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ROUND TABLE CONFERENCE

What is good practice in supervision for behavioural and cognitive therapists?

One of the criteria for registration as Behavioural and Cognitive Psychotherapist in the BABCP is that a trained therapist makes their own arrangements for supervision for a minimum of 1 hour per month. We asked three practitioners what they thought would be good practice in supervision of behavioural and cognitive therapy.

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Supervision is becoming a sacred cow and I am not aware of any empirical evidence that experienced therapists under supervision obtain a better outcome than therapists who are not receiving supervision. Indeed there is very little in the literature on what good practice in supervision for behavioural and cognitive therapists consists of or what skills makes a good supervisor.

The tradition of "supervision" for trained therapists stems from psychodynamic therapy and counselling and has been embraced by cognitive therapists as they attempt to treat personality disorders. Behavioural psychotherapists have for years discussed difficult cases amongst themselves but this might be regarded as one level of supervision. Supervision is also different from audit in which a therapist's work or case notes may be under the scrutiny of a co-therapist. Most of this article is derived from a workshop run by Christine Padesky and Kathleen Mooney from the Centre for

Cognitive Therapy in Newport Beach, California where I had the opportunity to develop some of the skills in supervision for cognitive therapy.

Different types of supervision are recognized. Supervision can consist of discussion; role-play (of the therapist or of the patient); use of audiotapes or videotapes. For less experienced therapists it may consist of direct observation of the therapist or cotherapy with the patient. Preparation by the supervisee is essential and will make supervision as cost efficient as possible. The supervisee should formulate a specific consultation question and provide the relevant data to allow the supervisor to answer that question. The data will need to include a concise verbal or written summary of the patient's demographic data, presenting problems and goals, objective measures, diagnosis, case formulation, and the strategies that have or have not been successful. The consultation questions might be about:

1. Strategy

Strategy refers to the tasks being applied (eg exposure or reverse role play of healthy beliefs). Questions on strategy are common when the patient has reached an obstacle to their goal or the supervisee is less experienced.

2. Case formulation

A formulation is a description of the patient's core beliefs and behaviours that are hypothesised to drive the current problem. Supervision may consist of tightening up a case formulation or the strategy may fail.

3. Therapist focused supervision

Issues concerning the therapist's beliefs and behaviours may become the focus of supervision when they interfere with therapy.

The issue is more relevant in treating patients with severe personality disorders. Alternatively the therapist may be traumatised if dealing with patients in PTSD or childhood sexual abuse. Supervision is not therapy and there needs to be clear boundaries when the therapist's own beliefs, emotions and behaviours are under discussion.

The workshop provided me with a framework to conduct supervision in the future. I learnt that good supervision is a process akin to Socratic questioning in cognitive therapy. It consists of four main stages:

1. **Data collection.** The supervisor needs to discuss the agenda including the time required for supervision; clarify or prioritise the consultation questions; the type of supervision requested (eg discussion, role play); and collect further data required for him to answer the consultation question.
2. **Listening.** The supervisor must actively listen to what he thinks the supervisee is saying (or not saying) to clarify what the supervisee thinks the problem is.
3. **Summarising.** The supervisor should summarise the data or the case formulation to check whether both they both agree upon what the problem is.
4. **Synthesising or analysing the problem.** At the end the supervisor makes a hypothesis and asks how it might apply to the problem presented by the supervisee. If this leads to agreement then it may lead to a change in strategy in an experiment. Less experienced therapists may require a didactic teaching or references to literature.

A few centres will have the luxury of an experienced supervisor who can lead a group of therapists when a minimum of one hour a month needs to be spent on the therapist's own cases. Even experienced supervisors need to organize supervision of their own cases and I wonder how many consultant psychotherapists do this now? For therapists who are isolated geographically, then peer supervision over the telephone can be recommended. In this case, the supervisee needs to send an audiotape, a summary of the case and a formulation to the supervisor beforehand.

In summary good practice in supervision is hard to achieve and demands a high standard from both the supervisor and supervisee.

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The cognitive behavioural psychotherapies were developed as brief symptom-focused approaches applicable to a narrowly-defined range of disorders, eg phobias, obsessions and depression. The last decade, however, has witnessed a very rapid expansion in the range of Axis I disorders which can be treated cognitive-behaviourally (to include panic disorder, hypochondriasis, general anxiety disorder, post traumatic stress disorder, substance abuse, etc) and the application of these approaches to the whole range of Axis II personality disorders.

This ever-widening spectrum of treatable disorders poses major intellectual and technical challenges for cognitive therapists. This challenge is compounded by the existence of a substantial diversity of theoretical frameworks and technical procedures within the domain of Cognitive Behavioural Therapy (CBT) and further complicated by

an increasing number of integrationist approaches with dynamic and experiential models, eg Ryle's Cognitive Analytic Therapy (CAT) and Young's Schema Focused Therapy (SFT).

At this exciting, but also confusing, evolutionary stage of CBT the issue of good practice in supervision is both timely and problematic. Timely because the topic is relatively neglected at a practice and research level, and problematic because of the unaddressed logistic and training issues. This paper will briefly address five issues which the author considers central to good practice of supervision in CBT and in so doing hopefully highlight areas that need further work and discussion.

1. Regular Supervision

Given the clinical scenario outlined above there is a clear need for CBT therapists to have regular supervision for their work. No therapist, irrespective of level of experience, can or should expect to reach a level of knowledge and competence where further supervision is unnecessary. This view is recognised by organisations such as the British Association of Behavioural Cognitive Psychotherapists (BABCP) and the British Association of Rational Emotive Therapy (BARET) where a minimum standard of one hour supervision per month for all therapists is recommended.

This minimum criteria is undoubtedly a reflection of the limited availability of CBT supervisors rather than an indication of what is judged to be clinically necessary. From discussions with some of my cognitive behavioural colleagues a clear consensus emerges of an optimum of one hour supervision per week with one hour per fortnight is seen as an acceptable compromise. If the gap between what is seen as the minimum

necessary and the optimum in practice is to be narrowed we will undoubtedly need more CBT supervisors and more time for supervision in our work schedule than is currently seen as appropriate.

2. Sequential Focal Supervision

For the reasons outlined above, no single supervisor can be expected to be able to offer skills for supervision for all problems amenable to CBT and for all the spectrum of approaches available within CBT. Therapists should therefore expect to seek supervision sequentially from a range of supervisors to meet their changing needs. In this context it could seem crucial that therapist and supervisor agree from the outset, explicit focus and goals for the supervisory period, specifying the supervisory methods to be used and the methods for assessing progress towards achieving supervision goals. This would help keep supervision more focused, more collaborative and facilitate transition from one supervisor to another. This model of learning matches the CBT model of therapy and should therefore fit readily with both supervisor and trainee alike. The absence of such clear boundaries carries the risk of endless supervision with unnecessary therapist dependence and over-identification with the supervisor.

3. Supervision Format

Given the limited availability of supervisors in CBT and the increasing number of therapists training in and practising CBT, a range of supervisory formats will need to be utilised if the substantial needs for supervision are to be met even at a minimum level. One-to-one supervision is the most resource consuming option and, in the absence of any evidence of its superior

efficacy compared with small group supervision, should probably be the exception rather than the rule.

For experienced therapists, peer group supervision has a lot to recommend itself, for routine supervision. For novice therapists and experienced therapists working with particularly difficult patients, small group supervision with an appropriate senior supervisor would seem the preferable option. In settings where supervision is not available locally this may be obtained by telephone consultation or by sending audio tapes for supervision by mail. The former, as judged by the experience in the NIMH multi-centre study of depression, does not seem particularly effective. The latter, advocated by Dryden (1984) can be a very effective method of obtaining supervision.

4. Self-Supervision

Many therapists report considerable benefit from self-supervision. This supervision is typically of audio-taped sessions and can be enhanced by using one of the available therapy session supervisory scales, eg the modified Cognitive Therapy Scale, Freeman et al (1990), or the RET Supervision Form, Walen et al (1980). These scales provide clear operationalised guidelines for evaluating session structure, therapeutic relationship and therapeutic technique. The CTS has been widely utilised and modified most recently as a result of its use in the NIMH multi-centre study.

Self-supervision can be supplemented with patient feedback on the impact of therapy using brief questionnaires such as the "Client Report of therapy Session" form described in Freeman et al (1990). I have found this perspective extremely valuable in my self-supervision. In particular, the patient perspective often provides feedback on

therapists empathy and technical skillfulness - aspects which may, in my experience, not be reflected adequately in self-supervisory scales. Self-supervision is now, however, without its limitations, the most important of which is undoubtedly its limitation in picking up therapists blind spots.

5. Focus of Supervision

Supervision in CBT tends to be patient problem focused and technique orientated. While this focus seems adequate for simple problems, eg unipolar depression in an otherwise healthily functioning patient, as patient problems become more complex, eg panic disorder with co-morbid personality disorder, there is an increasing recognition of the need to broaden the focus of supervision to include the therapeutic relationship and the therapists personality style and personal blind-spots. Ellis (1985) for example has written a very useful paper on this subject "How to Deal with Your Most Difficult Client - You", and Freeman et al (1990) devote a section of their book to managing therapists blind-spots. Whether cognitive therapists working with difficult patients may benefit from personal therapy, rather than limited work on their blind-spots in supervision is an important issue and has been addressed in an earlier paper in this journal by Holmes (1994). One of the new Senior Registrar Training Schemes in Cognitive Therapy (South Trent) has, in recognition of this special problem in working with difficult patients, incorporated a personal therapy experience in CBT into its training programme.

Final Comments

While carrying out the background reading for this paper I became acutely aware of the dearth of material on supervision in CBT

at a descriptive and empirical level. As a consequence the views in this paper are derived largely from my own experience and the title of the paper carries the addendum - a personal view. Each of the supervision issues I have addressed undoubtedly requires further discussion and evaluation. A number of logistic and training issues would seem to require urgent attention. Firstly, the need for basic information on the level, type, location and availability of CBT supervisors in the UK. Secondly, information on the current supervisory experience, or lack of it, among CBT therapists. Finally, the need for a training programme for CBT supervisors.

All of these issues need to be addressed if a framework is to be developed that will provide milieu in which good practice in supervision in CBT can be achieved.

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In recent years there has been a vast effort to ensure that clinical standards are maintained, with the widespread introduction of audit. At the same time, particular concerns have been expressed about standards of psychotherapy, and the qualifications of some practitioners. In an effort to ensure uniform, high standards, establishment of national registration of psychotherapists has been commenced. Therapists registered through the BABCP have to show that they are receiving one hour of supervision per month.

It may be asked whether such supervision is necessary or useful for trained therapists. If the aims of such supervision are examined, then the benefits become clear.

1. To identify, and help the therapist to correct, any deficiencies in training.

There have been up to now, no national requirements for training in behavioural-cognitive psychotherapy (BCP). Recently the Royal College of Psychiatrists' Guidelines for psychotherapy training for general professional psychiatric training have included a mandatory requirement for trainees to have seen two cases. However BCP training is still difficult to obtain, and existing therapists have very different experiences eg. attendance at training courses, supervision from colleagues, and there may be gaps in both theoretical knowledge and practical skills. Supervision of the trained therapist should remedy any

inefficiencies by recommending reading and rehearsal of practical techniques.

2. To ensure that quality of BCP is maintained.

Supervision must aim to ensure that BCP delivered by trained therapists is of an adequate standard. An increasing number of controlled studies exist which indicate the clinical outcomes which can be obtained with good quality BCP, in a number of disorders. Measures of clinical outcome must be examined to ensure that expected improvements are achieved. Once trained, it is not uncommon for therapists to start to cut corners, particularly if there are many other demands on their time. Supervision should help to prevent therapists from skipping steps which are found irksome, such as measurement, and from repeating errors in techniques which "dilute" the effectiveness of therapy, leading to dissatisfied patients and unnecessary disillusion for therapists. Supervision should also help the therapist to utilise and if necessary develop new clinical strategies to overcome practical difficulties in treatment. These methods can help to ensure that satisfactory treatment is delivered to patients.

3. To stimulate interest in and use of new developments in BCP.

If supervision can achieve these aims, there can be no doubt that it should be welcomed, but providing such supervision is not an easy task. There may well be practical difficulties to overcome, such as finding a supervisor with adequate experience and skills. It may be even more difficult to find a supervisor with sufficient time, and it may be that supervision has to be carried out in groups. This inevitably means that detailed analysis of only a few cases from

each therapist's workload will be possible. However, the exchange of ideas and experience within a group of trained therapists may help to compensate for any disadvantages. One hour per month might be adequate for supervision of an individual therapist, but if supervision is in a group, then an hour per week will be more appropriate. The cost of supervision may present difficulties and reciprocal arrangements between hospitals may be a solution. The supervisor may have to help the newly trained therapist to adapt to changes in their working practice, such as protecting time for BCP, and starting to supervise trainees.

With limits to supervision time, then its content must be carefully planned. It would be possible to restrict supervision to the examination of the case-notes of each patient, looking at the number of sessions used and the measures of outcome, but while this may be of some value, supervision should be more than this type of audit. To adequately ensure that quality of BCP is maintained, then practical techniques must be directly examined. Each therapist must have an audio or video recording facility in everyday use and should bring recordings to supervision. The nature of any difficulties, and their solutions, will be much clearer to both therapist and supervisor if the appropriate therapy session is directly observed. However, the therapist should not always choose the cases which are supervised. It is valuable from time to time for the supervisor to replay tapes of routine treatment to review the choice of techniques and their quality. Completion of an agreed list of competency checks should be carried out, and feedback given. Therapist and supervisor should be able to work collaboratively on solutions to difficulties. Use of role-play will be necessary, as will the ability to

improvise, especially if the therapist is dealing with difficult cases. Recent advances in BCP should be critically reviewed and incorporated into regular clinical practice, if appropriate. If a therapist experiences problems within the therapeutic relationship with a patient, then supervision can examine the cognitions and behaviours involved, so that solutions may be found.

All concerned should be aware that supervision of the trained therapist is not the same as supervision of trainees. One of the most important differences is the style of supervision for therapists, which should be much more collaborative. Attitudes to supervision are crucial, and it will take considerable effort to establish a good relationship between therapist and supervisor. The therapist must be prepared to listen to and act upon the supervisor's advice, while the supervisor should in turn recognise that some therapists may find scrutiny of their work even more threatening than do trainees. Both should be aware of behaviours which indicate problems, such as avoidance of sessions or producing tapes, or a hostile response to constructive criticism. The therapist and supervisor should then examine their cognitions about the supervision and appropriate changes can be made.

If the supervisor is sensitive to the strengths and weaknesses of the therapist, and the therapist regards supervision as a positive opportunity to improve their practice, then supervision can be rewarding and worthwhile and is to be recommended.

If you have a particular question about the theory or practice of behavioural cognitive therapy which you would like to see discussed in this way please write to :

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