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Using cognitive therapy supervision to address supervisee and patient avoidance: Parallel and interpersonal processes

Niel McLachlan[1]* and Lauren Miles[2]

[1]Consultant Clinical Psychologist, Cambridgeshire and Peterborough Foundation Trust, CAMHS, Winchester Place, 80 Thorpe Road, Peterborough, PE3 6AP, UK
[2]CAMHS Practitioner, Cambridgeshire and Peterborough Foundation Trust, CAMHS, Winchester Place, 80 Thorpe Road, Peterborough, PE3 6AP, UK

Abstract

This article aims to provide an overview of cognitive therapy supervision within the context of psychotherapy-based supervision. Following a brief discussion of the literature emphasizing the importance of the supervisory alliance, therapist development, and improvement for clients, a further focus is a series of formative conversations during cognitive therapy supervision informing treatment of a young person with low mood within the interpersonal context. The article focuses on the transfer of the content of these discussions to therapy as well as the supervisee's assumptions which could potentially impact on treatment outcome. The outcome of the therapy is summarized and the article concludes with details regarding the supervisor's own thoughts and feelings, decision-making processes and planning within the supervisory relationship.

Introduction

Proctor [1] described supervision as a co-operative, facilitating process with a two-fold aim. The first is to develop the worker and a second aim is to ensure responsible practice. In order to achieve this, Proctor [1] proposed the three-function interactive model of supervision. The three functions refer to the formative task, i.e. the personal and skill development of the supervisee, the normative task which refers to monitoring and evaluation of the supervisee and thirdly, the restorative task supporting the well-being of the supervisee.

Bernard and Goodyear [2] distinguish three primary categories of supervision models. According to them, developmental models of supervision focus on supervisee development and keep the supervisor attuned to the different needs of supervisees at different levels of training. Within this framework some developmental models of supervision may draw on psychosocial developmental theory or others may include cognitive learning theory, whilst focusing on the professional needs of the supervisee.

Supervision process models on the other hand observe the supervision process itself. These models [2] take an interest in supervision as an educational and relationship process. One such model was developed by Hawkins and Shohet [3], known as the seven-eye model, identifying seven supervisory phenomena that the supervisor may wish to focus on at any given moment. The model is further referred to as a double matrix model. In the first matrix the supervisor pays attention to the supervisee-client relationship and in the second matrix the focus is on the supervisor-supervisee relationship. The seven eyes relate to the different modes the supervisor uses to navigate the different relationships. The first mode focuses on the client, the second on the strategies and interventions the supervisee uses, thirdly there is a focus on the supervisee-client relationship, the fourth mode focuses on the supervisee, the fifth focus is on the supervisory relationship, the sixth mode is when the supervisor focuses on him/herself and the seventh mode implies a focus on the wider context, i.e. organizational and social context.

In line with the perspective of the developmental models [2], Hawkins and Shohet [3], argue that it is helpful for the supervisor to be aware of the developmental stage of the supervisee. As a general rule, supervisees who are new to their work need to start with most of the supervision focusing on the content of the work and their interventions. As the supervisees' skills develop, other areas such as the internal processes of the supervisee, often become more central within supervision.

The third category, psychotherapy-based models, refers to supervision models based on psychotherapy theories. Psychotherapy-based models of supervision assume that the supervisor works as a therapist and a supervisor and that many of the techniques used in therapy are also used in supervision [2]. When clinical supervision aims to teach the supervisee therapeutic skills, Sloan, White and Coit [4] argue that in order to maintain a clinical focus during supervision sessions, it is important to employ a supervision model which reflects the therapeutic orientation from which the supervisee works. Such an approach also allows for the incorporation of specific effective supervisory behaviors such as case presentation, joint working, direct observation, role play, audio and video recording review and the provision of theory-practice links which is important from a formative perspective.

Cognitive therapy supervision

Psychotherapy-based supervision

The templates for best practice in Cognitive Therapy Supervision have been provided by Padesky [5] and Liese and Beck [6]. A

Correspondence to: Niel McLachlan, Ph.D, PG Dip CBT, Extra Mural Cert CT, Consultant Clinical Psychologist, Cambridgeshire and Peterborough Foundation Trust, CAMHS, Winchester Place, 80 Thorpe Road, Peterborough, PE3 6AP, UK, Tel. 01733-777939, E-mail: niel.mclachlan@cpft.nhs.uk

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more recent update of these views is provided by Beck, Sarnat and Barenstein [7], who in line with Sloan, White and Coit [4], argue that psychotherapy-based supervision structures the learning process by providing a coherent approach to therapy. Knowledge, theory and techniques derived from a specific orientation inform the conduct of treatment and provide a clear focus for supervision. The authors [7] suggest Cognitive Therapy Supervision shares some commonalities with cognitive therapy treatment such as the importance of developing a relationship, planning sessions based on a case conceptualization, using techniques within session such as guided discovery and role play, and responding to automatic thoughts and beliefs. The structure of Cognitive Therapy Supervision also closely parallels the structure of a Cognitive Behavioral Therapy (CBT) session with the following elements: a check-in, a bridge back to the last session, setting the agenda, working through agenda items, summarizing, assigning homework and getting feedback [7].

In cognitive therapy supervision, supervisors also listen to therapy tapes employing the Cognitive Therapy Rating Scale Revised (CTS-R) [8]. When listening to tape recordings supervisors should ask themselves the following questions: "what seems to be the client's most important problems, cognitions, behaviors and emotions, what other data is needed to conceptualize the client and formulate an overall treatment plan, what did the supervisee do well, what were weaknesses, what does the supervisee need to learn in terms of conceptualization, techniques and strategies when planning for the next session" [7, p.65]. The authors [7] also stress the importance of assessing the strength of the therapeutic relationship in the first instance when listening to tapes because a problematic alliance may lead to a client prematurely ending therapy.

In line with Proctor's [1] views regarding formative function, Beck, Sarnat and Barenstein [7] conclude that the aim of Cognitive Therapy Supervision is to help supervisees to integrate theory into clinical practice. Although not attended to produce therapeutic benefits to the supervisee, supervision also pays attention to supervisee's beliefs and the impact of these beliefs on practice.

Restorative and formative role of supervision in cognitive therapy

Corrie and Lane [9], in an expansion on the formative role of supervision, describe supervision in CBT as an essential component of therapist development. Reiser and Milne [10] also stress the importance of incorporating educational, developmental and learning principles in clinical supervision. The authors identify the following strategies to enhance learning in supervision: educational role play, interactive methods, the review of audio or video recordings and giving constructive feedback. To strengthen this learning alliance, Lombardo, Milne and Proctor [11] emphasize the importance of emotion and the supervisory alliance. Parallel to therapy, supervision should be characterized by the agreement of supervision goals and mutual engagement of the supervision tasks to compose the supervisory bond. In addition, such a bond can be strengthened by supervisors supporting their supervisees in recognizing their thoughts and beliefs and how these may contribute to their emotions and behaviors during supervision and in clinical sessions.

Prasko, *et al.* [12] argue that actions aimed at establishing the supervisor-supervisee relationship should reflect principles similar to those employed to establish the therapeutic relationship. The supervisor's behavior should include examples of respect, empathy, acceptance and encouragement, similar to how clients should be treated. However, the authors stress that supervision is different from therapy in that supervision should be an educational process aimed at improving therapeutic competencies of the therapist when working within a specific model or with specific clients. The above arguments are in line with Proctor's [1] views regarding the restorative and formative functions of clinical supervision. As an extension of these views [1], Milne, Leck and Choudri [13] summarize the overarching purpose of supervision as the fostering of safe and effective clinical practice.

Parallel and interpersonal processes in supervision

In order to account for interpersonal processes in therapy and supervision, Bennett-Levy and Thwaites [17] developed the self-practice, self-reflection approach in cognitive therapy. Within this approach CBT supervisees practice CBT techniques such as completing thought records on themselves, resulting in reflection on this experience and their practice. Sloan, White and Coit [4] highlight the benefits of becoming aware of own cognitions, emotions and behavior in therapeutic work with clients, such as exploring in supervision how having an underlying assumption about a client or the therapy process may compromise the application of cognitive therapy. It is also important for the supervisor to evaluate their own thoughts, feelings and behavior within this process [18].

According to Prasko, *et al.* [12] there is an important parallel reflecting the therapist-client relationship in clinical supervision. In many respects the supervisor offers an example to the therapist of how clients should be approached. It is also the responsibility of the supervisor to work with supervisees' attitudes affecting the therapeutic relationship. Friedlander, Siegel and Brenock [18] described parallel processes as a phenomenon in which supervisees unconsciously present themselves to their supervisors as their client has presented to them. The process reverses when the supervisee adopts attitudes and behaviors of the supervisor in relating to the client. According to Russell, Crimmings and Lent [19], parallel processes can be useful due to the fact that as the supervisee becomes aware of the parallels in the relationships with the client and the supervisor, understanding of the client's difficulties increases. Secondly, the supervisee learns how to respond to the client just as the supervisor has responded to the supervisee [19].

In their overview of parallel processes in supervision, Bernard and Goodyear [2] focused on the following description by Friedlander, *et al.* "the process is initially triggered by the client or by some aspect of the client-therapist relationship, it occurs outside the awareness of the participants and the supervisee (therapist) serves as a conduit of the process from the client-therapist relationship to that of the supervisor-supervisee" [p.65]. Milne *et al.* [20] explored whether cognitive therapy methods used in supervision were transferred to the therapy process by providing examples of this process. For example, in one session the supervisor explained the cognitive model of Obsessive – Compulsive Disorder to the supervisee, who in turn explained it to the client in a further session. The authors do note, however, that this mirroring of actions does not necessarily produce good therapy. However, they also state that supervision and therapy necessitates change and an awareness of these processes helps to promote learning and effective change.

Outcomes in supervision

According to Milne, *et al.* [14], effective supervision impacts positively on routine clinical practice when it contributes to supervisee's learning in terms of changes in attitudes and skills. Callahan *et al.* [15] note that supervisors may account for approximately 16% of the

variance in outcome beyond that accounted for by the client's initial severity and the treating therapist's (supervisee's) attributes. Their findings suggested client–focused supervision, i.e. supervisor empathy and supervisor problem solving, when compared with supervision focused on case management, resulted in improved client outcome. In order to improve supervision, Milne and Reiser [16] suggest that supervision should account for therapist drift and difficulties with client engagement, as commonly reported by clinicians within community settings. This can be achieved by incorporating client vignettes with poorly engaged clients and using role plays to address common barriers likely to be encountered by practitioners who are modifying their usual approach to session structure and cognitive therapy in general.

Summary

In line with the three function interactive model of Proctor [1], the emphasis in cognitive therapy supervision is to improve clinical practice by developing the supervisee (formative function) [7,13]. In order to achieve this, the importance of the interpersonal processes in therapy and supervision as well as the learning alliance is stressed (restorative function) [11,17]. Within this environment, characterized by a collaborative therapeutic and supervisory relationship, corrective feedback and the gauging of supervisee's competence is essential (normative function) [7].

Case example

The purpose of the following descriptive case study is to discuss a series of formative discussions employed during eight Cognitive Therapy Supervision sessions. The formative discussions were used to guide the treatment of a seventeen year old girl, Sophie (pseudonym)*, presenting with low mood within the interpersonal context.

The discussions will highlight parallel processes in the transfer from supervision to treatment by demonstrating how Sophie's avoidance in therapy triggered avoidance within the therapist (supervisee).

**The patient provided written consent for the releasing of confidential material in this manuscript.*

A further focus is to illustrate how the supervisee's avoidance was addressed by focusing on interpersonal processes in supervision, i.e. supervisee's thoughts, feelings and behaviors in relation to the treatment process. Finally, the case discussion focuses on the supervisor's behavior during supervision.

Supervisory context

Setting

The client, Sophie, described below was seen within a Child and Adolescent Mental Health (CAMH) outpatient clinic offering services to children, young people (age range: 5-17) and their families who present with mental health difficulties.

Supervisor

The supervisor is a Consultant Clinical Psychologist and an Accredited Behavioral and Cognitive Psychotherapist and Supervisor within the above-mentioned service.

Supervisee

The supervisee is a Children's Nurse with specific training in child and adolescent mental health working in the above-mentioned service and is in her second year of training as a Cognitive Therapist on a Post Graduate Diploma Course in CBT.

Presentation of case material

In order to make the complex interplay of information in the sections below more concrete, the discussion will attempt to follow a structured approach focusing on one or more of the following: the therapeutic context, the identification of parallel processes between therapy and supervision (by focusing on supervisee's reactions based on Sophie's responses in therapy sessions), the problematic interpersonal processes experienced in therapy (by focusing on supervisee thoughts, feelings and behaviors in supervision) and the supervisor's behavior and interventions during supervision.

Assessment

Sophie was referred to her local CAMH clinic via her General Practitioner (GP) following a two year history of low mood and self-harm, she denied any suicidal ideation. Sophie's low mood was in turn impacting on her sleep and appetite and causing excessive restlessness. Sophie lived with her mother, stepfather and a younger half sibling. Sophie stopped contact with her biological father around the time her difficulties started and she recognized this lack of contact as a significant loss. Sophie described experiencing intermittent bullying throughout her schooling. Throughout the initial assessment Sophie was tearful when discussing her low mood and self-harm, however digressed the conversation away multiple times to discuss topics of interest.

Based on the supervisor's experience of working with young people who employ different avoidance strategies to cope with negative affect, as well as an awareness of immediacy within the therapeutic context [21], the supervisor started to hypothesize within supervision that Sophie was using avoidance as a coping strategy during therapy sessions [supervisor behavior].

Formulation

Throughout subsequent therapy sessions, a collaborative formulation was developed. Sophie presented with persistent low mood in the context of interpersonal difficulties relating to assumptions that she was unable to cope alone and would always let people down and be abandoned due to a belief of worthlessness. This resulted in a sense of hopelessness regarding future achievements and relationships.

To safeguard herself, Sophie adopted maladaptive coping strategies, specifically cognitive, behavioral and emotional avoidance [22], however when this avoidance broke down Sophie would become overwhelmed and self-harm as a form of release. This avoidance was fundamental to maintaining Sophie's difficulties and was therefore a key theme raised throughout the supervision process.

Drawing on existing knowledge of the Beck Cognitive Model [23,24] of depression, the supervisor speculated [supervisor behavior] that Sophie's negative self-beliefs were triggered by difficulties within the interpersonal context. Taking into account the history of bullying, trauma was also considered as a reason for avoidance in the preliminary formulation during supervision [25].

From supervision to treatment: Parallel and interpersonal processes

Sophie attended a total of fifteen clinic appointments over an eight month period. During this time, eight supervision sessions were held specifically concentrated on Sophie, three of which involved the reviewing of session recordings using the Cognitive Therapy Scale - Revised (CTSR) [8]. Supervision sessions were held on a fortnightly to monthly basis for one hour duration. A supervision contract was

agreed and signed prior to supervision commencing and reviewed as necessary. The following discussion will focus on the content of these supervision and therapy sessions, highlighting supervisee experiences, supervisor conduct and parallel processes in therapy.

Supervision session 1

The supervisee initially shared uncertainty as to whether Sophie's significant level of avoidance was indicative of low mood or anxiety-related difficulties [supervisee question]. This question was in line with the cognitive therapy model, which recognizes that accurate diagnosis enhances cognitive specificity, i.e. specific disorders are associated with specific cognitive content, and consequently a more focused intervention [26]. In order to address this issue, it was agreed during supervision to structure future therapy conversations employing cognitive maintenance cycles [5] to gather information [supervisor response]. This intervention was based on the supervisor's advice that the process of compiling maintenance cycles would enable the supervisee to identify specific themes in Sophie's presentation [27,28] which in turn could inform the diagnostic process.

During therapy Sophie shared that she was unable to cope with relationship breakdowns and a common theme of "I'm not good enough for others" emerged as a result of the conversations based on the completion of different maintenance cycles. In order to cope with this fear, Sophie employed a number of avoidance strategies, i.e. seeking acceptance and reassurance from others, withdrawing from interpersonal relationships and self-harming.

Supervision sessions 2 and 3

During supervision sessions 2 and 3, it was agreed that Sophie's presentation could potentially be explained as that of low mood within the context of interpersonal difficulties. Based on this decision, it was decided to initially complete a social inventory with Sophie to identify her rules for engagement with others [29]. Following this a longitudinal formulation was then developed in line with Beck's cognitive model of depression [22,23]. The supervisor made these recommendations [supervisor behavior] based on theory-practice links, i.e. within the Interpersonal Therapy Process, social inventories are often used to inform the therapist about the quality of adolescent relationships [29]. In addition, the Beck Model allows a focus on assumptions or rules of engagement within the interpersonal context [22,23].

Supervision session 4

Supervision session 4 was informed by the feedback discussion based on a review of a videotaped session using the CTS-R [8]. It was clear from the observation that Sophie was using general conversation as an avoidance strategy. By discussing topics such as school life, she managed to dictate the agenda during the session and avoided having to talk about interpersonal conflict and her inability to be assertive in these situations. Although recognizing this strategy, the supervisee expressed unease with being more "directive" in sessions [indicating supervisee avoidance]. The supervisor assumed that this statement was the result of the supervisee being scared Sophie may disengage from therapy. This in turn triggered a questioning style based on Socratic Method [30,31] in supervision [supervisor behavior]. Through recounting the session in supervision, the supervisee identified personal beliefs about not being a good therapist and being "untherapeutic" when attempting to be directive as factors which may compromise the application of cognitive therapy [the supervisee's belief was triggered by Sophie's response]. In order to address the supervisee's and Sophie's avoidance, it was agreed to make agenda setting a clear focus in the next therapy session [supervisor introducing a strategy to address supervisee's unhelpful assumption]. The supervisor made this recommendation based on the knowledge that setting an agenda would allow for a collaborative, structured approach as well as enabling the supervisee and Sophie to discuss difficult material, i.e. addressing Sophie's avoidance within the context a safe environment [32].

Supervision session 5

During further therapy sessions Sophie's key relationships and her behaviors when dealing with conflict were explored. Based on a discussion in supervision session 5, it was agreed to share a longitudinal Cognitive Therapy formulation [22,23] with Sophie [supervisor using theory-practice links to guide discussion]. The supervisor recommended this as the Beck Model would allow for an integration of the interpersonal context as well as self-beliefs within therapy [22]. Based on this intervention Sophie concluded in therapy that her difficulties could be attributed to her being "weak willed" i.e. avoiding confrontation when encountering interpersonal difficulties.

Supervision session 6

Supervision session 6 was informed by a feedback discussion based on the review of a second video recorded session [8]. Based on the video review both supervisor and supervisee concluded that Sophie continued to use avoidance, i.e. discussing topics irrelevant to her agreed treatment goals as a way to distract from the agenda. During this supervision session it was agreed to use tactful "interrupting" [32] as a strategy in treatment sessions to aid cognitive restructuring [supervisor sharing knowledge of literature to aid supervisee development]. The supervisors behavior was characterized by Socratic dialogue and scaffolding [30,33] in order to promote guided discovery on the part of the supervisee.

To structure this formative discussion, Bennett-Levy and Thwaites' [17] six-stage process model of self-practice and self-reflection for addressing therapeutic relationship difficulties in clinical supervision was employed. This model specifically applies when the supervisee experiences a relational problem with a client. Bennett-Levy and Thwaites [17] identify the first stage as the Focused Attention stage. During this phase the identified problem raised becomes the focus for reflection in the supervision session. The supervisee identified avoidance through excessive talking as the problem. During stage two [17] the identified issue is brought to mind by means of mental representation. The supervisor helps the supervisee to evoke thoughts, feelings and behaviors activated at the time of the session through role-play or by reconstructing the experience. Stage three [17] is characterized by helping the supervisee to identify underlying feelings. Using a reconstruction of the session based on video feedback during stage three, the supervisee identified feeling scared to interrupt Sophie for fear of "losing her all together" as the underlying feeling causing her avoidance, an example of the parallel process of avoidance in Sophie and the supervisee.

In stage four [17] the supervisee and supervisor use their conceptual knowledge to create an interpersonal conceptualization of the problem. In this case, Sophie's avoidance-strategy (excessive talking surrounding irrelevant topics) resulted in avoidance from the supervisee within the therapeutic process (concerns regarding Sophie disengaging associated with the supervisee being scared to interrupt and focus on agreed therapy goals). In order to put the agreed procedural skills (interrupting) into practice, a role play to model the appropriate skills to the supervisee was conducted as part of phase five [17] [supervisor

using a cognitive therapy technique to aid supervisee development]. Phase six in the Bennett-Levy and Thwaites [17] model refers to the supervisee attempting to implement the proposed newly learned skill in therapy. In a follow-up therapy session, the supervisee prepared Sophie and agreed on "interrupting" as an important component of future therapy. This intervention allowed Sophie to engage with the cognitive restructuring process and a new rule emphasizing the importance of not avoiding within the interpersonal context was formulated.

Supervision session 7

By supervision session 7 Sophie had stopped attending (cancelled two consecutive sessions). In addition to identifying an avoidant coping style, personal circumstances were also considered as a reason for disengagement, i.e. sitting exams. At this stage, the supervisor was of the opinion that advising the supervisee to interrupt Sophie when avoiding in session might have been introduced too early in the therapy process. Consequently, the supervisor felt anxious about potentially losing Sophie in therapy and disappointing the supervisee. According to Lesser [35], anxiety can arise for the supervisor in response to feelings of responsibility to both the supervisee and the client. In line with the views of Ladany and Walker [36], this experience was shared with the supervisee within supervision as a form of didactic mentoring and to strengthen the supervisory relationship [supervisor offering self-disclosure]. To compensate for Sophie's disengagement, it was agreed with the supervisee to in the first instance conduct a telephone interview with Sophie after which she re-engaged with the therapy process [evidencing collaboration between supervisor and supervisee].

Supervision session 8

Subsequent to another video recording review, supervision session 8 focused on the progress Sophie had made as observed during the video and from the CTS-R [8] and it was agreed to make this progress explicit in therapy [supervisor introducing a helpful strategy when working with hard to engage young people].The supervisor recommended this strategy based on previous experience and understanding of the importance of summarizing within the therapeutic process with young people to help them regain control [37]. Sophie was discharged following this intervention.

Outcome

Following frequent recognition of the progress made within sessions, subsequent agendas set by Sophie focused on reflecting on how she had developed her assertiveness within relationships, adopting maintenance cycles to illustrate this. She also reflected on her challenging of cognitive and emotional avoidance which had in turn resulted in a general improvement in mood and no further self-harming behaviors. The final two sessions therefore focused on relapse prevention planning given the high rates of relapse and reoccurrence in persistent low mood [25,38].

At this stage, end of treatment outcome measures were also completed and comparisons drawn between these and the pre and mid treatment measures. The Revised Children's Anxiety and Depression Scale (RCADS) [39], Work and Social Adjustment Scale (WSAS) [40] and the Beck Depression Inventory (BDI) [41] were completed to obtain generic and disorder specific measures of progress. Whilst there was minimal change in the pre and mid outcome measures, which was likely attributable to ongoing avoidance, there was a significant improvement in all three measures by the end of treatment with results no longer reaching the clinical range. Specifically, the RCADS total depression score reduced from 69 to 21, the WSAS total reduced from 24 to 7 and the BDI total reduced from 26 (increasing to 27 at the midpoint) to 10 at discharge. These outcomes were used as further evidence of progress within the therapy sessions.

Supervisee reflection

Frequent supervision sessions were imperative to maintaining the focus of the treatment and to provide opportunity to increase self-awareness. Through recognition of ongoing avoidance, both in Sophie's presentation and within the supervisee, whose fear of causing offense resulted in further avoidance, formative discussions in supervision focused on the influence of personal beliefs on the therapy process. This was further supported by the joint reviewing of session recordings. Whilst this was initially anxiety provoking due to fear of judgement from the supervisor, it allowed for constructive feedback to be provided. Through this repeated process, personal beliefs surrounding being an ineffective therapist were raised and challenged. This was beneficial in recognizing how these beliefs were in turn preventing Sophie challenging her own beliefs within therapy. This process was also supported through the supervisor expressing personal feelings of anxiety in relation to Sophie disengaging, making the supervisee feel their own anxiety was justified and therefore normalized [36].

The knowledge gained from formative discussions held within clinical supervision acted to guide the focus of treatment. It could be hypothesized in line with Milne's, *et al.* [20] view that without this direction Sophie's treatment may have exceeded 15 sessions with a potential delay in discharge. This positive outcome for Sophie further confirms the contribution of supervision, characterized by congruence of theoretical orientation, supervisory empathy and problem solving, on client improvement [15].

Supervisor reflection

Considering parallel processes in the supervisory-therapy process, sensitized the supervisor to reflect on his own beliefs and feelings, resulting in actions which optimized the effectiveness of the supervision. Having agreed a supervisory contract [9] also allowed for a clear focus on reciprocal roles and expectations within supervision. The contract and use of video recording feedback further facilitated a safe environment in which to provide corrective feedback without it being viewed as critical and an assault on the self of the supervisee.

These strategies further encouraged a climate of openness and self-disclosure within supervision. It allowed the supervisor to fluctuate freely between the role of collaborator and coach which eased the process of negotiating a balanced power relationship within supervision [9].

Conclusions

This article focused on formative discussions in clinical supervision and the transfer of the content of these conversations to therapy [20]. In addition, it also focused on the supervisee's beliefs and assumptions about the therapy process [17] as well as supervisor's conduct [18]. The formative discussions aided by video recording reviews identified and addressed the supervisee's assumptions which could have compromised the application of cognitive therapy and provided a focus during therapy with positive effect [7].

Competing interest

The authors declare that they have no competing interests. This manuscript has not been published elsewhere and has not been submitted simultaneously for publication elsewhere.

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