Do as I say and as I do: Reflections on three methods of evidence-based clinical supervision of
graduate-level trainees.

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The clinical training many therapists received during graduate school ranks among the most intensive periods of direct feedback in their careers. The supervision provided during these years is a major influence on trainees' development from novices to (eventual) experts. We believe the efforts of supervisors in this pivotal developmental stage often receive too little attention. Supervisors may not know which training methods will be most effective for trainees with diverse clinical backgrounds and varying levels of prior knowledge and ability. This is in part because training in supervision remains limited or unavailable in a surprisingly large number of programs (Falender & Shafranske, 2014; Lyon, Heppler, Leavitt, & Fisher, 2008), leaving many supervisors to rely on their own experiences of supervision during clinical training (Crook-Lyon, Presnell, Silva, Suyama, & Stickney, 2011).

Despite these limitations, our clinical supervisors successfully implemented developmentally-appropriate supervision methods based on available research evidence and established theoretical frameworks. Here we describe and demonstrate, in order of increasing developmental demands, three methods our supervisors used to scaffold our training: deliberate practice, feedback on client progress, and embodying the spirit of the treatment. These methods are grounded in the research and theory of learning, relatively straightforward to apply in graduate practica, and flexible enough to adapt to diverse trainee backgrounds and abilities.

Deliberate Practice

Deliberate practice, defined as “individualized training activities especially designed... to improve specific aspects of an individual's performance through repetition and successive refinement” (Ericsson & Lehman, 1996), is an important mechanism for increasing expertise in

psychotherapy (Goodyear, Wampold, Tracey, & Lichtenberg, 2017). Therapists who engage in more frequent deliberate practice to improve their therapeutic skills have shown better client outcomes (Chow et al., 2015). It may be difficult to imagine how focused, deliberate practice could apply to psychotherapy, which is complex, dynamic, and allows for substantial latitude in focus and prioritization, even in manualized treatments. In cognitive therapy (CT; Beck, Rush, Shaw, & Emery, 1979), for instance, trainees can implement a variety of interventions at any given moment: cognitive restructuring, reflective listening, Socratic questioning, and homework review, just to name a few. For students in graduate training, this can be an overwhelming set of options! Deliberate practice is a way to provide more focus on essential therapy skills.

Our supervisor used deliberate practice methods to teach cognitive restructuring during training preceding our practicum in CT for depression. He divided a white board into three columns to represent a simplified thought record: 1) a description of the situation, 2) hypothetical negatively-biased automatic thoughts, and 3) alternative responses to those thoughts. Our supervisor generated content for the first two columns, and challenged us to think of plausible and helpful alternative responses for the third column.

*Supervisor (S)*¹: Say your client, who just lost their job, goes to the checkout counter to pay for groceries and their credit card is denied. Their automatic thoughts are, “I failed my family,” “I’m so incompetent,” and “Everyone at the store thinks I’m a loser.” What alternative responses might you and your client generate?

Trainee (T): How about, “I couldn’t provide for my family this time,” in response to the automatic thought, “I failed my family”?

S: That’s a start. Anything more?

¹All vignettes are combinations of clinical conversations and do not reflect any specific client, trainee, or supervisor comment.

T: “I’m resourceful – I’ve always found a way to provide for my family before. Maybe I can buy some of these groceries now and see if there are other community resources for food when I get home.”

S: Great! Let’s write that down. Okay, we’ve still got, “Everyone at the store thinks I’m a loser” – what can we do with that one?

After we addressed each of the automatic thoughts on the board, our supervisor erased the original content and started a new example. We viewed these exercises as a form of “lightning round” cognitive restructuring, which required quick replies to a diverse array of negative thoughts. As training progressed, we felt increasingly able to generate multiple possible alternative responses to negative automatic thoughts. By using deliberate practice to generate alternative responses quickly and repeatedly, we developed a mental roadmap of common themes in depressive thoughts (e.g., all-or-nothing thinking, discounting the positive) and the types of alternative responses that were most promising for them. This pattern reflects the development of novices, who tend to memorize lists and rules, into experts, who organize knowledge around a few core components to guide their thinking (Persky & Robinson, 2017). As a result, we could swiftly anticipate which core beliefs each negative thought might indicate and guide treatment to address those beliefs. Thus, a foundation was laid to integrate other core components of the model into our training in a natural, iterative manner.

Feedback on Client Progress

Soliciting and synthesizing feedback from one’s supervisor is an essential component of supervision. One limitation of the supervisor-trainee relationship is, as our supervisor put it, “In order to ask for help, first you have to realize you need it.” Trainees do not always perceive when they make errors or exhibit gaps in their knowledge; similarly, supervisors will never be

mind-readers, and supervision time is limited. One strategy our supervisor used to address these limitations was to examine clients' session-to-session progress in a spaghetti plot². By regularly examining this graphical depiction of clients' pre-specified treatment targets during supervision (Figure 1), we could determine quickly and collaboratively which trajectories indicated progress, stability, or deterioration (Swift et al., 2015) – information that facilitated effective use of limited supervision time. A substantial body of research suggests that tracking and receiving feedback on client progress may reduce the percentage of clients who ultimately deteriorate by 15% and improve the percentage of clients who ultimately recover by 30% (Lambert, 2017). By examining client progress in an easy-to-read graph, supervisors can ensure that even clients who might be overlooked by trainees will be brought to their attention. In Figure 1, we would likely identify clients 2, 3, and 5 as high priority cases. These three clients' depression scores are either elevated and stable (i.e., clients 3 and 5) or rising (i.e., client 2).

Of course, effective supervision includes feedback on not only what trainees are struggling with, but also what trainees are doing well. Our supervisor also used these spaghetti plots to discuss and reinforce what we did in sessions that preceded improvements in depression scores (e.g., sessions 10-12 for client 1). Linking in-session behaviors to graphical trends in clients' symptoms strengthened our understanding of the effects of our interventions.

Supervisor (S): So what happened in sessions 10-12 with client 1?

Trainee (T): My client seemed to be more active in coming up with alternative responses. They sounded more hopeful, and they reported connecting with the alternative responses at an emotional and cognitive level.

S: That all sounds good. Was that different from prior sessions?

² The R code to generate such plots can be found here: <https://osf.io/k762d>

T: I guess so! I don't think we did much differently, but maybe that was the point. Because my client was willing to practice cognitive restructuring over and over again with different aspects of the same strongly held belief, they could truly believe in the alternative responses. Before this session, they completed all their homework but it hadn't clicked yet.

Reviewing graphical data of client symptom trajectories allowed our supervisor to help us connect our in-session behaviors to clients' symptom changes empirically and consider both which interventions to implement and when to do so. This approach can be adapted to any treatment involving a target for change that can be regularly assessed. It can also be used to call attention to other factors contributing to change in the client's life, such as environmental stressors or major life events. Reviewing visual representations of clients' progress bolstered our confidence in the treatment and our growing abilities. This has functioned as an antidote to periods in training when it felt like only mistakes and shortcomings were highlighted in supervision or when we experienced "imposter syndrome". Finally, plotting this data helped us recognize that not all clients progress in a clear, linear fashion – in fact, almost no one does! However, thoughtfully reflecting on the principles that led to even small gains after certain sessions may benefit trainees and clients alike even, or especially, in very challenging situations.

Embodying the Spirit of the Treatment

Expertise in providing evidence-based treatment involves a thorough appreciation of how the treatment's methods and strategies cohere in a theoretical model of change. Underlying these specific methods and techniques are evidence-based principles about how the therapy is hypothesized to work. These principles are grounded in research on psychopathology and human behavior, with each component of an intervention intended to address various aspects of

the theoretical model. However, as trainees, it can be challenging to grasp how all the pieces fit together when we are so focused on learning the basics.

One way our dialectical behavior therapy (DBT; Linehan, 1993) supervisor fostered a deeper understanding of the treatment model was to embody the spirit of core DBT principles in supervision. She was especially skillful in embodying the spirit of dialectics. In DBT, adopting a dialectical approach means embracing and synthesizing the truth present in two opposite and seemingly contradictory ideas (e.g., acceptance of painful emotions vs. desire for change). Our supervisor frequently noted and embraced examples of dialectics that emerged in supervision:

Trainee (T): I'm feeling stuck with a client. One of our targets has been her tendency to show up late to events in her everyday life. We've tracked her lateness for weeks, and we keep rehashing how important timeliness is to her goals. It just feels like nothing's working – she's even started showing up late to *our* sessions! She says it's a big problem, and I'm feeling really frustrated, because I don't know how to help.

Supervisor (S): I can hear the frustration in your voice. This sounds like a tough situation.

T: I just feel like we're never going to make any progress if she can't even show up to session on time!

S: So, to take a dialectical approach: on one hand, you're feeling frustrated because you keep addressing this one target and aren't seeing change. And, on the other hand, you're saying you can't make any progress until she stops being late. That really leaves you two in a stuck place, where you can't work on anything until she is able to do the hardest thing.

T: I see what you mean.

S: What would happen if we accepted both things – that her being late is a big challenge that you’re both still working on, and that there may be other things to focus on, too? Perhaps spending less time on being late during each session, while continuing to acknowledge the lateness as a problem when it happens, is a way of dialectically honoring the truth in both parts.

By modeling a dialectical approach, our supervisor did multiple beneficial things at once. First, she addressed an issue we raised about a challenging case. Second, she modeled and explicitly labeled how a DBT technique (i.e., dialectics) could address that issue in a way we could imitate in sessions. Third, by embodying the spirit of DBT with dialectical strategies, she tacitly encouraged us to keep the core model in mind when considering how to respond to challenges in implementing DBT. Finally, the dialectical approach validated our experience that the issue was a frustrating problem with no initially obvious solution. Our supervisor openly acknowledged the apparent contradictions within the situation that contributed to us feeling stuck. As a result, we experienced the value of acknowledging those feelings, which allowed us to explore thorny issues nonjudgmentally instead of grasping for an immediate solution. Experiencing the benefits of this approach firsthand during supervision helped us envision more clearly how that process could be therapeutic for our clients during sessions.

By engaging us in dialectics in supervision, our supervisor relied on observational learning principles (Bandura & Jeffery, 1973) to guide our clinical development. We learned to model our in-session thought processes and behaviors off these demonstrations to the point that we could almost hear our supervisor’s voice coaching us during sessions. Although we cannot say for sure whether this learning resulted in better outcomes for our clients, some research

suggests that such downstream benefits may be possible. For example, clients of therapists who engage in relatively more intensive mindfulness practice may have better overall outcomes (Grepmaier et al., 2007; cf. Swift, Callahan, Dunn, Brecht, & Ivanovic, 2017), raising the possibility that clients benefit from therapists' modeling of a mindful stance in treatment. Similarly, trainees may benefit from supervisors' effective modeling of treatment techniques and principles. As available evidence is quite limited, we look forward to more direct tests of the role of supervisory modeling in future studies.

Conclusion

Taken together and in the order described here, each of the preceding examples demonstrates how supervisors may scaffold graduate clinical training to meet the developmental needs of trainees using theory-informed and evidence-based training methods. Supervisors may incorporate deliberate practice of fundamental therapeutic skills in training sessions starting before trainees see their first clients. This ensures that trainees grasp the fundamentals of the treatment, upon which they can build during the practicum year. When trainees begin seeing clients, supervisors and trainees may use graphical printouts of client progress toward agreed-upon goals to identify collaboratively which clients need the most attention and discuss which strategies are most effective for whom. Finally, as trainees become more comfortable with these aspects of supervision, supervisors may more strongly emphasize and embody the spirit of the treatment. This expert-level approach can help trainees navigate unexpected therapeutic moments by following the principles their supervisors model. Thus, each aspect discussed here coheres in a developmental model of clinical training in which supervisors respond dynamically to the needs and strengths of their trainees during graduate school.

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Figure 1. Example spaghetti plot of Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) scores used to gather feedback on client progress in supervision.