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Introduction and Overview of Evidence-Based CBT Supervision

What a State We're in

We are not the first to be concerned by the gap that exists between the vital role of supervision in professional practice and the means by which clinical supervisors are prepared and developed. The phrase “something does not compute” sums it up succinctly (Watkins, 1997, p. 604). Although Watkins was referring to the neglect of supervisor training, his phrase applies just as well to the way that many advocates of CBT supervision have neglected evidence, failing to create an evidence-based approach to their supervision practice, despite the impressive commitment to evidence in therapy (Milne, 2009; Reiser, 2014). We recognize this is a timely moment to bridge that gap, in recognition of the increasing international status of clinical supervision (Watkins & Milne, 2014). This manual makes things compute by providing both a wealth of research-based evidence, which will improve CBT supervisors’ training, and robust support for supervisors in their everyday supervision practice.

Now You're Talking!

The gap becomes even more apparent when one considers the value of supervision, which is rightly regarded as the signature method of training in the mental health professions (Bernard & Goodyear, 2014). Our interventions are called talking therapies, but CBT places special emphasis on taking the correct action (Waller, 2009). This principle applies equally well to CBT supervision in that the role of experiential learning, which involves repeated cycles of reflection, experiencing, conceptualizing, planning, and experimenting, is viewed as the primary mechanism of development (Reiser, 2014). Our preferred summary of experiential learning is provided by Kolb (1984), who noted that humans are primarily adapted for learning: we are effectively “the learning species.” It follows that “learning is an increasing preoccupation for everyone ... and an increasing occupation” (pp. 1–2). This underscores the importance of action and helps us understand why clinical supervision is such a marvelous and quintessentially human activity. Not only is it deeply satisfying, it is also highly effective. Although research on clinical supervision – CBT supervision in particular – has been sparse and of variable quality, there is reason to believe it is the single most effective method for helping supervisees (therapists) to develop the competence, capability, and professional identity

they need (Falender & Shafranske, 2004; Callahan et al., 2009; Milne & Watkins, 2014). Supervision is also perceived by supervisees as the main influence on their practice (Lucock, Hall & Noble, 2006), and is currently recognized by governments as an essential component of mental health services. In the United Kingdom the Care Quality Commission (2013, p. 6) states that “clinical supervision is considered to be an essential part of good professional practice,” and a clear example of the UK government’s investment in supervision can be found in the Improving Access to Psychological Therapies program (IAPT: Department of Health, 2008). In addition, supervision has strengthened its status internationally in recent years (Watkins & Milne, 2014), and CBT supervision has developed significantly (Reiser, 2014). Therefore, this is a timely moment to attempt to tackle the long-standing gaps and build a bridge for CBT supervision as a professional specialization (Milne, 2008).

Getting Our Act Together

How, then, can we bridge the gap between how training and supervision are conducted and the evidence base, so that we better realize the great potential of CBT supervision? Consistent with the IAPT approach, Dorsey and colleagues (2013) claim that the gold standard for supervision in clinical trials is:

- Assessing the fidelity of therapy
- Developing competence through behavioral rehearsal
- Reviewing therapy through direct observation (usually audiovisual recordings)
- Monitoring clinical outcomes

Training CBT supervisors in these methods, and supporting them so that they maintain the standards and continue to develop expertise, are as challenging as supervising therapy, but have been afforded far less interest and attention (Although we refer throughout this manual to therapy, we recognize that supervision should embrace all professional activities). Even less is known about supervisor training than supervision itself and the gaps in our knowledge base are even wider when it comes to organizational support for supervisors (see chapter 9). Although Watkin’s (1997) concern that something does not compute has been eased by what he regards as a sea change in supervisor training, his review concludes that we are still in the formative stage and know little about structuring, timing, covering, delivering, or evaluating supervision training (Watkins & Wang, 2014). Milne and colleagues (2011) reached a more optimistic conclusion, based on their systematic review of 11 controlled evaluations of supervisor training, which they believed provided enough empirical support to recommend the following training methods:

- Role-playing and use of simulations
- Observational learning (competence modeled live, or by a video recording)
- Corrective feedback, ideally based on direct observation
- Teaching (verbal instruction, discussion, and guided reading)
- Written assignments (e.g., learning exercises, quizzes, and homework)

Note how similar these methods are to the gold standards for supervision itself, not to mention CBT. This suggests a fundamental role for experiential learning (Kolb, 1984) in mental health interventions (see chapter 4). This manual reflects this status and draws attention to relevant commonalities.

How Can We Act Together?

Inspired by the potential of CBT supervision to improve competence in supervisees through experiential learning, this manual addresses the gaps in supervisor training and evidence-based supervisory practice. Our approach has been to develop an accessible, state-of-the-art product, designed to enhance supervisory training in CBT in a way that is consistent with evidence-based practice, including relevant competence frameworks. This manual, together with associated internet content (e.g., video demonstrations of competent practice), has been developed in six user-friendly modules, reflecting the popular and logical training cycle, starting with goals and ending with evaluation. Each module includes a guideline, condensing the essential information found in the chapters. We also tested the guidelines and other materials at supervisors' workshops, paying close attention to feedback and retaining only the material rated as clear and accurate. To ensure that the manual was state-of-the-art we reviewed the latest ideas from the best available supervision manuals and guidelines (Milne, 2016). We also studied the wider literature for evidence, such as controlled studies and systematic reviews of staff training (see chapter 3). Finally, we learned important lessons about effective dissemination and uptake through experiences with a prior manual that showed promise (Milne, 2010; Milne & Dunkerley, 2010). It is for these reasons that we are confident that our current effort will further enhance supervisors' training.

Our project is ambitious in at least two ways: it addresses the shortage of suitable training resources and fosters successful dissemination. When we surveyed the current supervisor training manuals we found that most were restricted to academic discussions of supervision, but provided minimal interactive content, limited internet-based connectivity, and, with very few exceptions (Milne, 2009; Sudak et al., 2016), had minimal enactive, DVD-supported content. While these manuals are excellent for restricted, classroom-based teaching or as a reading assignment, they are neither user-friendly nor accessible across disciplines and countries, and none appeared to be easily adaptable to the highly enriched, complex experiential and procedural learning required for the effective training of clinical supervisors. This last shortcoming seemed especially egregious, as experiential learning lies at the heart of our method in CBT therapy and supervision. In short, most manuals offer limited practical support and do little to advance supervision in practice.

We have addressed dissemination by studying what works and then incorporating useful lessons (Milne, 2016). In particular, we sought to work closely with the British Association for Behavioural Psychotherapy (BABCP) through a working party which guided us toward the most accessible and appealing approaches for this manual. As we have noted, we also piloted and evaluated some sections of this manual with CBT supervisors and trainers (see Table 1.1), and conducted a survey of senior CBT supervisors in the UK in order to assess training needs (Reiser & Milne, 2016). The survey indicated that only one third of respondents were satisfied with the resources available to them for supervisor training.

Is This Manual For You?

This manual has been written primarily for workshop leaders who train CBT supervisors. However, supervisors and those who support and guide trainers and supervisors (e.g., consultants, managers, administrators, training directors), working in clinical

Table 1.1 The rating scale used to evaluate the six guidelines during supervision workshops.

Guideline Evaluation Form

Please take a few minutes to give your opinion of the guideline that you have just read. When rating, remember that the guideline is intended for *new CBT supervisors*. We are interested in knowing whether it is ready for use, or ways to improve it. If you prefer, feel free to write comments on the guideline itself.

Name of the guideline: _____ Today's date: _____

Rating Scale: 1 = Not yet acceptable 2 = Acceptable 3 = Good

| | | | | |
|---|---|---|---|---|
| 1 | Was the guideline easy to read? (Concise; user-friendly; expressed simply; right level of detail). | 1 | 2 | 3 |
| 2 | Did the content seem factually accurate? (e.g., was the information comprehensive?) | 1 | 2 | 3 |
| 3 | Was the guideline acceptable? (Expressed appropriately; relevant; "face-valid") | 1 | 2 | 3 |
| 4 | Is the information credible? (Current and relevant? Reflect other practice guidelines?). | 1 | 2 | 3 |
| 5 | Does the guideline enable competence in supervisors? (Are there practical suggestions or helpful ideas?) | 1 | 2 | 3 |

Comments
Please add any notes to clarify the ratings that you have made above, or to offer suggestions for improving the guideline:

.....
.....

mental health services will also find it useful, as we have included suggestions and materials (e.g., slideshows and learning exercises) for trainers in addition to guidelines and video clips which supervisors and others can use independently (including supervisees). Thus, we offer guidance and resources to trainers, but also provide directed self-instruction for supervisors. For those who support supervisors, chapter 9 is devoted to what we know about restorative and normative CBT supervision. Further information on our systemic and organizational emphasis is set out below.

In addition to a focus on workshops and those who lead them as part of introductory and subsequent training in CBT supervision, the manual is designed to support and enhance multiple training functions, including:

- Providing training to individual supervisors in a continuing education/professional development workshop format
- The initial credentialing and certification of supervisors
- Assisting in a "train the trainers" approach suitable for agency or organization-based training of supervisors
- Providing supplementary materials and an interactive website for the continuing coaching/training of supervisors and supervisees

Our emphasis is multidisciplinary and systemic, and recognizes that supervision requires a nurturing environment if it is to flourish. In reviewing the literature (Milne & Reiser, 2016) we developed a "support our supervisors" (SOS) framework to clarify the kind of organizational support required for supervision to flourish. This describes an evidence-based and systematic organizational process to ensure that supervisors receive

the leadership, support, and development to perform their role effectively and with job satisfaction. The SOS framework differs from informal, traditional, or organizationally flawed arrangements (e.g., peer supervision) in that it positions supervision within a normative, formative, and restorative infrastructure. These functions are achieved by evidence-based methods, such as drawing on competence frameworks, undertaking gold standard training in supervision, and receiving supervision-of-supervision (or consultancy). Figure 1.1 presents our model.

The main components of the SOS model for present purposes are the inner supervision cycle, designed to develop supervisors' expertise, and the outer cycle, indicating how organizations influence supervision through such means as effective leadership and supervisor training. Note that the examples describe an organization's supportive function (e.g., peer support groups and work satisfaction surveys), which help supervisors "feel that they are supported, accepted, nurtured, acknowledged and validated" (Milne, 2009, p. 185). Therefore, the SOS model acknowledges the need for normative, formative, and restorative functions to be performed by supervisors' organizations, as these are the essential conditions for a systematic support infrastructure. In this sense, the manual is relevant for service managers, occupational health advisors, and others with an interest in creating a healthy workplace. This broader systematic approach is consistent with our collaborative, empirical stance in the development of materials for the manual. In fact, in order to make things compute, our focus throughout has been oriented toward developing systematic organizational support for the training and development of supervisors. Our position is inclusive: as far as reasonable, we want the manual to be helpful to everyone, not just the workshop leader or supervisor; and we provide information and make suggestions that are as relevant as possible to all those involved.

Will it Work?

We have noted that this manual is evidence-based, that is to say it is based on research findings, expert consensus, and theory, which support the effectiveness of the methods we recommend. This includes evidence from an earlier manual (Milne, 2010), the feedback of CBT supervisors and trainers who read parts of the present manual (see, e.g., Table 1.1), and corroboration from the CBT staff training literature (e.g., Beidas & Kendall, 2010; Rakovshik & McManus, 2010). So, we have good reason to believe that this manual will work. But consistent with the CBT model of collaborative empiricism, we urge continued evaluation of our manual, our methods, and our procedures. We would be delighted to collaborate with those who would like to undertake such an evaluation, and have previously piloted a suitable approach (Culloty, Milne & Sheikh, 2010).

Watch Your Language!

It seems that, like the NHS, the CBT community remains comfortable with the term "patient," so we will use it interchangeably with the equally acceptable term of "client." In mental health services these patients are seen by therapists who are also supervisees,

SOS Cycle

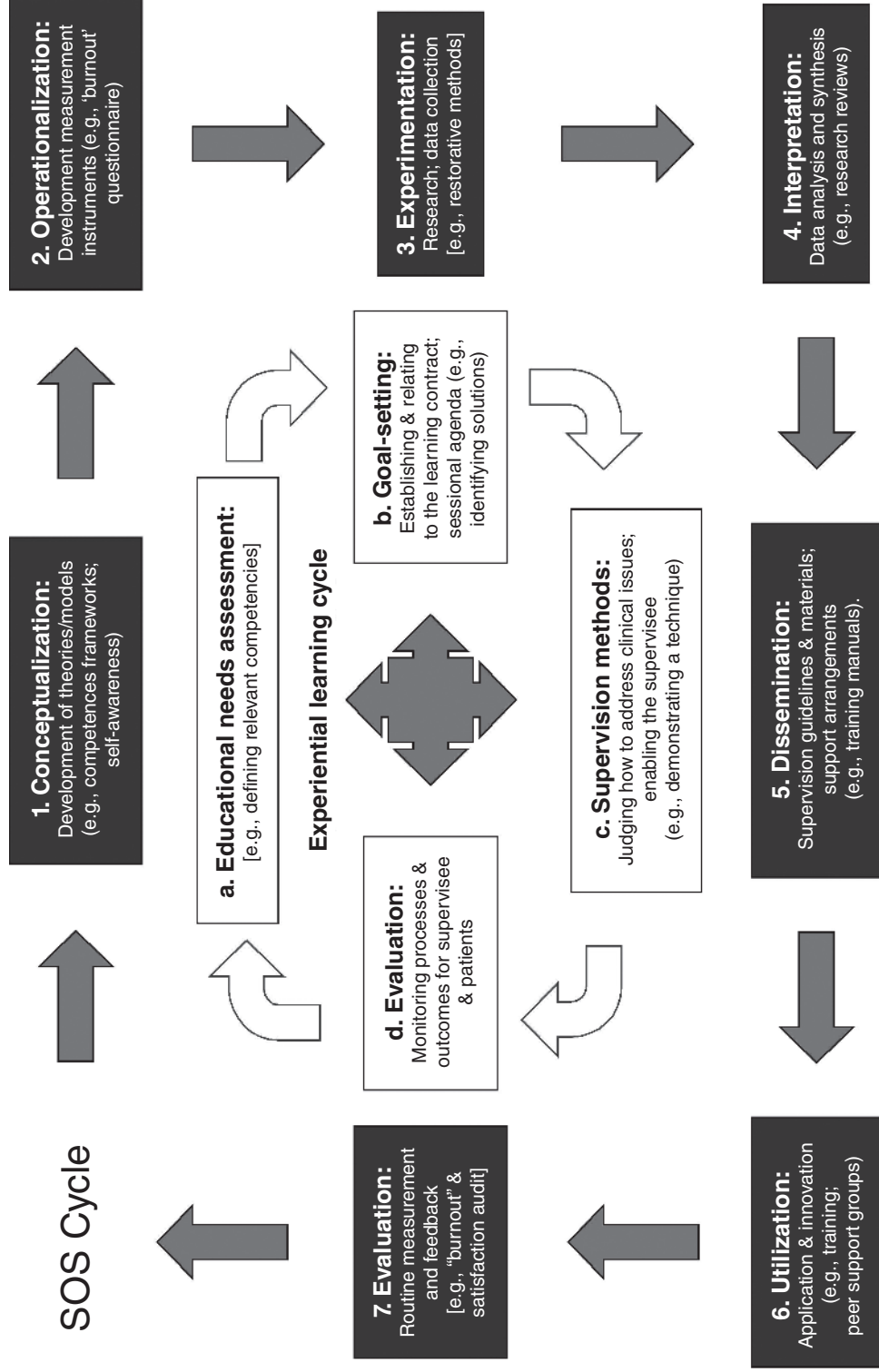


Figure 1.1 The supporting our supervisors (SOS) model, depicting how supervision needs to be enabled within organizations. Source: Milne & Reiser (2016).

in keeping with the NHS policy of career-long supervision. In the United States and many other countries, supervision stops when a therapist completes training and gains the initial professional qualification enabling registration as a mental health professional. However, in this manual we assume career-long supervision as this is the ideal, not least as it provides for continued development and sustained treatment fidelity, rather than regression to earlier levels of competence (Tracey, Wampold, Lichtenberg & Goodyear, 2014) or therapist drift (Waller, 2009). In receiving supervision, therapists are supervisees, so we also use these terms interchangeably. In turn, supervisors should be trained in CBT supervision before becoming a supervisor and then receive career-long education from workshop leaders or trainers, or benefit from supervision-of-supervision or consultancy. Other terms we use interchangeably are “clinical supervision,” “CBT supervision,” and “supervision,” however, we mostly use “supervision,” as we refer to both “CBT supervision” and “evidence-based clinical supervision” (Milne, 2009).

What’s New or Different?

We have said that this manual is readily accessible and can be considered state-of-the-art, designed to enrich supervisory training in CBT in a manner consistent with evidence-based practice. It is also collaborative, multidisciplinary, systemic, and inclusive. However, it also has some distinctive features: not only is it the first true and empirically based CBT supervision manual, to our knowledge it is also one of only two or three manuals following any therapeutic approach to be based on over a decade of programmatic research and development. The methods have therefore been tried and tested; our concepts and theoretical models are clear and carefully grounded; and we are committed to measurement and refinement. Support for these claims is given throughout the manual, most especially in chapter 2.

Where Next?

In chapter 5 we note that: “The empirical evidence-base behind supervisor training has to be the most meager in any area of supervision,” and does not appear to have improved significantly since Milne (2009) concluded that “the supervision of supervisors is the most deficient area in the whole enterprise of clinical supervision” (p. 186). However, there is now growing research attention to supervisor development (Inman et al., 2014), and an increasingly international recognition that supervisor training is necessary (Watkins & Milne, 2014). This view is shared by professional bodies (e.g., APA, 2015). In this improving context Watkins and Milne (2014) concluded that “More consistent, sustained, and systematic attention across researchers and educators will be needed if the evidence-based challenge of supervisor training is to be most fully realized as practical reality” (p. 688). We believe that this manual consolidates the knowledge base of CBT supervision and hope that you will find it instructive. We conclude by commenting on the organization of the manual.

How Do We Get There?

Chapters 2 and 3 provide context for the experiential work described in the following guideline chapters. They are similar to the typical organization of workshops, providing both a didactic or theoretical background and strategic knowledge. The guideline chapters (chapter 4–9) are the heart of this manual, setting out in detail procedural knowledge regarding the best available evidence on how to conduct CBT supervision. Each of these chapters follows the same format. It opens with a summary, including recommendations from the guideline. Unlike the traditional academic chapters 1–3, each guideline chapter is written in the concise style of the guidelines and summarizes the key evidence for each recommendation, starting with a definition and some background to the topic. Each recommendation from the guideline is then explained, drawing on the evidence that we identified. By “evidence” we mean the best available research findings, relevant theory, and expert consensus, including guidelines published by others and competence frameworks. We close each chapter with a brief conclusion and a guideline to each for use in workshops.

Six CBT Supervision Guidelines

All six guidelines have been checked by qualified mental health practitioners to ensure that they are clear and appropriate. Most of these practitioners are employed in the NHS, and most are CBT therapists and members of the BABCP. Guideline evaluation was conducted at supervision workshops led by Milne during 2015–2016, and included the ratings of 107 supervisors, resulting in 9–26 supervisors’ ratings for each guideline. Table 1.1 sets out the guideline evaluation form (GEF) used to record these ratings. This is an abbreviated version of the form used in Milne and Dunkerley (2010).

All six guidelines received an average rating of 2 or more (i.e., they were rated as “acceptable”) in each workshop. When changes were suggested these were considered and often made. The versions in the manual are therefore at least second drafts that have been vetted by this group of supervisors. For example, the process maps in each guideline were suggested at the first workshop during the consultation process. Participants in later workshops strongly endorsed these maps, and added suggestions on the optimal length (e.g., no more than two pages), as well as other desirable features (e.g., plentiful examples of typical situations). A working party of the BABCP also gave input, as did the supervision special interest group of the BABCP. As we shall see more fully in chapter 2, the guidelines are intended as recommendations regarding the key CBT supervision skills rather than as strict protocols, and suggest how the skills might best be applied. We welcome further suggestions for their development.

Guideline Design and Rating of Evidence

We have borrowed from existing guidelines so that our guidelines are as user-friendly and helpful as possible. For example, our approach has been to follow a standard format for all guidelines (NICE, 2014). The format:

- Offers a focus on the action that needs to be taken
- Includes only what readers need to know

- Reflects the strength of the recommendation
- Emphasizes the involvement of the patient in decisions
- Is written in plain English where possible and avoids imprecise language

There are several ways to summarize the strength of the research evidence supporting the recommendations. The American Psychological Association (APA, Division 12) has adopted the rating scheme devised by its working party (Chambless et al., 1998). This scheme distinguishes between “well-established” therapies with “strong” research support and “probably efficacious” therapies with more “modest” support. To meet the well-established standard, there should be several well-designed studies that have been conducted by independent investigators; the findings must be unanimous. Research support is regarded as modest and probably efficacious if there is only one well-designed study, or two or more adequately designed studies. Of significance here, it is possible for both the strong and modest thresholds to be met in a series of carefully controlled, single-case studies.

In the UK the main rating scheme is NICE’s (The National Institute for Health and Clinical Excellence, 2014). NICE takes the view that, because there is currently no well-designed and validated approach for summarizing a body of evidence, a narrative of the quality of the evidence should be provided. As some recommendations will have stronger research support than others, NICE (2014) suggests that the wording of recommendations should vary accordingly. This is consistent with APA’s approach (e.g., APA, 2015). There are three levels of research support or evidential strength: recommendations that must (or must not) be used; recommendations that should be used; and recommendations that could be used. Given the paucity of controlled research, we believe that the most relevant category for CBT supervision is “could,” with few “should” recommendations, and few or no “must not” cautions.

For recommendations on CBT supervision techniques that could be used, the present authors are confident that the intervention will do more good than harm for most supervisees. Our confidence comes in part from the available research, but, while piloting the guidelines, as already noted, we have also had the benefit of input from over 100 CBT supervisors throughout the UK. This is consistent with NICE (2014), in that a “strong” recommendation may be appropriate when the majority of supervisors and supervisees would be expected by the present authors to choose a particular supervision technique if they considered the evidence in the same way as the authors did. The “could” category recognizes that other techniques may also do good. Another reason for selecting this category of evidence is that it places greater emphasis on the supervisees’ context, values, and preferences.

When we believe that the evidence supporting a specific recommendation is strong we record this alongside the specific recommendation, otherwise the reader should assume that the recommendation is based on weaker evidence (i.e., the recommendations “could” apply). This implies that supervisors should spend more time considering and discussing the options with the supervisee than would be the case with strong evidence. This is congruent with the collaborative stance taken in CBT. In practice, NICE suggests using direct instructions for recommendations of this type where possible, such as the term “consider” (this is less directive than a “should” recommendation). Because it would be repetitive to keep using the term “consider” with most or all of our recommendations, we follow the general NICE (2014) guidance by making statements after each suitably worded recommendation in order to summarize the research evidence. Therefore, with regard to style and quality

rating, we follow NICE's approach, as the logic appeals to us; our collaborating organization, the BABCP, is also British; and this approach fits readily with APA's use in the US.

"Evidence" Includes Research Plus Relevant Theory Plus Expert Consensus

Given the inadequate state of research in CBT supervision, we welcome NICE's (2014) approach to other forms of evidence, which accepts that recommendations may need to be developed using a range of scientific evidence in conjunction with other evidence (e.g., expert testimony, the views of stakeholders, people using services, and practitioners). Furthermore, NICE acknowledges that theories should be considered ("conceptual framework or logical model/s," p. 169). For this reason, in chapters 4–9 we routinely consider the best- available research, judging it in the context of relevant theory and expert opinion.

Six PowerPoint Slideshows

Training materials are appended to each of the guideline chapters and, like the guidelines, are primarily intended for use in CBT supervisors' training workshops. The materials include a core slideshow in which we provide a few essential PowerPoint slides. These cover the recommendations, an example of supporting information, suggested learning exercises for each chapter, and slides recommending the use of video clips created for this manual. These clips illustrate the guidelines and are usually prepared as learning exercises within the slideshow.

We have kept the slides to a minimum, based on our experience of what works best in workshops (see the SAGE case study in chapter 2) and on what we know about training supervisors (see chapter 4). Guided by these principles, we use a few essential slides as an orientation to the topic, to suggest learning exercises, and to encourage workshop participants to read the guidelines for additional information. The slides are consistent with what we know about training CBT supervisors, in terms of encouraging needs-led training, a blend of evidence-based, experiential learning methods, the opportunity to observe demonstrations of competent practice, and the chance to self-assess and gain feedback.

However, if the participants' questions, comments, or discussion suggest that more slides would be helpful, our approach is to add our reserve slides (i.e., a 'just-in-time' teaching approach). The slideshows referred to in each guideline chapter are therefore those we would probably use if we were leading a workshop using this manual. As with the video clips, we recognize that other workshop leaders may have different preferences, so they should feel free to customize and contextualize their slideshow accordingly; we do though caution against use of the time available for wider considerations, if this is at the expense of the overriding goal of encouraging the participants' experiential learning.

Suggestions about Using the 18 Appended Video Clips with the Manual

The video clips can be accessed via the Wiley-Blackwell website. Each one lasts at least 5 minutes and all were prepared for the manual, with the exception of clip 3, which was kindly provided by colleagues from the University of Wollongong, NSW. With the exception of clips 4 and 12, all clips are role-plays. Although there was in some cases extensive planning, including consultation with the BABCP working party, the clips were not scripted, to ensure they would be naturalistic examples of how these participants usually provide CBT supervision. The video clips are intended to demonstrate the guidelines and provide competent and detailed modeling of CBT supervision. For example, all clips are expected to be rated between “competent” and “expert” on the SAGE rating scale (see chapters 2 and 3). But note that the video clips that we suggest are our own preferences; workshop leaders may wish to choose to use different clips.

The clips are rich in supervision material and most include multiple techniques and elements of more than one guideline. Therefore, several clips may serve equally well to illustrate something that a workshop leader wishes to highlight. This is demonstrated in the video catalogue (appended), which provides a breakdown of the overlap between the 18 clips and Roth and Pilling’s (2008) competences and the SAGE competence measurement instrument (Milne, Reiser, Cliffe & Raine, 2011). The catalogue is only a general guide, based on competences that the authors judged to be sufficiently clear and proficiently demonstrated (i.e., equivalent to at least a “competent” rating of 3 on SAGE).

A Note of Thanks to the 11 Video Participants

The participating supervisors are all qualified and multidisciplinary mental health practitioners, with considerable experience in providing CBT supervision within the health services. They were either actual supervisees or were the supervisors’ role-playing supervisees.

All patients’ names used in the video clips are fictitious, and all those who kindly helped us to compose the video catalogue have checked their clips to ensure that they contain suitable material. However, some of the material is based on actual incidents, and while no identifying material is found, workshop leaders and participants (and others) should treat the video content with the usual professional confidence.

A disclaimer

The guidelines and all other materials in this manual are support tools and require professional judgment for their proper use, appropriate to a particular context and/or participant group. Those who use our materials should be suitably qualified and must take full responsibility for judging the suitability of the guidelines, materials, suggestions, and other recommendations, taking into account their circumstances and clients (e.g. supervisors receiving training in supervision). This applies to workshop leaders, supervisors, or other professionally qualified users. We also assume that anyone using these materials does so in the context of their professional practice guidelines, supervision, management, and other appropriate arrangements.

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