Instead, hypothesize what might be getting in the way. Ask the client for feedback. Consider the possibility that the assignment needs to be more specific to the needs of a particular client or that you can do more to explain the assignment and demonstrate how it's done. Maybe the client harbors some negative beliefs about homework, owing to such factors as low confidence, mistrust, sensitivity to interpersonal control, or other issues. Maybe clients will be more willing to take charge and give themselves an assignment if you give them the chance to do so. In other words, make the process more collaborative. In any event, nicely and consistently show clients that you want to give them every opportunity to succeed in therapy, and doing homework has been shown to be one of the key ingredients in what makes CBT work. You can tell clients that they can still benefit from CBT even if they don't do the homework, but add that you want to increase their chances even more, and that's why you're willing to keep giving assignments, in the hope that they will come around at some point and thus will benefit more. Don't let it be a power struggle. Homework should be more of a benevolent offering."
4. "When you give your clients a homework assignment, feel free to announce to them that you are giving yourself a corresponding homework assignment. For example, your homework could be reading the remainder of their journal writings that you didn't have time to discuss

in the session, or it could be reading part of the same self-help book that you are asking them to read, or taking their advice to read or view something that will teach you something about their culture, or any other appropriate assignment that shows that you are willing to practice what you preach. Obviously you don't have to do this every session, and with every client because that might be unwieldy. Nonetheless, for those times when you overtly give yourself an assignment, it can be a nice finishing touch to a session, like a demonstration of solidarity with the client."

5. "We have to remember that we as clinicians are not the final judges about what makes sense and what doesn't make sense in the lives of our clients. If we endeavor to 'walk a mile in their shoes,' then there will be times when we can understand why clients do or believe things that look 'irrational' to the naked eye. To be accurately empathic, and to maximize collaboration, we as clinicians need to look for the 'function in the dysfunction and the logic in the illogic.' By doing so, clients will be more apt to believe we 'get it,' and they may feel more accepted and may become willing to consider making changes."
6. "I know you're trying to be vigilant about the client's negative thoughts and trying to effect change—and I applaud the fact that you are working so hard—but it may be better if you reduce the frequency and the vehemence of your attempts to get the client to engage in rational responding. First of all, it's more efficient and it creates a better flow of therapeutic dialogue if you listen and collect examples of the client's thinking style. Second, by having patience and occasionally summarizing, not only will you be more relaxed but there also will be less risk that the clients will feel like you're micromanaging their thoughts. Third, bear in mind that not all of your interventions will 'take' on the spot. Sometimes the best you can do is to 'plant seeds'—you know, by providing a few key reframes of what the clients are thinking—and then see if some of those seeds sprout over the coming weeks. I used to be overzealous with some clients early in my career, totally with good intentions, just like you. It was as if I had the dysfunctional belief, 'Nobody leaves this office until their cognitions are changed!' We don't have to have that belief."

7. "Take the time to learn the finer details of your clients' lives. Learn the names of the significant people in their lives and their most important dates on the calendar, such as birthdays and happy and sad anniversaries. Remember where they went to school, what they do for a living, where they have lived, and other details that will help you to know them as individuals. If you invest the time to gather these sorts of facts, you will be able to allude to them from time to time in the course of your therapeutic dialogue, and this will solidify the therapeutic relationship. Your clients will see that you know them as individuals and not just as a name on your schedule."
8. "Go the extra mile to write good clinical notes for each therapy session, and please do this promptly while things are still fresh in your mind. Then, before the next session, review the notes you wrote from the previous session so that you are optimally oriented to the issues on which you and your client are working. This will help you feel better prepared and more organized, and it will greatly help you to set a relevant agenda. In addition, you will be serving as a role model for the client. After all, if you can remember the details of a given client's therapy session from last week, the client likely will see the merits in remembering what happened in his or her own previous sessions."
9. "Good therapy is a mutual education process. You are the expert in CBT, but your clients are the experts on what it feels like to be them. Exchange information. Sometimes clients will be more willing to accept your assessment comments and proposed interventions if you have been willing to let them educate you first. By the way, this is not only a beneficial stance to take in treating a given client, but it is also true with regard to your professional development. Clients have a lot to teach us about all sorts of things. For example, they may have gone through life-cycle events you have not yet reached but that you could benefit from understanding a bit better. Similarly, your clients can teach you a great deal about their culture. Be receptive to being a student, even with your clients."
10. "If you have diligently, earnestly applied a CBT case conceptualization and its corresponding treatment approach to a given client, but

the client is not improving, don't despair and don't assume that you are being ineffective or that your client is just being 'difficult.' Consider the possibility that the case may be more complex than you first thought. Maybe the diagnosis needs to be revisited. Maybe there is something going on in the client's personal life outside the clinic that is interfering with treatment. Maybe there is a medical condition that needs to be considered. In other words, ask yourself, 'What data are we missing? Is there important clinical information that the client has not yet disclosed for some reason?' Please bear in mind how difficult it must be to reveal things such as suicidal feelings, or to talk about a trauma history, or to come out as a sexual minority, or to disclose an addiction. Then think about how you can create an environment in which it will be safe enough for clients to explore such weighty subjects if they haven't done so thus far. But don't give up on clients or yourself just because progress is slow to occur."

Another important skill that the CBT supervisor would do well to assess is the supervisee's facility in answering a new client's questions about CBT. This is an anticipated interaction that can be role-played in supervision so that the supervisor can gauge how clearly the supervisee can explain the cognitive–behavioral model of treatment. Related to this psychoeducational skill is the supervisee's ability to address the client's concerns or questions about the official diagnosis (if one has been proffered).

As noted, supervisors offer their supervisees didactic information about CBT and opportunities to practice the skills that emanate from such information. Therapists do the same for their clients. In terms of supplemental didactics, supervisors and their supervisees can discuss which CBT self-help books (or other relevant psychological literature for the informed layperson) can be recommended to which clients. Well-known CBT books such as *Mind Over Mood* (Greenberger & Padesky, 2015) and *The Feeling Good Handbook* (Burns, 1999) are widely read by clients as "take-home guides" that accompany their treatment, and many CBT therapists-in-training are familiar with these seminal manuals. However, there are any number of other high-quality CBT-related books on a wide

range of topics (e.g., on overcoming problems associated with the full range of diagnostic areas, utilizing mindfulness, coping with life stressors, helping loved ones) that may be assigned to clients, and supervisors are in a good position to endorse their use. In addition, there are important texts that are not specific to CBT per se that are nonetheless potentially helpful to clients, including such classics as Victor Frankl's (1959) *Man's Search for Meaning* and Kay Redfield Jamison's (1995) *An Unquiet Mind.* Supervisors who are personally familiar with such writings may instruct their supervisees to read one or more of these publications, both for general professional growth and to be better informed about their potential usefulness as homework assignments for their clients. An important point about assigning readings is that it is advisable for the therapists and/or their supervisors to have first-hand familiarity with the material before asking clients to read it.

There are other characteristics of effectiveness as a therapist that are somewhat difficult to quantify but that we hypothesize may enhance the delivery and impact of therapy. Although not routinely mentioned in therapy manuals, these characteristics are ripe for discussion and modeling in supervision. Such qualities have been described by some authors as "meta-competencies" (see Corrie & Lane, 2015; Newman, 2012; Roth & Pilling, 2007), and they include (but are not limited to): (a) clarity of communication style; (b) good sense of timing in delivering interventions (e.g., being fully prepared to discuss a highly sensitive and heretofore sidestepped topic the moment the client alludes to it); (c) excellent memory for the details of clients' lives, their case conceptualizations, and the contents of previous sessions; (d) a wide range of verbal repertoire, tone of voice, and empathic nonverbals; (e) appropriate use of humor (in which the client and therapist laugh together, lighten the mood, and bond a bit more); (f) facility in being well organized so that clients are tended to (and corresponding documentation and consultation managed) in a thorough and prompt manner; and (g) the resiliency to impart an air of hopefulness, encouragement, and steadfast commitment to help, even when clients are entrenched in hopelessness and helplessness. These are the sorts of qualities that help make therapy more memorable and inspirational for clients, thus facilitating the clients' retention and maintenance

of important therapeutic principles and their motivation to participate more fully in the process of treatment. Such meta-competencies begin with the supervisor.

SETTING EXPECTATIONS FOR SUPERVISION

Supervisees benefit from learning early on what is expected of them and what they can expect from their supervisors. From a practical standpoint, supervisees should be given at least a rough estimate of the number of clients they will need to treat, over what time frame, in what format of supervision (e.g., individual and/or group), with how many supervisors, and using which methods of documentation (e.g., written vs. electronic), among other topics. Supervisors have a choice about how collaborative they wish to be in establishing expectations about supervision. In some settings, the institutional rules and culture may require supervisors to impose set parameters of supervision. If the environment is more flexible, supervisors can initiate a collaborative conversation with supervisees about the sorts of expectations that may be most appropriate. This discussion may be in the form of a "needs assessment" (Corrie & Lane, 2015; Milne, 2009), in which supervisors ask the supervisees directly about their perceived strengths and weaknesses, their previous training experiences, their sense of self-efficacy in and familiarity with certain types of clients and clinical problems, and their opinions about what they need to work on the most to become more competent overall. As such, a needs assessment may allow for supervisors to tailor a course of clinical training to the specific needs of each supervisee. At the same time, the supervisees will be aware of what they have to work on to grow as professionals. This sort of clarity is good for the entire supervision enterprise.

Likewise, supervisees benefit from knowing what they can expect from their supervisors: for example, how often will they meet (once per week?) and how long will each meeting last (a "50-minute hour?"). If the supervisor is unavailable for any reason, will he or she provide a backup or on-call supervisor for the trainee? Under what conditions should the trainee consult with the supervisor between formal, scheduled supervision

sessions? Should such extrasupervisory contacts occur only in a clinically critical situation, or are routine questions okay? Under what conditions will the supervisor directly meet with the supervisee's client(s)? For example, will the supervisor meet with the supervisee's client(s) as a matter of routine, or will this happen only in crisis situations? How often will the supervisor provide formal, summative feedback? Indeed, setting expectations in supervision goes both ways.

These expectations can be spelled out in the form of a supervisory contract. Exhibit 1.1 demonstrates a section of a sample contract, which includes the supervisee's required activities, the types of competencies the supervisee is aiming to acquire, and the responsibilities of the supervisor. As such, it is a document that is congruent with a collaborative professional relationship (Thomas, 2007).

EVALUATION OF THE SUPERVISEE

Supervisors necessarily keep track of the progress of the clients being seen in treatment by their supervisees because their well-being is of paramount importance. At the same time, supervisors actively keep tabs on the progress of their supervisees in learning the foundational and functional competencies of delivering CBT. Supervisors evaluate their supervisees regularly during the course of their work together by giving routine feedback, also known as *formative* evaluation. This can be done at every supervisory session by commenting on various aspects of the trainees' management of their cases, including their handling of the therapeutic relationship; their case conceptualizations; treatment plans; level of proficiency in the use of specific techniques and homework assignments; clarity, accuracy, and thoroughness of their session notes; degree of professionalism in their behaviors and attitudes; demonstrations of thoughtful self-reflection; and responsiveness to supervisory feedback itself. This is quite a substantial list of factors about which to be aware and on which to comment. Although it would be easy to give short shrift to this part of the supervisor's job, perhaps to focus solely on how the clients are progressing in treatment, there is evidence that the quality of supervision is significantly improved when supervisors make it a point to provide their

Exhibit 1.1

Sample "Supervisory Contract" Document Items

I agree to . . .

1. Maintain a caseload of "n" clients for a period of approximately 12 months.
2. Write all therapy notes and reports promptly, and maintain them in an organized fashion in the client's chart so they may be cosigned by the supervisor.
3. Protect my clients' confidential information by keeping the charts in a secure place, using disguised information in case conferences, refraining from discussing cases outside of the training sessions, and using password protection or encryption when sending digital transmissions of client data (e.g., session recordings).

I will learn to . . .

1. Create written cognitive–behavioral conceptualizations for each case.
2. Structure sessions for good time management and good organization of material.
3. Utilize a range of cognitive–behavioral interventions and homework assignments.
4. Foster and maintain healthy, appropriate therapeutic relationships with clients.
5. Learn to use self-reflection to assist my work.

I can expect that my supervisor will . . .

1. Give me constructive feedback in supervision.
2. Listen to at least four full-length recordings of my therapy sessions over the course of 12 months and provide me with ratings on the Cognitive Therapy Rating Scale (CTRS).
3. Provide me with four formal summaries of my progress as a cognitive–behavioral therapist over the course of 12 months.
4. Take professional, ethical, and legal responsibility for the welfare of the clients.

trainees with ongoing feedback both positive and reflective of areas for improvement (Milne, 2009; Milne, Sheikh, et al., 2011).

It is particularly useful if supervisors take the time and make the effort to observe actual work samples, such as audiovisual recordings of their trainees' session(s) with clients. Although this activity is often time intensive, it is the best way to assess the quality of the supervisees' actual in-session work. When time is limited, the supervisor may opt to watch only a segment of a supervisee's session, perhaps to give feedback or suggestions on a discrete issue as it occurred. On the other hand, if the supervisor intends to do a formal rating of the supervisee's adherence to the CBT model and/or competence in delivering the treatment, it is necessary to observe the entire session. As noted, competent supervisors must create an atmosphere of support so that the supervisees will be more likely to submit their recordings with a minimum of trepidation and with the positive expectation that they will receive useful, constructive guidance. When the supervisees make the extra effort to create these recordings, the supervisors should review them as soon as possible both as a sign of respect for the work of the supervisee (and thus to positively reinforce it) and to provide timely clinical feedback.

In addition to providing routine, ongoing feedback, supervisors also periodically provide their supervisees with summative evaluations, which become a formal part of the supervisees' record in their training program. Official summative evaluations of trainees that are subpar may potentially have a negative impact on the trainee's future in the field and thus need to be written in such a way that the critique is constructive and spells out the supervisee's ongoing training needs in as hopeful and respectful a way as possible.

If routine feedback has been given properly, such that supervisees know where they stand at any given time, the summative evaluations will be a natural extension of the process, and the supervisees are likely to perceive congruence and fairness in their evaluations. Summative evaluations should not surprise or shock supervisees with unexpected critiques that have not been discussed previously (see Davis, 2008). Instead, corrective feedback should be given in such a way that the supervisees have ample opportunity to work on shoring up their weaknesses. Summative

evaluations ought to be based on a number of concrete factors, such as the timeliness and contents of the supervisees' clinical notes, the supervisees' punctuality and attendance in supervision and meeting with their clients, their case write-ups (e.g., formal case conceptualizations), their scores on measures of their in-session adherence to and competence in delivering CBT (e.g., on the Cognitive Therapy Rating Scale, Young & Beck, 1980; Blackburn et al., 2001), and the objectively measured progress of the clients (e.g., reduction in suicidal ideation and gestures, stable improvements on self-report inventories, corroborating indicators of improvement, such as reports from clients' family members and/or consulting professionals on the same case). Using a combination of such measures lends credibility to the supervisors' feedback, gives the supervisees a more accurate and objective way to assess their own progress in training, and overtly indicates areas in which the supervisees can strive to improve their work.

Whether the supervisors are providing formative or summative evaluations, it is important that they do not fall prey to what has been dubbed in the literature as "the tyranny of niceness" (Fleming, Gone, Diver, & Fowler, 2007), whereby supervisors fear being anything other than supportive of their supervisees and thus avoid giving them the sort of direct, constructively critical feedback that may be essential to their professional development. We agree that it is vitally important for the supervisors to promote a positive, hopeful atmosphere in supervision in which the trainee can flourish, but we also believe that a measure of supervisors' competence is their ability to be supportive of and invested in the supervisees' progress as clinicians even as they are pointing out areas that need further work. In doing so, supervisors serve as role models for their supervisees, who themselves undoubtedly will need to balance genuine support with corrective feedback in their work with clients. Giving supervisees constructive feedback also helps ensure the proper treatment of the clients, which is the top priority.

In contrast to the tyranny-of-niceness phenomenon is the problem of supervisors who take a "no news is good news" approach in providing feedback. Such an approach can give supervisees the mistaken impression that they are underperforming, when in fact the supervisor is silently thinking that much of the work is "obviously" going well. A lack of feedback is often

cited by therapists-in-training as an example of a poor supervisory experience (Phelps, 2011). Indeed, the supervisor's failure to provide supervisees with adequate performance evaluations is a surprisingly frequent ethical violation (see Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999).

It can also be useful to give supervisees the opportunity to evaluate their supervisors in return given that supervisors potentially have much to learn about how their trainees are perceiving and receiving their work in supervision. Such feedback can help supervisors to make adjustments in their approaches and help administrators who are in charge of an organization's supervision infrastructure, policies, and assignments to address any problems in their program of supervision. However, we must remember that supervisees are in a vulnerable position when it comes to giving potentially critical feedback to their supervisors because they may fear retaliation, with implications for their standing in a training program. Thus, it is best if such feedback can be given anonymously. Clearly, this has to be handled carefully as many training programs are sufficiently small that it would be fairly easy to surmise which supervisee wrote what about whom. A less formal method of eliciting feedback from supervisees can take place as a routine occurrence in each supervision session, simply as a way to "check in" and see how the meeting went that day. This procedure can be viewed as part of the structure of a supervision session, analogous to the therapist's asking for feedback from clients in each therapy session. The supervisor's friendly and inviting demeanor can reassure the trainee that the purpose of such feedback is to improve the supervisory experience. A running theme throughout this text is that supervisors have authority and power, but they must use this authority and power wisely and benevolently. Nowhere is this more evident and important than in the area of providing and receiving evaluative feedback.