Increasing the Use of Evidence-Based Practices in Counseling: CBT as a Supervision Modality in Private Practice Mental Health

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Abstract

This paper demonstrates how Cognitive Behavioral Therapy (CBT) supervision can be applied in a private practice mental health setting. The CBT model of supervision is a good fit for a private practice mental health setting because of its action orientation and empirical grounding. The CBT modality meets the challenges of a private practice mental health setting since it is appropriate for the types of issues presented by clients in counseling. While CBT is an effective therapy to use for supervision and counseling in a private practice mental health setting, it is recommended that mental health practitioners expand their professional identity by receiving CBT training in conjunction with other therapeutic modalities to have a more expanded and integrative approach in supervision and counseling.

Keywords

Author's Notes

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Introduction

As part of professional development, many mental health counselors go beyond the scope of service delivery to clients and extend their practice to training new counselors (Bernard & Goodyear, 2018). After receiving training as a clinical supervisor, the professional chooses a modality of supervision to utilize as an intervention with the supervisee. A supervisor's theory of counseling may be the basis of supervision sessions. For example, the supervisor may choose an intervention from among the many psychotherapy-based supervision models (Pearson, 2001; Smith, 2009). However, cognitive-behavioral therapy (CBT) is considered one of the most viable therapies used in evidence-based practice in the treatment of mental disorders (David, Cristea, & Hofmann, 2018; Field, Beeson & Jones, 2015; Gaudiano, 2008; Leichsenring, & Steinert, 2017; Society of Clinical Psychology, 2014). Research studies of CBT far outnumber those of any other psychotherapeutic approach (McMain, Newman, Zindel, & DeRubeis, 2015). Meta-analysis of the effectiveness has shown CBT therapy to be somewhat effective. Certainly, against no treatment at all, but very effective in treatment of depression and anxiety disorders and clinical issues as meta-analysis provides evidence (Cuipers, Cristea, Karyotaki, Rejinders, & Huibers, 2016; Cuipers, Donder, Weissman, Ravitz, & Cristea, 2016; David, Cotet, Matu, Mogoase, & Stefans, 2018; Driessen, Hegelmaier, & Abbass, 2015; Tolin, 2010). It is an approach that is empirically grounded and useful in cognitive-behavioral supervision to build relationships and to teach techniques of the theoretical orientation (Smith, 2009).

Cognitive Behavioral Therapy is a combination of cognitive therapy (Beck, 1976) and behavioral therapy (Wolpe, 1958). The behavioral component utilizes techniques such as: modeling, role-playing, feedback, reinforcement, individualized goal-setting, and evaluation for the purpose of teaching counseling skills (Pearson, 2006). The cognitive component consists of the following: collaborative goal setting and monitoring as well as the use of cognitive strategies

for increasing counselors' and clients' awareness of their own thought processes that they bring to the therapeutic alliance (Milne & Dunkerley, 2010; Pearson, 2006).

Probably one of the most salient differences between CBT and some other modalities is that while the therapeutic relationship is viewed as important in CBT, it is not seen as sufficient to help facilitate or create the change the client is hoping to achieve (MacLaren, 2008). Successful and competent practice of CBT in real world settings involves a wide variety of interventions like mindfulness, positive psychology and assisting the supervisee to look at cases more complexly than the simple alleviation of a client's symptoms (Helmes & Ward, 2017; Hick & Chan, 2010; Mak & Chan, 2018; Marrero, Carballeira, Martin, Mejias, & Hernandez, 2016; Olgata, et al., 2018; Seidi & Ahmad, 2017). They may perhaps, engage in client personality reorganization or exploring client motivations for maintaining behaviors, or exploring emotions (Pretorius, 2006). These interventions make use of the therapist therapeutic relationship as a catalyst for change. MacLaren (2008) states that the knowledgeable use of appropriate interventions is a fundamental part of CBT, and it is the combination of the relationship and the interventions that ultimately fosters lasting, generalizable change for clients.

Cognitive behavioral supervision has been recognized as important in the process of enhancing cognitive behavioral therapy (Gordon, 2012; Milne, et al., 2010). Furthermore, CBT supervision employs cognitive behavior therapy specific skills. Moreover, these skills help make CBT supervision distinct from constructivist and problem-solving supervision approaches (Milne, Sheikh, Pattison, & Wilkinson, 2011). Cognitive-behavioral supervision makes use of observable behaviors and reported cognitions (Milne & Reiser, 2017; Newman, 2013; Smith, 2009). At the nucleus of CBT is a collaborative relationship between supervisor and supervisee. This collaborative relationship is a catalyst for change by the supervisee but does not necessitate

change; it provides for the foundation for learning and growth. Given the foundations of CBT therapy and supervision, the purpose of this paper is to review how Cognitive Behavioral Therapy can be applied to supervision in a private practice mental health setting. Key concepts of supervision including supervisory relationship, supervisor accountability and ensuring competency to clients will be presented. Lastly, recommendations that embrace best practices for mental health therapists will be considered.

CBT as a Supervision Model

Generally, there are three approaches to counseling supervision: models grounded in psychotherapy, those that are developmental, and those that are process oriented (Bernard & Goodyear, 2018; Lampropoulos, 2013; McLachlan & Miles, 2017). Psychotherapy-based approaches contribute positively to the supervision environment since psychotherapy theories are designed to promote growth and change in clients; likewise, they can be similarly helpful in promoting growth and change in supervisees (Pearson, 2006; Sloan, White, & Coit, 2000; Smith, 2009). In CBT supervision, the supervisor takes on the roles of teacher, counselor, and consultant (Vyskocilova & Prasko, 2013). From the cognitive-behavioral approach, examples of the supervisor using the teacher role entails active interventions such as exploring, evaluating, and modifying thoughts of the supervisee that can be emulated by supervisee with their clients (McLachlan & Miles, 2017). Additionally, the supervisor and the supervisee can practice strategies and interventions for the supervisee to utilize in their counseling sessions. For example, a supervisor in the role of counselor can use Socratic dialogue to address a supervisee's impasse with their clients. Finally, from the perspective of the consultant role, the supervisor can address treatment plan issues, problems the supervisee brings to supervision, and examine the work the supervisee is doing with their clients. CBT as a supervision model can best be critiqued

as an effective modality when seeing it in action in the important areas of supervisory relationship, the supervisor's accountability, and in the supervisor's competent service to clients.

The Supervisory Relationship

While the roles of the supervisor using the CBT model are relevant, equally important is the supervisory relationship (Ladany, Friedlander, & Nelson, 2005). Clinical supervision can be defined as an intervention provided by a more senior member of a profession to a more junior member (Bernard & Goodyear, 2018; Falender, 2018; Pearson, 2006) in which the focus is on the supervisee's clinical interventions that directly affect the client, as well as those behaviors related to the supervisee's personal and professional functioning (Bradley & Kottler, 2001; Falender & Shafranske, 2007; Milne & Reiser 2017; Newman, 2013; Patel, 2004; Pearson, 2006). CBT supervision recognizes that relationship skills are an important part of supervision, in addition to supervisors shifting between various roles such as: counselor, consultant, and teacher within the arc of the supervisee's growth (Morrison & Lent, 2018). Beck (1995) characterized the therapeutic relationship with a client as being warm, empathetic, caring, and the therapist having genuine regard for the client. Accordingly, the relationship of the supervisor with the supervisee would echo those qualities. Having established those supportive interactions, supervisors also view situations of supervisees and their clients from a position which strives for objectivity, in order to act in the clients' best interests. Moreover though, this position of objectivity is also implemented with a sensitivity to individual differences and with flexibility (Kaiser, 1992; Pretorius, 2006). The following concepts are essential to the supervisor/supervisee relationship and therefore the working alliance. The concepts include power and authority, shared meaning, trust, accountability, safety, telling the story, evaluation, and respecting cultural differences.

Power and authority. Important to supervision are the elements of power and authority which need to be addressed in the supervisory relationship so as not to interfere with the development of a genuine caring relationship between supervisor and supervisee (Falender & Shafranske, 2016; Newman, 2013; Patel, 2004; Pretorius, 2006). Since supervisors, by position, hold the greater power, they are obligated to use it in an ethical manner (Reiser & Milne, 2017). If the supervisor shames or attacks the supervisee rather than responding with empathy and authenticity, the supervisory relationship can lose vitality and productivity and result in chronic disconnection between supervisor and supervisee and as a consequence, both supervisee and supervisor may remain isolated in the relationship and neither party contributing to professional growth (Abernethy & Cook, 2011; Jordan, 2004). In the role of teacher, the supervisor assumes the responsibility for setting appropriate limits and boundaries with regard to such issues as the structure of the supervisory session, the parameters of acceptable professional behavior, and a focus on the supervisee's rather than the supervisor's needs (Kaiser, 1992). This appropriate use of power sets boundaries to create a safe space for the supervisee to share his or her work without being shamed (Milne & Dunkerley, 2010). Finally, the supervisor needs to be an authority in the sense of having something to teach whereupon the trainee will trust that there is something to learn (Milne & Reiser, 2013). If supervisors adopt a hierarchical style of authority, the supervisee might feel intimidated and thus feel they are being placed in a lesser or subordinate role in the relationship. Using suggestive interventions by the supervisor would be advantageous over using directive ones. Other aspects of the supervisor's position of authority are gender, role shifts, and parallel process (Colistra & Brown-Rice, 2011). In terms of parallel of process, a parallel can be drawn between a supervisor who uses power arbitrarily and destructively and a parent who does the same (Bernard & Goodyear, 2018; Kaiser, 1992). With

care and concern, the CBT supervisor can employ empathic approaches and lean more toward collaboration.

Shared meaning. Collaboration leads to shared meaning. While CBT supervisors strive for collaboration in their relationship with supervisees, they have to be mindful of the various roles supervisees are engaged in as well. Supervisees are called on to engage in multiple roles simultaneously: therapist, student, client, supervisee, and colleague (Falender & Shafranske, 2016; Milne & Dunkerley, 2010; Olk & Friedlander, 1992). As a therapist, they are expected to apply therapeutic skills with their clients and in turn in the roll of supervisee report to their supervisor who accepts responsibility for the direction and goals of supervision and discusses issues related to the supervisee's professional growth (Olk & Friedlander, 1992). Collaboration has been recognized as an essential component in supervision regardless of theoretical approach (Bernard & Goodyear, 2018; Ratliff, Wampler, & Morris, 2000). Supervision creates a dialogue of collaboration in order to define expectations, identity, and meaning. On the other hand, this collaboration breaks down when a hierarchical type relationship emerges between the two participants (Milne, et al., 2008). Especially when the supervisor directs dialogue through interruptions, questions, selective formulations, and topic shifts. In CBT terms, this is problematic in particular with the emergence of irrational thoughts (Reiser & Milne, 2017; Ratliff, Wampler, & Morris, 2000). A more egalitarian approach over a hierarchical approach is recommended to achieve shared meaning in a CBT supervisory relationship (Newman, 2013).

As the process develops supervisees gain experience and confidence, the supervisory relationship becomes more collaborative and characterized by greater negotiation (Ratliff, Wampler, & Morris, 2000). Even though CBT supervisors may hold the formal power in the supervisory relationship, there is a deliberate incorporation of shared power that promotes the

growth and development of supervisees. Some novice supervisees, that are beginning to employ the elements of CBT therapy, prefer more structure and direction from supervisors while advanced supervisees having learned the essentials of CBT may prefer a less structured environment (Quarto, 2002). For advanced supervisees, a less directive supervisory relationship is recommended to permit supervisees to develop and rely on their own resources to gain greater awareness and competence in clinical service. The CBT model in supervision supports supervisors functioning as teachers with beginning supervisees and as colleagues with more advanced supervisees. Regardless of developmental level, all supervisees need support and encouragement (Beck, 1995). A goal of supervisors should be to establish a solid working alliance with their supervisees and to be flexible when shifts in relational control occur so as to keep the working alliance strong (Quarto, 2002).

Trust. While shared meaning is important in the supervisory relationship, trust is equally important. A supervisee's trust and feeling of safety will be based on the supervisor's interest in the supervisee's work as well as the supervisee's personal growth (Taylor, Gordon, Grist, & Olding, 2012). The supervisee's trust in the CBT supervisor will be affected if the supervisee experiences the supervisor as overly intrusive or being absent; lack of trust may also be experienced if the supervisee feels confronted (James, Milne, Marie-Blackburn, & Armstrong, 2007; Reiser & Milne, 2017). Respectful treatment of the supervisee, which includes messages that the supervisee is safe to risk and to make mistakes, are an essential ingredient for creating trust in the relationship (Beck 1995; Kaiser, 1992). In CBT terms, an effective way to increase trust in the supervisory relationship is through an uncomplicated self-disclosure, and by a mutual effort to get to know one another better on both a personal as well as professional level (Milne &

Reiser, 2011). A working alliance is established when there is reciprocity expressed through knowledge, support, and encouragement.

Accountability

While establishing rapport with supervisees in the CBT supervisory relationship sets the context, accountability is the process of supervision (Milne & Dunkerley, 2010). Before supervisees are willing to disclose personal information about themselves or their clients, they need to feel that the supervisory relationship is collaborative in nature and is driven by shared meaning, mutual empathy, authenticity, and empowerment. Accountability is taking responsibility for one's behavior and for the impact of that behavior on self and others (Kaiser, 1992; Törnquist, Rakovshik, Carlsson, & Norberg, 2018). Responsibility is a distinguishing CBT component. Supervisory accountability can best be observed through the supervisor creating a safe environment, allowing the supervisee to self-disclose, providing constructive supervisory evaluations, being sensitive to cultural differences, and engaging in didactic/experiential supervisory sessions (Milne & Reiser, 2011).

Safety. As stated above, the supervisor can foster a safe environment through self-disclosure that will give the supervisee confidence that the supervisor has both personal awareness and empathy. Respect and safety are important elements in the supervisory relationship; respect is demonstrated by the attention of the supervisor to the particular learning style and developmental stage of the supervisee as well as the supervisee's personal level of vulnerability to criticism (Kaiser, 1992; Milne & Dunkerley, 2010). Vulnerabilities usually include embarrassment of feeling uncertain, lack of confidence in skills, and concern for personal limitations. Again, the supervisor may use selective self-disclosure to normalize these issues for the supervisee (Abernethy & Cook, 2011; Goldfield, Burckell, & Eubanks-Carter,

2003). To attend to these issues that create disconnections and barriers to growth, supervisors need to create a safe environment and be sensitive to the supervisee's vulnerability while communicating that counseling is complex and ambiguous. The supervisor takes responsibility for addressing problems and tensions in the relationship, and by doing so, the supervisor not only responds in a trustworthy way by addressing relationship challenges but also models the behavior for the supervisee to use with their clients (Milne, 2008).

Telling of the story. Initially in the supervisory relationship, the supervisor might experience some resistance on the part of the supervisee. The supervisory relationship can be intimidating to supervisees and provoke anxiety. Supervision-induced anxieties cause supervisees to respond in a variety of ways, with some of the responses being defensive which serve the purpose of reducing anxiety and are rooted in their inner dialogue of inferiority; this is the root of supervisee resistance (Bernard & Goodyear, 2018; Bradley & Gould, 1994). Accordingly, this resistance is a defensive behavior or coping mechanism to guard the supervisee against perceived threats or anxiety. Irrational perceived threats might entail feeling judged by the supervisor as an inadequate counselor or feeling they are going to receive a negative evaluation. Additionally, the anxiety the supervisee might be feeling could stem from not feeling in control. Sometimes when resistance occurs, the supervisee will give into irrational thoughts and withhold information about their clients in counseling or purposely not self-disclose. In order to overcome these challenges in the relationship, supervisors need to realize the supervisee's vulnerability as a novice counselor and continue to encourage and empower them (Milne & Dunkerley, 2010). Professional growth in the supervisee ensues when there is an alliance between the supervisor and supervisee. Other techniques for managing resistance might include role-playing or videotaping supervisory sessions. Through role-playing or viewing

recorded sessions as well as homework assignments, discussion of the influences of resistance can foster growth and serve as a learning experience (Milne, Reiser & Cliffe, 2013).

Evaluation.   Another aspect of accountability is experienced in the supervisor's evaluation of the supervisee (Milne & Dunkerley, 2010).   Supervisors need to explain that evaluation of the supervisee is constructive and essential when making judgments regarding the quality of the supervisee's work including checking to see if the supervisee is doing competent work with their clients and following the ethical code of the profession. Through evaluation, supervisors make judgments about supervisees' as competent therapists and also their cooperativeness in supervision (Milne, et al., 2008; Milne, Resier & Cliffe, 2013; Taylor, et al., 2012; Törnquist, et al., 2018).   Striking a balance between supervisees' autonomy to make clinical judgments and supervisors' responsibility to ensure competent clinical practice is a necessary supervisory skill; supervisors make judgments about when to confront supervisees through their evaluations or directions and when to allow supervisees' judgments to stand (Kljenak, 2011; Ratliff, Wampler, & Morris, 2000).

Respecting cultural differences.   A third aspect of accountability is the supervisor's respectful attitude toward the supervisee's gender, gender identity, sexual orientation, age, socioeconomic status, disability and cultural identity. Multicultural supervision is a dynamic process in which the supervisor assists supervisees with increasing their awareness about culture and diversity (Hays & Iwamasa, 2006).   Multicultural counseling competencies include three main elements: a) counselor awareness of own assumptions, values, and biases; b) understanding the client's worldview; and c) development of culturally appropriate interventions and strategies (Colistra & Brown-Rice, 2011; Sue, Arredondo, & McDavis, 1992). Gaining knowledge about the supervisees' cultural and diversity is an essential component of cross-cultural supervision

(Newman, 2013; Patel, 2004). Research indicates that when culture and diversity is acknowledged in supervision, supervisees find a more meaningful working alliance with the supervisor and increased satisfaction with the supervision experience (Colistra & Brown-Rice, 2011; Inman, 2006; Jordan, 2004).

Education: didactic, experiential. A final aspect of accountability in the supervisory relationship is providing an educational atmosphere using CBT that is didactic and experiential in nature (Newman, 2013; Gordon, 2012). In the supervisory relationship, supervisors using the CBT modality will structure sessions (Falender & Shafranske, 2007). This is accomplished by collaboratively explaining CBT concepts, setting an agenda, systematically addressing problems, reviewing information from previous sessions, identifying problems, providing feedback, journal writing, teaching new skills, providing tools, role-modeling, role-playing, and assigning homework. In supervisory sessions, the CBT supervisor will shift roles from teacher to consultant to counselor. Throughout sessions, the supervisor empowers the supervisee using encouragement, support, and genuine warmth and concern (Beck, 1995). Through assessing problems and implementing goals, the CBT supervisor uses techniques that are experiential such as role-playing, role reversal, modeling, using imagery, using Socratic questioning, and teaching techniques. For example, the supervisee might want to learn a relaxation technique to use with their clients so the supervisor will explain the technique, demonstrate the technique, and then practice the technique with the supervisee. Interventions used in the supervisory relationship are cognitive, behavioral and emotive in nature and the techniques learned serve to change dysfunctional thinking patterns, behaviors, or emotions. Beck (1995) stated that CBT is an active, collaborative therapy approach guided by goals identified by the client, an ever-evolving formulation of the client, their strengths, and their problems. Evidence shows that in CBT, the

therapist and client are equal participants in the relationship and CBT therapists use support, empathy, and unconditional positive regard in their relationships with their clients (MacLaren, 2008). This same equality and caring can be applied in the supervisory relationship.

Competent Service to Clients

While the supervisory relationship and the supervisor's accountability are important in the CBT supervision modality, so is competent service to clients (Taylor, et al., 2012; Gordon, 2012). Competent service to clients and supervisees entails the supervisor having perceptual/conceptual, executive, and personal skills. Fundamental competence as a supervisor requires abiding by a code of ethics and being ethical in one's behavior. According to Kaiser (1992), ethical behavior is based on a feeling of caring about others as well as engaging "our best self." Additionally, transparency, authenticity, and role clarity are essential elements when providing competent service to clients as well as supervisees. When therapists go over informed consent in sessions, clients are given complete descriptions of procedures; engaging in client perceptions checks is fundamental to CBT and operationalizes transparency (Johnston & Milne, 2012; Loades & Armstrong, 2016). Presence, immediacy, and transparency are integral to all cognitive behavioral practices and cut across CBT therapeutic processes (e.g., self-monitoring, cognitive restructuring, and behavioral interventions) (Friedberg, Tabbarah, & Poggesi, 2013; Weck, Kaufmann & Holfling, 2017).

Perceptual/conceptual skill. While one aspect of competent service to clients and supervisees involves clarity of roles and expectations, supervisors also need to exercise perceptual/conceptual skill. Perceptual skill is the ability of the supervisee to observe what is happening with the client (Kaiser, 1992). Conceptual skill, on the other hand, is the ability to interpret what is happening to the client (Bernard & Goodyear, 2018). CBT supervision

recognizes five specific goals for the supervisor: 1) to develop a supervisory system, process, or style that encourages supervisees to seek and respond to the supervisory process; 2) to evaluate, formatively and summatively, supervisees in the professional knowledge, skill, confidence, objectivity, and interpersonal interactions domains to determine their current developmental levels and professional strengths and weaknesses; 3) to enhance supervisees' growth in necessary, identified areas so that their provision of services and job and self-satisfaction improves; 4) to monitor the welfare of clients served by supervisees; and 5) to provide training so that supervisees can develop their own supervision skills (Bennett-Levy, McManus, Westling, & Fennell, 2009; Knoff, 1988; McMain, et al., 2015; Milne & Dunkerley, 2010, Milne, et al., 2008; Newman, 2013; Talyor, et al., 2008). Through a counseling role, the supervisor role models to the supervisee empathy, positive regard, respect, congruence, genuineness, authenticity, and an ability to use confrontation positively and strategically (Knoff, 1988). Finally, from the consultant role, the supervisor functions in a more collaborative relationship with the supervisee (Loades & Armstrong, 2016; Reiser & Milne, 2017; Weck, Kaufmann & Holfling, 2017) .

Isomorphism. Through a phenomenon known as isomorphism, what happens in the relationship between supervisor and supervisee will be replicated in the relationship between therapist and client (Bernard & Goodyear, 2018; Koltz, Odegard, Feit, Provst & Smith, 2012; Lee; 1999). The concept of isomorphism presumes that the supervisor's use of authority will influence the way in which the supervisee uses authority with clients (Reiser & Milne, 2017). The goals of counseling established in the supervisory relationship will similarly be seen when the supervisee counsels their clients. For the quality of the supervision relationship to be effective and isomorphic, both the supervisor and supervisee are introspective about their own

challenges and perceptions. Subsequently both then discuss any issues that have potential conflict.

Parallelism. While isomorphism addresses occurrences in the supervisory relationship being replicated by supervisees in counseling their clients, parallelism is similar but describes the phenomenon of the supervisee unconsciously presenting themselves as their clients have presented to them (Bernard & Goodyear, 2018; Koltz, et al., 2012; Lee, 1999; Sloan, White, & Coit, 2000). Many times, in the supervisory environment, the supervisee will explore personal issues related to therapeutic dilemmas they experience with their clients. In doing so, they play a role in supervision like that played by a client in counseling (Olk & Friedlander, 1992). Concurrently, the supervisee is also a student whose skills are being evaluated closely by the supervisor and as a result, role conflict can arise because the supervisee is expected to simultaneously reveal areas of weakness and present competencies and strengths (Waltman, 2016). The supervisee needs to be encouraged to talk about personal concerns, doubts, and feelings of inadequacy so that these concerns do not surface in the supervisee's relationship with their clients in counseling.

Transference. Another area of perceptual/conceptual skill executed by the supervisor in supervisory or counseling sessions is addressing issues of transference. CBT understands transference to be a client's response to the clinician based on generalized beliefs and expectations they have about relationships rather than how the clinician actually behaves towards the client (MacLaren, 2008; Reiser & Milne, 2017; Waltman, 2016; White, 2007). The concept of transference may be juxtaposed with the concept of parallel process. If the client is engaged in transference with the supervisee, in turn, the supervisee may engage in transference to the supervisor. Two supervisee transference issues are of concern in supervision. Negative

transference where the supervisee perceives the supervisor as critical or harsh would be a barrier in the supervision relationship. On the other hand, positive transference can be disruptive with the supervisee idealizes the supervisor. Working directly with the issue of transference, in the here and now, whereby the supervisor makes a concerted effort to show themselves as a "real" person will assist in diminishing both types of transference. The supervisor shows their warmth, openness and acceptance. In addition, the supervisor also self-discloses their own experiences of anxiety, making mistakes and having doubts when they were a supervisee. This may help the supervisee become more aware of how their beliefs and behaviors are played out in the supervisory relationship, therapeutic relationship and their other relationships that affect their emotional state. Having access to a supervisee's attachment style can provide valuable information of how previous relational experiences and current expectations guide their emotional responses in relationships, and how these responses may appear in the form of transference (Parpottas, 2012; Vyskocilova, Prasko, Slepecky & Kotianova, 2015).

Countertransference. While supervisee's attachment styles are activated in supervision in the form of transference, conversely, the supervisor's countertransference may be characterized as a reaction towards the supervisee's transference (Frederickson, 2015; Parpottas, 2012). Countertransference is related to the concept of parallel process in that they dynamic of the therapist and client is replicated in the dynamic of supervisor and supervisee. Using countertransference to describe the supervisor's response to the supervisee based on generalized beliefs and expectations, CBT supervisors are advised to continually monitor their feelings and behaviors during supervision to help identify what a supervisee may have said or done to activate any reactions (MacLaren, 2008; Goldfried, et al., 2003). Subsequently, the supervisor would inquire as to the potential countertransference of the supervisee and their client. To overcome

countertransference, supervisors must continually do introspection and challenge faulty beliefs that are creating friction with their clients or supervisees in the supervisory relationship (Vyskocilova, et al., 2015).

Executive skill. The second aspect of competent service to clients and supervisees is accomplished through executive skill. Executive skill is the ability of the supervisee to intervene effectively (Bennett-Levy, et al., 2009; Kaiser, 1992). Using the CBT modality requires the supervisor to be training the supervisee in the unique interventions designed for treatment. Interventions will include: assigning homework, recognizing cognitive errors, identifying underlying assumptions, finding alternative explanations, testing beliefs, estimating realistic consequences and practicing rational responses, to name a few (Banon, et al., 2013). CBT supervision may be seen as valuing the supervisor teaching the above-mentioned interventions (identifying and disputing cognitive errors) to the supervisee. This contrasts with client-centered supervision that may tend to value relationships. Consequently, CBT supervisors need to be alert that they are viewed more favorably when both the supervisor and supervisee share similar opinions about interventions, and there is a greater degree of perceived compatibility between both (Newman, 2013). The CBT supervisor is instructed to include empathy, understanding, nonpossessive warmth, and genuineness in their supervision, as well as, CBT interventions (Goodyear & Bradley, 1983).

Personal skill. The last aspect of competent service to clients and supervisees encompasses personal skill. Personal skill is the supervisee's ability to develop increased self-awareness (Weck, Kaufmann & Holfling, 2017). It is a commitment to personal growth (Kaiser, 1992). As in the case of countertransference, parallel process is part of the dynamic of personal skill. One part of personal skill is for supervisors to constantly being doing their own personal

introspection and challenge their own faulty belief system to grow. Accordingly, supervisees will replicate this process and will become more cognizant of their own unresolved issues and the impact their actions may have on clients. The supervisor aids the supervisee in identifying those situations in which the supervisee's "ethical ideal" is compromised so the supervisee can work more effectively with their clients (Reiser & Milne, 2017). Additionally, a skilled CBT supervisor is able to formulate problems, offer techniques and create interventions in cognitive-behavioral with their supervisees but in a warm, genuine way (MacLaren, 2008; Zivor, Salkovskis, & Oldfield, 2013).

Private Practice Mental Health Setting

When utilizing CBT modality in a private practice mental health setting, licensed professional counselors-supervisors consider the environment of the agency including clientele being serviced and professional qualifications. Since theoretical orientation informs counseling, professional counselors with the added qualification of supervision as part of their licensure should adhere to one theoretical modality to become more grounded and gain experience before receiving training in other modalities (Crawford, 1988; Heffler & Sandell, 2009; Spruill & Benshoff, 2000). When supervisors in private practice use the same modality such as CBT with supervisees, the supervisees will gain knowledge of CBT and model skills learned with their clients. In other words, the modality of CBT in private practice mental health settings used by Licensed Professional Counselors-Supervisors (LPC-S) with supervisees will be the model used by supervisees with their clients (Zivor, Salkovskis, & Oldfield, 2013). This is further supported by Cummings, Ballantyne, and Scallion (2015) research stating that not only does a purposeful use of CBT skills encourage trainee professional and clinical development, it also models for trainees' appropriate approaches to their clients. By teaching trainees CBT skills in supervision,

they can in turn use these same clinical skills with clients (Cummings, Ballantyne, & Scallion, 2015). Additionally, the type of clientele and supervisees that come to private practice mental health settings for either counseling or supervision will see if they are a good match for the agency depending on the credentials of the professional in private practice. The supervision process used by supervisors adhering to the CBT modality can be observed in private practice mental health settings by knowing the environment, clientele served, and professional qualifications of the counselor/supervisor.

Environment

The environment and agency standards might be a unique challenge for many supervisees in training. In private practice mental health settings, supervisees must adhere to rules and regulations set by the supervisor; however, private practice settings are not structured in the same way as public mental health settings, vocational rehabilitation, or hospital settings. Private practice settings allow for the counselor to provide services in unique ways with the resources available (Neuer & Anita, 2013). In private practice, the counselor relies primarily on insurance companies whom they are providers for to compensate for services provided (Harrington, 2013). A managed care system must strive to balance the interests and priorities of three parties: the consumer, the provider, and the payer (Bennet, 1992). The consumer and practitioner are forced to define their activities in an intentional and deliberate manner with the third party in mind; the process must be accountable (Smith, 1999). Since the principles and practice of CBT will be incorporated in the private practice mental health setting, supervisees entering the environment for the first time need to decide if it is a right match for them. Some supervisees might have reservations about learning a modality in which the supervisee has not been trained. It is at this point that the supervisee must decide if the environment in which they will be receiving

supervision is suitable for the supervisee's particular needs. Supervisees unfamiliar with a CBT environment will soon learn that the environment is oriented toward didactic, structured, and problem-focused techniques. Supervisees might also find it challenging to learn CBT techniques such as staying with a client's presenting problem. Additionally, the supervisee might also have difficulty adopting the collaborative stance of the CBT therapist, which is more directive than in other forms of therapy and find it difficult to impose structure on their client work (Owen-Pugh, 2010; Wills, 2008). In essence, environments that utilize CBT as a modality in supervision are more didactic in nature and supervisees that are willing to learn this modality will learn new coping skills to enhance therapy with clients as well as learn the CBT model to add to the supervisee's repertoire (Owen-Pugh, 2010; Wills, 2008). Finally, CBT is a flexible and adaptable modality which is useful in a private practice setting; therefore, CBT supervision in this environment would also be appropriate.

Clientele Served

Mental health counselors who generally hold a master's degree as a Licensed Professional Counselor (LPC) in private practice, primarily counsel clients struggling with life stresses and those lacking coping skills to adjust (Baer, 2005). Through training under a CBT focused LPC-S supervisor, supervisees are taught methods and techniques of CBT and in how to apply them with their clients in counseling. For example, Cummings, Ballantyne, and Scallion (2015) stated that specific supervisory processes used in CBT supervision can promote trainee learning. Furthermore, CBT processes used purposefully and regularly such as a) setting a supervision agenda for each meeting, b) encouraging trainees to problem solve prior to receiving specific supervisory input, and c) providing regular formative feedback are replicated by supervisees with their clients (Cummings, Ballantyne, & Scallion, 2015). Many of the clientele

served in private practice under a master's level LPC are dealing with addictions issues, dysthymia, anger issues, parenting issues, anxiety, PTSD, and adjustment disorders. CBT is an effective modality for teaching coping skills, practicing new skills, and in meeting the client where they are at emotionally. The supervisee is still being socialized to the process of supervision and cognitive-behavioral therapy (CBT) and thus the supervisor is more directive (Cummings, Ballantyne, & Scallion, 2015). Finally, the clientele seen in private practice mental health settings are different compared to those seen in public mental health, hospitals, and vocational rehabilitation environments in which diagnosis might include clientele with psychiatric diagnoses experiencing severe psychosis. Many clients seen in private practice mental health settings have less intense presenting issues, are independent enough to come to outpatient counseling, and have resources to pay for counseling.

Professional Qualifications

Some of the unique qualifications of mental health counselors in private practice might include: 1) being fluent in the language used by clientele, 2) having cultural sensitivity, 3) extensive training in servicing people with disabilities, 4) extensive training in CBT, and 5) excellent administrative skills needed to operate a private practice (i.e. billing, record keeping, and working collaboratively with other mental health professionals). Moreover, one unique challenge of supervisors in private practice is when to self-disclose either to clients in counseling or supervisees. Since the therapeutic relationship is about relating to another person, self-disclosure needs to be tempered by tact and compassion and used as a means to encourage reciprocity when clients lack experience in sharing experiences (Carew, 2009). This same principle can be applied to supervisees earning their internship hours as part of their requirements in receiving supervision for licensure. Supervisors who promote the benefits of

self-disclosure will also tend to examine and explore its use within training, by self-reflection, supervision and personal development (Carew, 2009).

CBT Model is Suited for a Private Practice Mental Health Setting

The CBT modality meets the challenges in a private practice mental health setting since it is appropriate for the types of issues presented by clients in counseling (Baer, 2005). If counselors receive CBT supervision training, and the positive aspects of parallel process and isomorphism dynamics are engaged, supervisees will increase their use of evidence-based interventions (CBT) with their clients. Many clients, as well as supervisees, respond well to a more structured environment that CBT provides. In private practice, supervision using CBT involves: 1) agenda setting; 2) homework review; 3) 10-15-minute skills training; 4) case discussion; and 5) new homework (Murrihy & Byrne, 2005). Additionally, in private practice, CBT provides training for supervisees including: role modeling, behaviour rehearsal, feedback, provision of information and interactive discussion (Murrihy & Byrne, 2005). The components of the CBT model increase the effectiveness of qualified counselors through practice, repetition, and years of experience. The CBT model of supervision is a good fit for a private practice mental health setting because it is action oriented and empirically grounded. Furthermore, CBT was identified as the preferred choice of treatment for most common mental health problems (Zivor, Salkovskies, & Oldfield, 2013). CBT, being grounded in research and clinical practice, holds potential for being an integrative psychotherapy and is likely to become the gold standard, even if it is not superior to a "pure form" approach (Zivor, Salkovskies, & Oldfield, 2013). The downside of the CBT model as a supervisory modality in a private practice mental health setting is addressing transference and countertransference issues. However, by incorporating a therapeutic relationship theory or other developmental models in conjunction with CBT, these

issues can be resolved by staying with the client's presenting issues and underlying meanings and addressing them in meaningful and constructive ways.

Discussion

CBT serves as an excellent model in supervision because the method of supervision will be similar to the CBT approach used with clients. Since clinical supervision entails observing, assisting, and providing feedback to supervisees, a CBT modality provides a framework with structure and techniques that are beneficial for training in the supervisory relationship in a private practice mental health setting. CBT supervision gets its prominence from its being evidence-based and the success of CBT therapy. In sum, CBT has a robust evidence base for many disorders. Consequently, in the past 10 years, published guidelines by the American Psychiatric Association and the National Institute for Health and Care Excellence have recommended this therapy for the treatment of depression, obsessive compulsive disorder, generalized anxiety disorder, panic disorder, PTSD, BPD, schizophrenia, and bulimia nervosa (McMain, et al., 2015). Accordingly, CBT will continue into the future with more force and importance.

CBT is a dynamic treatment, and it will undoubtedly have a different look in the future (Kraemer, Wilson, Fairburn & Agras, 2002). As previously stated, mindfulness and positive psychology have been incorporated into CBT (Claessens, 2010; Helmes & Ward, 2017; Mak & Chan, 2018; Olgata et al., 2018; Seidi & Ahmad, 2017). Although CBT is changing and becoming more expansive, it will keep its essential principles. CBT supervision will change in dynamic ways also to keep in stride with the therapy. Although CBT may become more inclusive, it is probable that it will not become an eclectic therapy. The research and collection of data which are essential principles of CBT will in all likelihood remain (McMain, et al.,

2015). Parallel to CBT, supervision will keep expanding in a similar fashion mirroring what happens in therapy.

Gaudiano (2008) stated that CBT is evidence-based and has a long history of researching its effectiveness which makes it one of the most popular forms of treatment. The one aspect that is lagging is research into the effectiveness of CBT supervision (Alfonsson, et al., 2018). While safe and effective therapy should be possible to measure objectively and subjectively with standardized measures, the intermediary goal of well-conducted psychotherapy is much more difficult to assess since there is no consensus definition or conceptualization of high-quality CBT. Moreover, there have been several attempts to operationalize the essential components of CBT and while there is an overall agreement of major principles and content, developing sound measures has proven to be a challenge. As CBT becomes even more prominent in private practice, there needs to be an expansion in research as to the effectiveness of CBT supervision.

On the horizon are new technologies that will shape treatment (Kobak, Mundt & Kennard, 2015). CBT treatment and supervision are poised to take advantage of these opportunities which will further the prominence of the modality. CBT is highly structured, has produced several manuals for clinicians, has a linear progression, emphasizes self-responsibility, self-monitoring and homework, and includes ongoing outcome measurements (Bennett-Levy, et al., 2009; Milne & Dunkerley, 2010). A number of technology-enhanced CBT treatments have been used with a variety of psychological diagnoses. Moreover, the treatments included computer-administered CBT self-treatment, computer-assisted CBT treatment, mobile phone monitoring and communication, psychoeducation, remote live treatment via videoconference, and online therapist training (Aguilera & Muench, 2012). CBT supervision will in all

probability stay on course with these developments and utilize the emerging technology which will only further CBT therapy in private practice.

Conclusion and Recommendations

While the purpose of supervision is to guide supervisees along their developmental process of becoming competent and caring counselors, anxiety and resistance within the supervisory relationship may hinder a supervisee's growth (Abernethy & Cook, 2011). Growth is accelerated in the supervisory relationship when supervisees experience freedom and safety to make mistakes and learn from them which entails mutual authenticity and empathy in discussing vulnerabilities in the supervisory relationship (Abernethy & Cook, 2011; Jordan, 2004). No single theory in and of itself is sufficient to bring about change in a client's presenting issues; however, CBT is the most empirically supported treatment model for a wide range of disorders and problems (Alfonsson et al., 2018). The umbrella of CBT now covers a group of heterogeneous psychotherapeutic interventions linked by common philosophical principles (Claessens, 2010). Because of its openness and flexibility, CBT continues to evolve through the interplay of theory, research and clinical observation (Mansell, 2008), but also it has consistently remained receptive to assimilating ideas and strategies from other therapeutic approaches and research findings (Claessens, 2010).

While research shows that it is possible to evaluate the effects of psychotherapy on patients' well-being and health, it is also possible to do the same with CBT supervision and its impact on supervisees and their clients (Alfonsson, et al., 2018). It is recommended that evidence-based guidelines for CBT supervision be developed and evaluated systematically (Milne & Dunkerley, 2010). With guidelines as a tool for bringing evidence base to bear on practice, a systematic review on the effects of CBT supervision can then be conducted on the

effects of CBT supervision following established guidelines regarding literature research, data synthesis, and reporting (Alfonsson, et al., 2018).

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