Chapter 13

# Developing Cognitive Therapist Competency: Teaching and Supervision Models

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Cognitive therapy was one of the first therapies to provide detailed specifications for treatment stages, structure, and methods. The seminal text on the therapy, *Cognitive Therapy of Depression* (Beck, Rush, Shaw, & Emery, 1979), was originally written as a therapist training manual to standardize treatment interventions. Clear specificity in treatment methods allowed researchers to evaluate how closely therapists adhered to treatment protocols and whether different elements of these protocols correlated with positive treatment outcome.

While treatment outcome is generally used to measure the efficacy of therapy models, it can also be used as a measure of therapist competency. Several studies suggest that therapists obtain better treatment outcome for depression if they adhere closely to the structure of cognitive therapy (Shaw, 1988) and follow the standardized procedures of the therapy (Thase, 1994). Therefore, two possible criteria for therapist competency are knowledge of and adherence to treatment protocols.

While these studies have not been duplicated for all the various problems treated with cognitive therapy, the development of specific cognitive therapy protocols for specific disorders assumes that protocol adherence is linked to therapy outcome. Therefore, programs teaching therapists to conduct cognitive therapy usually teach cognitive conceptualizations for particular problems as well as specific procedures to be administered according to the principles and structure specified in cognitive therapy treatment protocols.

Therapist adherence to general cognitive therapy principles is often measured by ratings on the Cognitive Therapy Scale (CTS; Young & Beck, 1980) which was devised to measure therapist competency in applying cognitive therapy. The CTS seems to be a reliable and valid measure of therapist competency (Dobson, Shaw, & Vallis, 1985; Hollon et al., 1981; Vallis, Shaw,

& Dobson, 1986; Young, Shaw, Beck, & Budenz, 1981) with intraclass reliability coefficients ranging from .54 to .96 (Beckham & Watkins, 1989). Instructors and therapists wishing to rate therapists' cognitive therapy skills can use the CTS to rate an audiotape or videotape of a therapy session on general therapy skills (e.g., collaboration, interpersonal rapport, pacing of the session) and on specific cognitive therapy skills (e.g., focus on key cognitions, strategies for change, quality of homework assigned).

## TEACHING COGNITIVE THERAPY TO THERAPISTS

Competency as a cognitive therapist requires knowledge of cognitive therapy theory and the ability to apply this theory in a structured fashion. To do so, therapists must be able to formulate a useful case conceptualization and skillfully apply empirically based clinical methods within a collaborative therapeutic relationship. Programs that teach cognitive therapy must therefore teach therapists conceptualization skills, interpersonal processes necessary to the formation and maintenance of a collaborative therapeutic relationship, a range of clinical procedures, and treatment protocols that specify how and when to use particular procedures for particular problems.

### Content Required for Therapist Competency

Teaching cognitive therapy in the final decade of this century is more complex than it was in the late 1970s when a single treatment model existed for a single disorder, depression. Today there are specific cognitive therapy conceptualizations and treatment protocols for most syndromes described in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Further, positive treatment outcomes obtained in empirical studies contribute to the expectation that cognitive therapists should be able to treat multiproblem clients in brief format therapy. This complex task requires therapists to form rapid conceptualizations and be knowledgeable and skilled in the treatment of varied and interrelated problems. A brief history of the content taught in cognitive therapy training programs will illustrate this evolution and explosion in the knowledge base required to achieve "competency" as a cognitive therapist.

#### *The Evolution of the Cognitive Therapy Knowledge Base*

When Beck introduced cognitive therapy for depression in the 1970s, other therapies for depression were highlighting affect, biology, interpersonal relationships, and sometimes behavior. Beck proposed cognition and behavior as primary focal points for therapeutic intervention. Therapists wishing to learn this new therapy read *Cognitive Therapy of Depression* (Beck et al.,

1979) as the new template for depression treatment. To achieve competency, one learned Beck's cognitive model for understanding depression (Beck, 1967) and mastered the techniques described in the treatment manual (Beck et al., 1979).

The primary therapist skills taught in this latter book were methods for changing behavior, identifying cognitions, and teaching clients to test out negative thoughts and beliefs. Since affect was already predominant in this clinical population, only cursory discussion was given to the importance of cultivating affect in therapy. Therapists were taught to do therapy in a relatively new way. Each session was structured with a clear agenda, problem focus, and development of homework assignments to encourage client learning, observation, and experimentation between therapy sessions. Within sessions, there was a new concept of "collaborative empiricism" (Beck et al., 1979, p. 6) in which the therapist employed "Socratic questions" to guide client learning and reevaluation of negative depressogenic beliefs.

As cognitive therapy's efficacy for treating depression was established (Rush, Beck, Kovacs, & Hollon, 1977; Shaw, 1977; Blackburn, Bishop, Glen, Whalley, & Christie, 1981; Murphy, Simons, Wetzel, & Lustman, 1984; Beck, Hollon, Young, Bedrosian, & Budenz, 1985), the therapy became increasingly popular among therapists and researchers around the world. Paradigms evolved that applied its principles to an ever expanding array of problems including anxiety disorders, eating disorders, and relationship difficulties. With each new application, new conceptual models were developed and empirically tested. In addition, new content requirements for therapist competency were added.

By the mid-1980s, cognitive therapy was a treatment of choice for anxiety disorders. Beck and others developed cognitive conceptualizations for anxiety disorders (cf. Beck, Emery, & Greenberg, 1985; Butler & Matthews, 1983; Clark, 1986; Salkovskis, 1985) . Cognitive therapists wishing to attain competency now needed to learn conceptual models for both depression and anxiety. In addition, while still structured and grounded in collaborative empiricism, the anxiety treatments required new skills for therapists.

Anxious cognitions often occurred as images so therapists learned methods for assessing and cognitively restructuring images. In contrast with depression treatment, affect was not omnipresent in sessions. Therapists needed to learn methods for inducing affect in session because "cognitive therapy cannot be done in the absence of affect" (Beck, 1990). Unlike depression, which was successfully treated by similar cognitive therapy methods regardless of type, anxiety disorders responded differentially to treatment. Therefore, cognitive therapists learned specific conceptualizations and treatment protocols for each anxiety disorder.

In addition to cognitive therapy for anxiety disorders, research-based treatment paradigms emerged for many other problems in the 1980s. Cognitive conceptualizations and treatment paradigms were developed for

problems as diverse as eating disorders (Garner & Bemis, 1982; Fairburn, 1985), substance abuse (Beck, Wright, Newman, & Liese, 1993), relationship problems (Beck, 1988; Baucom & Epstein, 1990; Dattilio & Padesky, 1990), and schizophrenia (Perris, 1988; Kingdon & Turkington, 1994).

In the late 1980s cognitive therapists began discussing applications of cognitive therapy principles to the treatment of personality disorders (Padesky, 1988; Pretzer & Fleming, 1989). By 1990 these ideas were collected in a text that outlined specific treatment emphases and strategies for each of the personality disorders (Beck et al., 1990). Cognitive therapy of personality disorders requires therapists to develop individualized case conceptualizations that include deeper schematic beliefs as well as the automatic thoughts and underlying assumptions that are the primary focus of depression and anxiety treatment. Conceptualizations of clients with personality disorders also include a greater emphasis on early developmental history and client interactions with environmental factors (especially familial and social) which influence schema development and maintenance.

Cognitive therapists treating personality disorders also emphasize the therapist–client relationship more than is required in the treatment of depression and anxiety. This is because the schemas central to personality disorder treatment often emerge most clearly within the therapy relationship. Schema change is central in the treatment of personality disorders. While therapists help clients with personality disorders evaluate and change maladaptive automatic thoughts and underlying assumptions, Beck and his colleagues proposed that the key to personality disorder treatment was changing maladaptive schemas (Beck et al., 1990). Thus, the required cognitive therapy knowledge base expanded to include methods designed to weaken maladaptive schemas and construct new ones. These skills include use of continuum methods, psychodrama, historical tests of schemas, and core belief data logs (Padesky, 1994a).

### *State-of-the-Art Content Requirements for Therapist Competency*

As the previous summary illustrates, the content to be mastered by cognitive therapists has grown enormously over the past 20 years. As always, cognitive therapy continues to evolve as clinical practice is teamed with research data. Each specific clinical application includes interventions to be learned and mastered. Once the basics are learned, a competent cognitive therapist develops an artful ability to conceptualize interlocking problems, make intervention choices, and solve problems in an efficient and effective manner to facilitate client learning and change. These ideals are challenging to achieve.

## Clinical Processes Required for Therapist Competency

Bridging the various domains of clinical application are the necessity for a positive therapy relationship and therapist ability to follow basic princi-

ples of cognitive therapy process: collaboration, guided discovery, and structure. These principles have remained the same throughout cognitive therapy's evolution, although cognitive therapists specify them more clearly over time.

### *Therapy Relationship Factors*

Beck's initial treatment manual (Beck et al., 1979) dedicated a chapter to the necessity for a positive therapeutic relationship including such nonspecific treatment factors as warmth, accurate empathy, genuineness, trust, and rapport. In addition, this book briefly discussed transference and countertransference issues in therapy, acknowledging their importance in cognitive therapy and the direct manner with which cognitive therapists address them. Thus, from the beginning, competent cognitive therapists were expected to be able to form and maintain positive therapeutic relationships.

Some later texts devote considerable discussion to interpersonal processes in cognitive therapy, especially important in therapy with clients with personality disorders (cf. Beck et al., 1990; Safran & Segal, 1990; Wright & Davis, 1994). Strategies for using a positive client–therapist relationship to promote change and using conflict in the therapy relationship to foster client learning are central to cognitive therapy (Newman, 1994; Padesky with Greenberger, 1995; Rane & Goldfried, 1994; Safran & Muran, 1995).

To promote schema change in personality disorders, cognitive therapists use the therapy relationship as a laboratory for testing core beliefs. For example, a client who mistrusts others is encouraged to risk trusting the therapist in small ways. Therapist and client examine affective, cognitive, behavioral, and relationship consequences of these experiments. To fully participate in this type of relationship "laboratory," a cognitive therapist needs good self-awareness in addition to relationship skills.

### *Cognitive Therapy Process*

The fundamental therapy processes in cognitive therapy are collaboration, guided discovery, and structure. Collaboration means therapist and client work together as a team jointly choosing therapy goals, constructing a meaningful conceptualization of problems, and developing plans for change. A collaborative relationship requires both therapist and client to be active and interactive within the therapy relationship. Each seek and receive feedback from the other; questions back and forth are encouraged. Collaboration in cognitive therapy requires the client also to be active outside the session as an observer, reporter of experiences, and experimenter. Therapists who are not willing to participate in a highly interactive therapy relationship are poor candidates for cognitive therapy training.

Guided discovery is the primary learning process in cognitive therapy. Therapists guide discovery both verbally through questioning and experien-

tially by helping clients devise experiments conducted in and outside of therapy sessions. Guided discovery is the engine that drives client learning in cognitive therapy. Encouragement of active client observation and examination of thoughts, emotions, behaviors, interpersonal patterns, and physiological responses is fundamental to guided discovery. Therapists with an understanding of scientific method and an enthusiasm for helping others learn for themselves are ideally suited to guide client discovery.

Finally, cognitive therapy is structured. Within sessions, cognitive therapists collaboratively set agendas with clients, clearly define goals, provide frequent summaries, and help construct specific, structured learning assignments. Across sessions, skills are taught in a stepwise fashion, clients are encouraged to keep therapy notes and records, and treatment protocols are followed as closely as ideal for a particular client's treatment.

The degree and form this structure takes can be quite different depending upon the client and the problems addressed. For example, cognitive therapy of panic disorder follows a highly structured treatment protocol over a brief number of sessions. Alternatively, cognitive therapy for posttraumatic stress disorder with a rape victim with concurrent borderline personality disorder would require more flexibility in structure, collaborating with the client to determine the types and degrees of session structure that can be therapeutically tolerated week to week. Therefore, the ideal cognitive therapist is capable of being highly structured in therapy, comfortable tracking a number tasks within a session, and yet sensitive to adapting therapy structure to individual clients in order to maximize collaboration and a positive therapeutic relationship.

In the following section a variety of teaching methods are described that foster the development of therapist competency in content, relationship factors, and cognitive therapy process. It is ideal if training and supervision programs model mastery of content, positive relationships (between instructor and student), collaboration, guided discovery, and structure.

## Teaching Processes

From the earliest years of cognitive therapy training, Beck preferred teaching methods that modeled the therapy and provided therapists with learning experiences to guide their discovery. His workshops and presentations include frequent use of Socratic dialogue to help participants discover theoretical principles. In addition, Beck employs experiential exercises to encourage students to gather data regarding their own thoughts, emotions, and physiological responses, linking these personal experiences to the topics of discussion. In these ways, from the beginning, cognitive therapy has been taught using principles of collaboration, guided discovery, conceptualization, and structure.

### *Collaboration*

Collaboration between instructor and student is central in the teaching and learning of cognitive therapy. Students are encouraged to play an active role in learning by (1) questioning the instructor, (2) participating in exercises designed to teach key therapy principles, and (3) thoughtfully answering instructor questions by drawing on clinical experiences and self-observation. Cognitive therapy instructors collaborate with students by (1) openly discussing the teaching agenda, (2) encouraging student input regarding topics and learning processes, (3) asking questions to guide student discovery, and (4) inviting student feedback on clinical demonstrations and theoretical principles.

Cognitive therapy instructors foster supportive, investigative teams. In large learning groups, these teams can be small groups of two to six members that learn via role plays and discussion, followed by instructor feedback. Smaller learning groups can work as a whole to encourage and foster learning. For example, group dyads can practice cognitive therapy skills in front of the group and receive feedback from colleagues on what they did well and what could be improved. A supportive atmosphere is necessary because therapists must feel safe and comfortable making mistakes in front of the group. If therapists feel group pressure to avoid mistakes, they will hesitate to try new approaches and new learning will be limited.

### *Guided Discovery/Empiricism*

Cognitive therapy employs guided discovery and empirical investigative methods as the principal methods for client learning and change. Using these same principles to teach cognitive therapy to therapists reinforces the importance of data-based learning. Knowledge of previous empirical findings provides a foundation for cognitive therapy training programs. Students are encouraged and instructors are required to stay abreast of clinically relevant empirical research. The most successful clinical applications of cognitive therapy have been developed in parallel with empirical studies of the clinical phenomena treated. Cognitive therapy instructors learn about research by reading professional journals, attending research symposia at national and international cognitive therapy conferences, and often by conducting research themselves.

In addition to learning from empirical research, cognitive therapists add to their own personal competency by regularly investigating the benefits and shortcomings of clinical methods learned. Instructors encourage student use of empirical methods by setting up learning experiments for student therapists to complete. For example, students learning to use Automatic Thought Records can be assigned to first complete Thought Records for themselves. The instructor can guide discovery by questioning students about what they learned using Thought Records. These questions can include queries about

a variety of factors such as what made it easy or difficult to notice automatic thoughts, what thoughts or emotions interfered with the task, what strategies helped the students, and how the experiences of these therapists might be similar or different from clients' experiences with this same assignment.

Following therapist practice of clinical methods and discussion of what was learned, therapists are asked to try the same methods with one or more clients to gather more information about the value and difficulties entailed in a specific clinical intervention. Practicing only a few new methods at a time facilitates student learning, especially if these methods are applied with several clients with the same diagnoses. Repeated practice with similar clients enhances therapist learning by allowing comparison of results from several closely spaced learning trials. Therapists with a full and diverse caseload can often create these learning circumstances by selecting two or three similar clients with which to practice particular cognitive therapy methods.

These experimental learning forays on the part of the student therapist will usually have a mixed clinical outcome; some clients will respond well to the interventions, others will not. The instructor or supervisor can encourage the learning therapist to use both positive and negative experiences to advance learning. A truly empirical stance on the part of the therapist consists of (1) formulating hypotheses (e.g., learning to use a Thought Record will help my depressed clients feel better), (2) conducting multiple experiments (e.g., teaching several depressed clients to use a Thought Record), (3) noting the outcome of these experiments (e.g., two clients benefited greatly from the Thought Record, one seemed to become more depressed in the process of learning the Thought Record), (4) analyzing these outcomes carefully (e.g., the client who did not find it helpful had a much more vegetative depression), (5) implementing further experiments (e.g., I could try more behavioral interventions with this client, or add medication), (6) reviewing the outcomes of these experiments (e.g., this third client is still quite depressed, but responding somewhat better to behavioral rather than cognitive interventions), and (7) drawing tentative conclusions (e.g., Thought Records seem helpful for most depressed clients; I will use behavioral and pharmacological approaches first with clients who have many vegetative symptoms) to be (8) further tested by additional clinical experiments.

Instructors foster therapist willingness to use this type of empirical approach if these methods are modeled in the teaching setting. Rather than didactically teaching "truths," instructors can summarize empirical findings and then devise learning experiments to see if and how these findings apply to the students' own experiences and clients. Students are encouraged to figure out why interventions are not always successful by examining the quality of the implementation of these interventions, characteristics of the client, and therapist beliefs and emotions that also influence treatment outcomes. Finally, students are taught that no clinical approach works perfectly with every client. The art and skill of therapy are best developed in a therapist

who consistently analyzes and learns from both positive and negative client feedback and outcome.

### *Conceptualization*

Another cornerstone of cognitive therapy instruction is teaching therapists to formulate a useful conceptualization of the client's problems. A cognitive therapy conceptualization will include beliefs (automatic thoughts, underlying assumptions, and schemas), emotional reactions, behavioral strengths and deficits, social factors that influence problems (both past and present), and consideration of biological factors. Persons (1989) recommends therapists look for the smallest number of explanatory elements that can account for all of the client's presenting problems. Thorough assessment of client beliefs is central to conceptualization in cognitive therapy, not because beliefs are considered the root cause of all problems, but because beliefs serve a powerful maintenance function for problematic behavioral and interpersonal difficulties (Padesky, 1994a).

A number of methods are used to teach case conceptualization to cognitive therapists. Often, beginning therapists are instructed to rely on empirically evaluated cognitive models to conceptualize client difficulties. For example, a client's panic disorder is conceptualized as the result of catastrophic misinterpretation of physical or mental sensations according to the model outlined by Clark (1986). Client depression is conceptualized as resulting from biopsychosocial stressors combined with negative cognitions about the self, world, and future (Beck et al., 1979). Therapists who adopt these template conceptualizations and follow the accompanying treatment protocols can be satisfied as long as these make sense to the client and treatment is successful.

Much of the time, however, clients present with more than one difficulty, requiring the therapist to combine or choose among generic conceptual models. Therefore, therapists must learn to develop individualized case conceptualizations. A number of training centers have developed case conceptualization forms to guide therapists in this process. These forms generally ask therapists to list a client's presenting problems, write a brief history of relevant events, describe the interpersonal process in therapy, and identify key underlying assumptions and schemas. This summary is used to write a brief treatment plan that is given to the supervisor for feedback. Written conceptualizations often are discussed with clients who may collaborate in their development.

Written conceptualization forms help the beginning cognitive therapist learn processes for constructing conceptualizations to guide treatment. More experienced cognitive therapists form written conceptualizations in collaboration with clients early in therapy, often as soon as the first or second session, with refinements added as therapy proceeds. Therapists are encouraged to discuss conceptualizations with clients as hypotheses to be evaluated

through observation, data collection, and behavioral experiments. Cognitive therapy conceptualizations are descriptive and closely tied to understanding and explaining the client's day-to-day experiences.

Cognitive therapy instructors and supervisors are encouraged to model and illustrate a variety of case conceptualization methods for students. Students are encouraged to experiment with diagnostically based conceptualizations, written case conceptualization forms, and diagrams of client patterns to discover which approaches are most helpful.

### *Structure*

Learning to do cognitive therapy in a structured fashion is often one of the most difficult tasks for therapists. Instructors model the use of structure in each teaching session by setting agendas, monitoring time usage, and seeking regular feedback from students on the learning pace followed. Students are encouraged to practice a more structured therapy approach within time-limited role-play assignments in which certain therapy tasks need to be accomplished. Role-play exercises are analyzed to find which strategies are effective for balancing structure, focus, and a positive therapy relationship.

Feedback from the "clients" in these role plays is usually very instructive. Therapists often believe that structure is disruptive to a good therapy relationship and client insight. As clients, therapists often discover that, compared with relatively unstructured interviewing methods, an empathic structured interview creates an atmosphere in which greater understanding from the therapist and more hope for improvement are experienced because a clearer treatment plan emerges.

Audio- and videotapes of therapists' sessions with actual clients are reviewed by the cognitive therapy instructor to assess whether the student therapist is adhering to a structured plan within the therapy hour. Therapists often need help learning to manage common impediments to structure such as agendas that are too complex for the time available, clients who have difficulty maintaining focus, and the demands of debriefing and developing homework assignments that can take more time than novice therapists allow. Discussion and role play of strategies for maintaining structure help develop a therapist's behavioral skills. In addition, therapist beliefs about the advantages and disadvantages of structure may need to be examined and tested using Thought Records and behavioral experiments.

## Teaching Methods

While most cognitive therapy training programs strive to incorporate the principles outlined above, a variety of teaching methods are employed to accomplish these learning goals. Most programs use several of the teaching methods below. Ideally, therapists wishing to become competent cognitive therapists will sample all these learning methods en route.

### *Reading Materials*

Cognitive therapists have written some of the most specific and wide-ranging topical descriptions of therapy in the history of psychotherapy. Therefore, students of cognitive therapy have no difficulty finding written references for almost any client population and set of problems. Cognitive therapy instructors facilitate student learning by selecting texts that combine the knowledge derived from empirical studies with clear and specific descriptions of their clinical applications.

Brief training programs sometimes use a single text that describes cognitive therapy applied to a variety of problems (cf. Freeman, Pretzer, Fleming, & Simon, 1990; Hawton, Salkovskis, Kirk, & Clark, 1989). Longer training programs usually ask students to study primary texts on cognitive therapy for specific problems such as depression (Beck et al., 1979), anxiety (Beck, Emery, & Greenberg, 1985), personality disorders (Beck et al., 1990), and other common clinical populations treated, such as couples (Baucom & Epstein, 1990; Dattilio & Padesky, 1990) or children (Kendall, 1991).

Cognitive therapy treatment manuals written for clients also facilitate therapist learning by providing a programmed text to use in therapy. A 12-chapter treatment manual written by Greenberger and Padesky (1995) teaches clients the basic cognitive therapy skills necessary for the treatment of many different client problems. Chapters teach how to identify emotions, identify automatic thoughts, use Thought Records to evaluate automatic thoughts, conduct behavioral experiments, and begin schema change methods. This client manual helps beginning cognitive therapists by providing written explanations for common cognitive therapy learning tasks.

Further, summaries, "hints," and troubleshooting guides in this client manual can be extremely helpful to a therapist learning to practice cognitive therapy. These written guidelines highlight key ideas and help solve common problems encountered in conducting cognitive therapy. A clinician's guide accompanies this client treatment manual and summarizes treatment protocols for a variety of cognitive therapy applications (Padesky with Greenberger, 1995). The clinician's guide also highlights common dilemmas faced by cognitive therapists, with recommendations about how collaboration and guided discovery can help resolve these difficulties.

Client treatment manuals also have been written for specific client problems such as depression (Burns, 1989; Eaves, Jarrett, & Basco, 1989), anxiety (Bourne, 1990), obsessive–compulsive disorder (Steketee & White, 1990), and relationship problems (Beck, 1988). Each of these client manuals provides a structured presentation of a cognitive therapy approach for treating these difficulties. Beginning cognitive therapists may find client workbooks a helpful addition to the therapy they conduct. Since workbooks provide explanations of cognitive therapy principles written in simple language, beginning therapists can model their own verbal explanations to clients on these written samples.

### *Clinical Demonstrations*

Written texts and manuals describe treatment principles in detail. Clinical demonstrations illustrate therapeutic processes and, sometimes, artistry. For example, a cognitive therapy text will describe collaborative empiricism and perhaps even provide written therapist–client dialogues. Yet these illustrations leave much out. A clinical demonstration provides added information about pacing, vocal tone and inflection, nonverbal communication between therapist and client, and the development of interventions in "real therapy time."

Clinical demonstrations can be live, videotaped, or audiotaped and may involve clients or role plays. Each format has its advantages and disadvantages. Live demonstrations are useful when learning therapists want consultation with a particularly challenging client or diagnosis. A clinical instructor can meet with a selected client to illustrate interventions *in vivo*. Live demonstrations also can be done impromptu during classes or workshops to illustrate treatment principles or to respond to student questions. Students who are skeptical about the usefulness of cognitive therapy for particularly complex clients are often reassured by a live clinical demonstration that illustrates therapy principles applied under challenging circumstances.

Live clinical demonstrations can be provided by students as well as the instructor. It is helpful for therapists learning cognitive therapy to practice its tenets under the observation of other therapists who provide constructive feedback. Initially, students are most comfortable providing brief role-play demonstrations of particular therapeutic principles (e.g., 5 minutes of guided discovery). Eventually, it is helpful for students to provide and watch demonstrations of complete therapy sessions.

The "piggyback" supervision model (Padesky, 1993a) can be used to provide live clinical demonstrations when a group of therapists in a common clinical setting are learning cognitive therapy. This method involves therapy demonstrations conducted in rotation by each learning therapist. The most experienced therapist begins by conducting a cognitive therapy session observed live by the other therapists. After this session, the therapist group discusses the session, emphasizing learning for all group members. The first therapist continues his or her demonstration case with weekly discussions and critique of the sessions. After 2 or 3 weeks a second therapist begins treatment with a new client; sessions are similarly observed and critiqued by the learning group. Within a few months, each therapist provides clinical demonstrations for the group and each group member has the opportunity to observe several sessions per week accompanied by group discussion and analysis.

Clinical demonstrations also can be provided on videotape. Videotapes have the advantage of being shown either full-length to capture many of the advantages of live interviews or in an edited format to emphasize key

learning points in a shorter period of time. In addition, videotaped interviews can be adapted flexibly to many teaching purposes. Therapists can watch videotaped segments and discuss them in relation to cognitive theory, case conceptualization, or interventions. An instructor can show a portion of a videotape and then ask students what choices they would make in the following minutes of the session. Videotaped role plays can illustrate several possible interventions and their outcomes with the same client in the same circumstances. Nonverbal aspects of cognitive therapy can be highlighted by watching a videotape of a session with the audio portion turned off.

Audiotaped demonstrations lack the visual portrayal of nonverbal therapy components, yet retain many of the other advantages of the videotape format. The main advantages of audiotaped demonstrations are increased portability and lower cost. Portability makes it easy for therapists to listen to audiotapes over and over again to enhance retention of therapy questioning patterns, pacing, methods for maintaining rapport, and other treatment principles that may be well-illustrated on a teaching audiotape. Audiotapes of student therapy sessions are used to analyze student strengths and weaknesses implementing particular cognitive therapy approaches with particular clients.

### *Classes and Workshops*

Most therapists who practice cognitive therapy attend one or more cognitive therapy classes and workshops. Even advanced cognitive therapists attend workshops or listen to audiotapes of workshops to update skills and learn recent developments from clinician and researcher specialists. The structure and teaching methods used in these classes and workshops influence their learning value.

Classes may be as short as a few hours or meet regularly for 1 or more years. While most workshops are a few hours to 2 days in length, cognitive therapy is best learned in programs where learning occurs over a number of weeks, months, or years. Longer periods of instruction allow time to practice the therapy while still meeting with the instructor for questions and feedback. A number of established training programs exist in Australia, Canada, Europe, Great Britain, the United States, and South America where clinicians can participate in multiweek to yearlong training programs. Therapists who live great distances from such training centers often benefit from serial 1- and 2-day workshops or weeklong programs accompanied by ongoing supervision. A few extramural training programs exist in which therapists can receive training long-distance by attending weekend or weeklong training workshops periodically throughout a year and weekly telephone supervision.

Methods used to teach cognitive therapy in these programs are as varied as the topics taught. Cognitive therapy instructors usually prefer interactive teaching methods in classes and workshops, regardless of size. When

teaching large groups of therapists, greater organization and creativity is necessary to engage the whole group in active learning processes. A few innovative teaching methods are highlighted here.

*Imagery Exercises to Guide Discovery.* Beck often uses imagery exercises to guide student discovery of key teaching points. For example, in an anxiety workshop (Beck & Padesky, 1984), Beck used guided imagery to help participants create vivid pictures of themselves as young children waiting at school for a ride home from parents who were quite late. Participants were instructed to note their thoughts and emotional reactions as time passed up to the time the parent eventually arrived, an hour late.

Following this imagination exercise, Beck questioned the audience about their emotional reactions while waiting for the parent (which varied from anger to happiness to terror) and the thoughts that accompanied these responses. He engaged the entire audience by asking individuals to describe their responses and other audience members to raise their hands if their experiences were similar. Using an overhead projector screen to write different moods next to a column of accompanying thoughts, Beck guided the audience to discover cognitive themes associated with particular emotions. Further questioning of the audience elicited information about the role of imagery in anxiety, the relevance of personal developmental history and schemas in relation to emotional vulnerability, and other theoretical points of interest.

Audience imagery exercises are a good way to generate the data necessary to construct learning points. Students are likely to recall these vivid learning experiences. Further, these exercises often parallel clinical methods used in therapy. After participation in imagery exercises, student therapists are asked to reflect on the power of creating vivid experiences in therapy, rather than simply intellectualizing about problems.

*Using Socratic Questions with Groups.* In therapy, Socratic questions are used to prompt active learning and to encourage a questioning, investigative attitude in the client. Socratic questions serve these same purposes with students. Beck's questions following the imagery exercise described above provide one example of Socratic questioning in a workshop. Instructors also intersperse questions into a lecture to encourage active learning. For example, an instructor might outline the cognitive theory for a particular problem and then ask workshop participants to identify treatment principles that follow from the theory.

As with all Socratic questioning, the level of questions asked should be appropriate to the knowledge base of those questioned (Padesky, 1993b). Beginning therapists can identify cognitive–affective connections but might have difficulty responding to questions that require independent formulation of a cognitive case conceptualization. Therapists with intermediate levels of cognitive therapy experience could respond to questions linking theory,

case conceptualization, and applied treatment principles. Advanced therapists can be questioned about all levels of cognitive theory and therapy as applied to particularly challenging cases.

*Group Demonstrations of Treatment Principles.* The instructor can demonstrate treatment principles by applying them to an entire group. One useful group demonstration is to complete a Thought Record regarding a situation workshop participants have in common. For example, staff at a hospital were required to learn cognitive therapy and many were skeptical that this new approach would be helpful for severely depressed inpatients. As instructor, this author modeled group therapy by helping staff identify their feelings and negative automatic thoughts in the current situation, "learning to use cognitive therapy on the unit," recording and evaluating these reactions on a Thought Record.

Identification of negative automatic thoughts allowed staff members to express their skepticism and reluctance to learn cognitive therapy strategies. Through guided discovery, the instructor was able to help staff members begin to test out their negative beliefs. By the time the Thought Record was complete, the group had identified a number of alternative responses to their negative thoughts. More importantly, the group experienced *in vivo* the powerful effects cognitive therapy methods could have on emotional and cognitive responses to an event. By identifying their own negative, hopeless beliefs, staff experienced cognitive therapy from a perspective similar to that of the depressed inpatients they would help.

*Experiential Exercises.* To learn cognitive therapy, therapists must practice it. Therefore, most workshops and classes include experiential exercises in which participants apply the methods taught. For example, in a 2-day workshop on schema change interventions, the instructor demonstrated methods for schema identification by helping participant therapists identify their own schemas activated in target clinical situations (Padesky, 1994b). Once they identified schemas, individuals volunteered to participate in instructor-led demonstrations of schema change methods in front of the group. Workshop participants then practiced these same methods individually and in dyads with discussion of learning and stumbling points. Many therapists commented that intensive personal experience of the methods taught provided a much richer learning experience than provided by lecture and demonstration only.

Experiential workshop exercises often are conducted in dyads or small groups. In dyads, one therapist takes the client role and the other the therapist. If a small group is involved, some members are designated "therapist" and "client(s)," other members are consultants or observers. To enhance learning, instructors usually structure practice exercises for beginning to intermediate therapists. For example, therapists are assigned a therapy goal, a clinical method to practice, and a particular client situation for the role

play. The client is instructed whether to enact a straightforward or more challenging clinical picture. The instructor(s) observes the small groups and provides consultation when requested. After a time-limited role play, the client gives the therapist feedback regarding what was or was not helpful. Then the larger group discusses what was learned in the role play and how to manage any obstacles encountered.

Beginning therapists often learn best from very structured, time-limited, and goal-oriented practice exercises. As cognitive therapists become more skilled, these role plays become more open ended, with greater therapist choice in goals, clinical methods, and level of client complexity. In this way, experiential exercises become more and more like actual therapy as therapist knowledge and experience increase. In advanced workshops, it is instructive to compare the results of different therapist choices with the same client situation.

## COGNITIVE THERAPY SUPERVISION

Cognitive therapy supervision parallels the therapy itself. Supervisor and supervisee establish a supervision problem list, set goals, collaboratively conceptualize roadblocks to attaining these goals, and strategize to overcome these problems. Within each supervision session an agenda is set, new skills are taught, guided discovery is employed, and homework is assigned. The major teaching methods described above are often employed including clinical demonstrations, role plays, didactic instruction, Socratic questioning, behavioral experiments, and frequent use of case conceptualization.

### Supervision Models

Supervision can include a variety of methods such as case discussion, video/audio/live observation, role-play demonstrations, and cotherapy. Supervision can emphasize a focus on mastery of cognitive therapy methods, case conceptualization, the client–therapist relationship, therapist reactions, and/or supervisory processes themselves (when the supervisor wishes supervision to improve supervisory skills and process). While most supervision includes a variety of methods and foci, the supervision grid in Table 13.1 provides a graphic outline of supervision options for purposes of discussion.

As Table 13.1 implies, within each supervision focus, learning can be achieved via any of the supervision modes. For example, a therapist attending supervision to learn cognitive therapy methods for treating panic disorder could learn these through discussion of a particular case, supervisor observation of treatment sessions, role plays in supervision, or enlistment of a cotherapist for the treatment itself, either the supervisor or a peer therapist. Similarly, any supervision method can advance learning about any super-

**TABLE 13.1.** Supervision Options Grid

| Focus | Mode | | | | |
|---|---|---|---|---|---|
| | Case discussion | Video/audio/ live observation | Role-play demonstration | Supervisor–supervisee cotherapy | Peer cotherapy |
| Mastery of cognitive therapy methods | | | | | |
| Case conceptualization | | | | | |
| Client–therapist relationship | | | | | |
| Therapist reactions | | | | | |
| Supervisory processes | | | | | |

vision focus. For example, role-play demonstrations in supervision can emphasize learning cognitive therapy methods, case conceptualization, use of the client–therapist relationship, therapist reactions, or supervisory processes.

Supervision is conducted in both individual and group formats. The supervisee(s) sets an agenda to determine how time will be spent, including choice of supervision modes and foci. In group supervision, it is best if all group members participate each session, although one or two members may receive the majority of the supervision time in any given meeting. An advantage of group supervision is that group members help supervise each other. In this way, therapists learning cognitive therapy have an opportunity to reflect on the principles they are learning and discuss their application with colleagues.

## Supervision Guidelines

While there are many supervisory options, a few principles can guide supervisory choices; (1) build on the supervisee's strengths; (2) choose modes and foci that help develop the next stage of competence; (3) build conceptualization skills so supervisees learn to help themselves, (4) when difficulties occur, use a supervisory road map to pinpoint the problem; and (5) pay attention to what is not discussed in supervision. These principles are illustrated with examples from the supervision models summarized in Table 13.1.

### *Build on the Supervisee's Strengths*

Since guided discovery is central to cognitive therapy, supervision employs this same process. A supervisee's strengths provide a good starting point

for guided discovery. For example, if a supervisee has good knowledge of cognitive therapy methods but poor conceptualization skills, the supervisor might ask the supervisee to role play a problem clinical situation (using a mode of supervision that is a strength). This role play could be followed by questions about how these interventions generally proceed (a focus on cognitive therapy method and process that is a strength) and how difficulties occur with this particular client. Then the supervisee could be asked to consider what client beliefs or interpersonal processes might be impeding progress (to begin to build case conceptualization skills).

In contrast, another supervisee might have good case conceptualization skills, yet poor knowledge of cognitive therapy methods. This supervisee might benefit from a initial focus on case conceptualization within a mode of case discussion. The supervisor could provide didactic instruction on therapy methods or elicit ideas from the supervisee by asking questions about how the case conceptualization might fit with cognitive theory and approaches. These discussions would be followed by role-play practice, perhaps with the supervisor initially modeling the methods that the supervisee needs to learn.

### *Choose Modes and Foci to Develop the Next Stage of Competence*

As the preceding examples suggest, supervision begins within modes that emphasize a supervisee's strengths and then shifts to modes and foci that will develop new competencies. Any supervision mode can help develop new competencies. However, it is recommended that each supervision relationship include video, audio, or live observation of sessions because a supervisee's verbal summaries of sessions can describe, at best, only elements of the session within his or her current awareness and understanding. Observation of sessions alerts the supervisor to supervision needs the supervisee may not recognize.

The various foci in Table 13.1 also are used to enhance therapist competence. For beginning therapists, supervision time is usually spent mastering cognitive therapy methods, clinical processes, and case conceptualization skills. Intermediate therapists continue work in these areas with additional attention given to the client–therapist relationship. Advanced therapists ask advanced questions in these three areas and additionally benefit from therapist-focused supervision and even supervision-focused supervision.

Therapist-focused supervision involves identifying therapist emotions and beliefs activated during therapy. While this focus of supervision can be instructive to therapists of all skill levels, it is particularly useful for more advanced therapists learning about schema processes in cognitive therapy. The following vignette illustrates how this supervision focus might be explored with an advanced therapist:

THERAPIST: I'm really struggling in my work with Andy.

SUPERVISOR: What's a struggle for you?

THERAPIST: At the end of the session, he never wants to leave my office. And, unlike with other clients, I find myself letting him stay longer rather than setting a clear stopping time.

SUPERVISOR: What focus would you like to take in working on this: review of strategies for ending on time, case conceptualization, looking at your relationship with Andy, or focusing on your own reactions that might be playing a role?

THERAPIST: I know what to do and I think I have a pretty good case conceptualization. I'd like to understand my own reactions better because they surprise me; I'm not clear what's going on.

SUPERVISOR: Alright. Let's imagine it is the end of the hour and Andy is indicating he doesn't want to leave. Imagine it vividly and see if you can capture your thoughts and feelings.

THERAPIST: (*Imagines silently for a few minutes.*) I feel scared. I want to be helpful to him.

SUPERVISOR: Do any images or memories come to mind?

THERAPIST: How I feel is just like I felt when my mother was waiting for my dad to come home. He was a policeman and she always worried about him. She was anxious and wanted me there. I wanted to go play but felt like I should stay because she was scared. But being with her made me feel anxious.

SUPERVISOR: In this scene with your mother, what were your schemas about yourself?

THERAPIST: I'm responsible.

SUPERVISOR: About the world?

THERAPIST: I suppose, "Unpredictable things happen."

SUPERVISOR: About your mother?

THERAPIST: I'm not sure. I guess. . . . She needs me.

SUPERVISOR: And if you are not there?

THERAPIST: She'll fall apart.

SUPERVISOR: And if that happens?

THERAPIST: I'll be all alone.

SUPERVISOR: What feeling did you have when you said that?

THERAPIST: Scared.

SUPERVISOR: So, you see yourself as responsible and at risk of being alone if you are not supportive to your mother. Also, unpredictable things happen and others will fall apart if they do. Is that right?

THERAPIST: Pretty close. It's even a deeper belief that "if I stay close, I can prevent the bad thing from happening." I know that's illogical, but I think I believed that as a child.

SUPERVISOR: Do you see any way these reactions and beliefs might be related to this therapy dilemma with Andy?

THERAPIST: Yes. He has the same apprehensive silences my mother had. I also feel quite close to him and want him to feel more secure. He does have some rough things happening in his life right now and I think I'd like to protect him from those.

SUPERVISOR: And do you think Andy will fall apart in the face of these bad things?

THERAPIST: I'm not sure.

SUPERVISOR: Do you think spending extra time with him is protective in a good way?

THERAPIST: Hmm. I don't know. All I know is it feels risky at the time to end the session.

SUPERVISOR: Do you think there is a way to help Andy, without reflexively responding according to your childhood schemas?

THERAPIST: I know that's a straightforward question. But I really can't think of anything, so I agree my schemas must be interfering. What ideas do you have?

In this example, the therapist has enough knowledge of schemas that she can identify her own when asked to do so. Even with this knowledge, the supervisor needs to ask questions to help the supervisee identify key beliefs attached to emotional responses. Notice that there is a fine line between therapist-focused supervision and therapy. One way this supervisor maintains a supervision focus is to ask how these particular schemas and this particular developmental event relate to the therapy problem under discussion. In supervision, therapist emotional reactions, schemas, and developmental history are used to inform understanding of the dilemmas faced by a therapist conducting therapy; they are not explored for their own sake.

### *Build Conceptualization Skills*

An ability to conceptualize client and therapy difficulties is critical to the development of therapist competency. Therefore, supervision aims to develop conceptualization ability rather than simply solving problems. Guided discovery can be used to foster analytical skills in supervisees following the stages outlined by Padesky (1993b):

1. *Begin with informational questions* such as, "How can I help you today?" "How would you prioritize your concerns?" "What mode or focus

of supervision do you think would be most helpful?" "What is happening or not happening in therapy that leads to your question?" "What are you doing that helps?" "At what point do your interventions break down?" "Do you have any idea what the problem is?"These questions require the supervisee to focus and define a problem area and encourage active participation in the supervision process. Further, they help educate the supervisee about areas of analysis that may be important to consider. In addition, they may elicit the information necessary to resolve the difficulty.

2. *Listen carefully to what the supervisee says or does not say.* Pay attention to how the supervisee describes the problem. What affect is present? Is the supervisee perplexed, ashamed, or anxious? Strong emotional responses may be clues that therapist beliefs are activated in the clinical situation or supervision and need to be addressed. Listen to assess the supervisee's level of understanding of the problem and the terms in which he or she is formulating it. For example, is he or she describing the problem as poor client motivation when the data suggests the client has skill deficits?

3. *Make frequent summaries and ask the supervisee to do the same.* Summaries provide an opportunity to mutually test your understanding of what has been discussed or role played. It is important to provide time in supervision to process feedback. Both supervisor and supervisee should write down helpful conclusions or hypotheses for future reference. Allow time for the supervisee to summarize what has been helpful or not. In turn, the supervisor can give feedback on what critical learning issues emerged from the supervisory session.

4. Finally, *ask analytical and synthesizing questions to foster the supervisee's conceptualization skills.* Basic synthesizing questions include, "How do you think this conceptualization might apply to the problem you had in the last session?" "So what might you do in the next session?" "If this doesn't have the desired result, what other options do you have? How do you predict this will affect the therapy relationship?" Therapists can be asked to draw their conceptual model on paper, linking beliefs, affect, behaviors, and situations.

### *Use a Supervisory Road Map for Locating Problems*

Supervision is mostly filled with problems to be solved. The supervisor must assess what type of problem exists before choosing a strategy for addressing it. A five-stage decision tree can be helpful. A negative response to any of the first four questions indicates that supervision can begin at that level. The fifth question looks for more subtle sources of difficulty:

1. Is there a cognitive model for understanding and treating this client problem? If not, it is necessary to construct a cognitive model for conceptualization and treatment.

2. Is the cognitive model for conceptualization and treatment being

followed? If not, explore reasons for not doing so. Discuss advantages and disadvantages of cognitive or alternative conceptualizations and treatment plans.

3. Does the therapist have the knowledge and skill to properly implement the cognitive therapy treatment? If not, help the therapist learn these skills and knowledge.

4. Is the therapeutic response following expected patterns? If not, formulate hypotheses about why client response is different from expected. Consider client beliefs, skill deficits, emotional responses, interpersonal patterns, life circumstances, and developmental history. Also consider the factors in item 5 below.

5. What in the client conceptualization/therapy relationship/therapist response might be interfering with success? Include hypotheses about the therapist (beliefs, skill deficits, emotional responses, interpersonal patterns, life circumstances, developmental history), the therapy relationship (e.g., is it positive and collaborative?), the cognitive conceptualization (e.g., is something missing or inaccurate?), and the treatment plan (e.g., are there additional approaches that might help?).

### *Pay Attention to What Is Not Discussed*

While important to address a supervisee's questions and concerns, it is also crucial to notice what is not discussed in supervision. Ongoing supervision should include a periodic review of a therapist's entire caseload. Otherwise, a few particularly troublesome cases may receive all supervisory help at the expense of other cases. Some supervisees will hesitate to discuss cases in which they feel particularly inept. Others may neglect to mention successful cases and thereby mislead the supervisor regarding areas of competency. Further, within case discussions it is important to note what information may be missing.

For example, one supervisee sought help for a client who was frequently noncompliant with homework tasks. The supervisee conceptualized the client as an extremely dependent woman who was unwilling to take on responsibilities. While the supervisee presented in great detail her hypotheses about why the client was not doing homework, the supervisor noted there was no mention of whether this client was responsible in any other areas of her life. When asked, the therapist noted that the client held two jobs. Further discussion revealed that the therapist felt critical of this client because she gave up a child for adoption 20 years earlier. The therapist concluded from this event that the client was "unwilling to bear her responsibilities."

Supervision helped this therapist see that her attitude toward the client was subtly judgmental and therefore harmful to the therapeutic relationship. The supervisor helped the therapist develop better understanding for her client's decision at age 17 to give her baby up for adoption. The ther-

apist realized she was not considering her client's age and circumstances when the decision was made regarding her child. Once the therapist's reactions were examined, she was able to see her client as a responsible adult. This shift in perspective allowed the therapist to be open to other conceptualizations of the homework noncompliance. The therapist discussed the problem with the client with genuine curiosity rather than judgment and the therapy impasse was resolved.

If supervision seems constricted or overly narrow in focus, supervisor and supervisee can explore their emotional reactions and beliefs to discover what is impeding supervision. For example, although it is ideal to have collaboratory supervision relationships, some supervisors or supervisees adopt a more evaluative or judgmental tone that can negatively impact creative exploration and disclosure of cognitive therapy learning experiences by the supervisee.

## COGNITIVE THERAPY FOR THERAPISTS

A final process that enhances the competency of cognitive therapists is participating in cognitive therapy as a client. To fully understand the process of the therapy, there is no substitute for using cognitive therapy methods on oneself. Most cognitive therapists use cognitive therapy in their own life at times. As described above, training programs and supervision often employ cognitive therapy methods to solve problems and enhance learning. It is also helpful for cognitive therapists to seek cognitive therapy when in need of psychotherapy.

Therapists, like most people, often enter therapy in a time of crisis. Cognitive therapy initiated during a crisis can be extended to include identification and exploration of schema issues that may maintain problem patterns. Others seek therapy for general self-improvement. Again, schema-focused therapy is immensely helpful for therapists wishing to understand patterns and make changes.

In regions or countries with only a few cognitive therapists, it can be difficult to identify a cognitive therapist who is not also a friend or colleague. Some therapists in these circumstances have chosen a therapist at some geographic distance and combined live sessions with telephone therapy. Other therapists form dyads or small groups for peer co-therapy. Therapists without access to another cognitive therapist could conduct structured manual-assisted self-therapy following procedures described in Greenberger and Padesky (1995) and Padesky with Greenberger (1995).

## SUMMARY AND CONCLUSION

Athough cognitive therapy has well-defined conceptual models and treatment protocols, developing competent therapists is not a simple task. As

cognitive therapy becomes more specified and sophisticated, therapists have more to learn in order to attain competency. Fortunately, the same processes and methods that characterize the therapy can be used to teach and supervise therapists.

Cognitive therapy instructors use the principles of collaboration, guided discovery, structure, and empirical investigation to ensure active student participation in learning programs. Supervisors build on therapists' strengths, choose supervisory methods that help develop therapist competency, and emphasize conceptualization skills to further promote therapist learning. Since the cognitive therapy field is dedicated to empirical research, cognitive therapists always need to improve competency based on new developments. Research on the relative merits of different teaching methods is in its infancy. The guidelines provided here are intended as a springboard for this research and further developments in the areas of training and supervision.

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