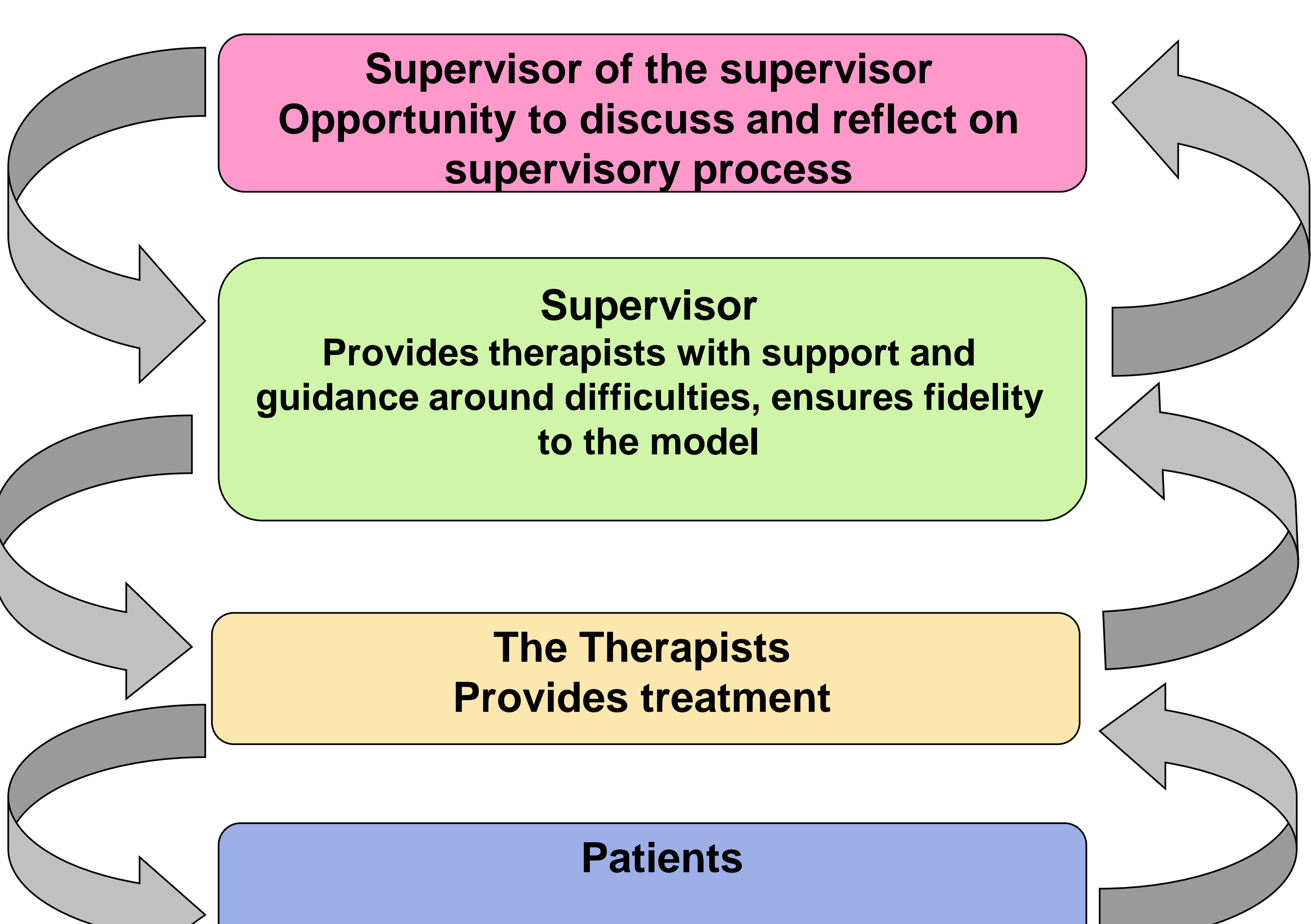
An experiential workshop to boost your CBT supervision skills

Dr Andrew Beck
Consultant Clinical Psychologist
Bradford Clinical Health Psychology

Why are we here?

- This is a (dauntingly) highly experienced group of clinicians who:
  - learned to supervise through observing our own supervisors
  - integrated bits of what worked and what we liked
  - are influenced by our core therapy model
- But seldom have chance to meet with our peers and think about what we do and why we do it
- There is little research evidence into what makes good supervision, or agreement as to how this might be measured
- But clear from supervisor training programs that structured, reflective days to think about this helps!
- Active supervision is the process of using skills practice, live material review and collaborative approaches to enhance skill development

Supervision in therapy



A working definition of Supervision:

‘The formal provision, by senior / qualified health practitioners, of an intensive, relationship-based education and training that is case / work focussed and which supports, directs and guides the work of junior colleagues (supervisees)’

Milne (1997)

The differences between Management Supervision and Clinical Supervision

- Often this is blurred.
- Both can occur in the same session and discussions can go from being one to the other.
- **The main functions of Management Supervision include**;
  - Line management accountability
  - Decision-making / Risk management /Safeguarding
  - Governance
  - Staff support and development
- **The purpose of Management Supervision:**
  - Ensure that work is being carried out according to Job descriptions, competencies, person specifications and Trust policies and procedures.
  - Ensure individuals receive feedback on their performance and positive support. This will include caseload management for staff.
  - Ensure that development and training opportunities are being accessed from the objectives agreed in the supervisee's personal development plan and KSF post outline.
  - To consider and review individual's work programme and delegate work as appropriate.

How it differs from clinical supervision

- Clinical supervision focuses on therapy / treatment dilemmas
- The aim is for the supervisor and supervisee to develop a good understanding of how and why therapy is not progressing and for the supervisee to leave with new ideas to try.
- It takes care of the emotional well-being of the therapist
- It may also include consideration of risk management of particular cases

The purpose of supervision

- To ensure the welfare of the service user and improve outcomes
- To facilitate the development of the supervisee in their clinical work
  - Support
  - Reflection
  - Learning
  - Evaluation
  - Take in to account the context of work
  - Clinical governance
  - Resources

Supervision as part of the Fidelity Framework

1. Intervention design (what is the right thing to do?)
2. Training of supervisors (has the right thing been done?)
3. Delivery of supervision (has it been done right?)
4. Receipt of supervision (did it result in the right outcomes?)
5. Supervision enactment (did it result in the right impact?)

Milne (2014)

Paired reflection
Personal experience of supervision

- Reflect on supervision that you have had in the past or are having currently

  What made it successful?

- Reflect on supervision you have had that hasn't worked?

  What contributed to that?

Responsibilities of Supervisor

- Safety of both patient and supervisee
- Effectiveness of the supervisee's work
- Maintaining boundaries
- Accountability to the organisation
- Working within Code of Ethics
- Evaluating competency

Responsibilities of Supervisees

- An ability to work collaboratively
- Capacity for self appraisal and reflection
- Contribution to active learning
- Reflecting on developing personal and professional role
- Capacity to reflect on the quality of supervision

Responsibilities of Supervisees

- "The whole success of clinical supervision ultimately rests with the willingness and commitment of clinical supervisees to engage in it and to learn from the experience"
  - Driscoll 1999
- So how do we prepare them for this?

Active Supervision
Idea developed by Mark Latham

- Definition is a supervisory processes that includes:
  - The enactment of skills
  - The application of theory or new knowledge
  - Exploration of the experience of the patient or therapist
  - The use of kinetic movement

ACTIVE SUPERVISION

- Usual methods used in supervision:
  - Case discussion
  - Diagrammatic caser formulation
  - Live samples (recorded or direct)
  - Evaluating competencies (CTS-R etc.)
  - Homework /assignments / reading
  - Rehearsal / skills practice
  - Modelling
  - Role-play
  - Self-practice / self-refection (SP/SR)
  - ROMs reviews

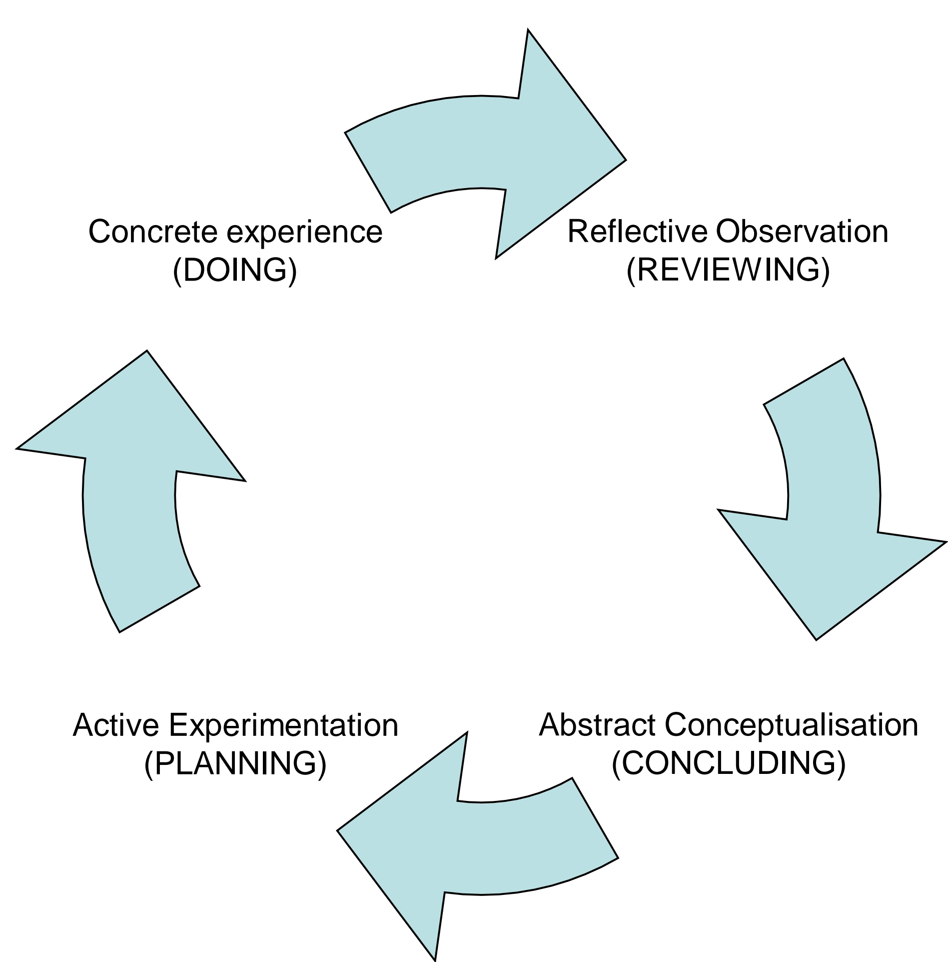
Reflective exercise

- Use the pie chart to reflect the portion of time you use each of these skills
- Work in pairs
- Does this seem like a good balance?
- Do you favour one approach over others?
- Why might this be?
- How can you ensure the balance best meets the needs of your trainees / supervisees?
- How would you like to do this differently?

Experiential learning central to many therapies…yet rarely used

- Survey of CBT accredited therapists (Milne and James 2002)
  - 2% used role play often (43% never)
  - 90% used case discussion often
  - ‘over reliance of case discussion ... with insufficient attention to rehearsal of techniques’
  - Verbal methods used 86% of time unless supervisors had specific training in experiential supervision

Why are experiential methods important?



The case for experiential supervision

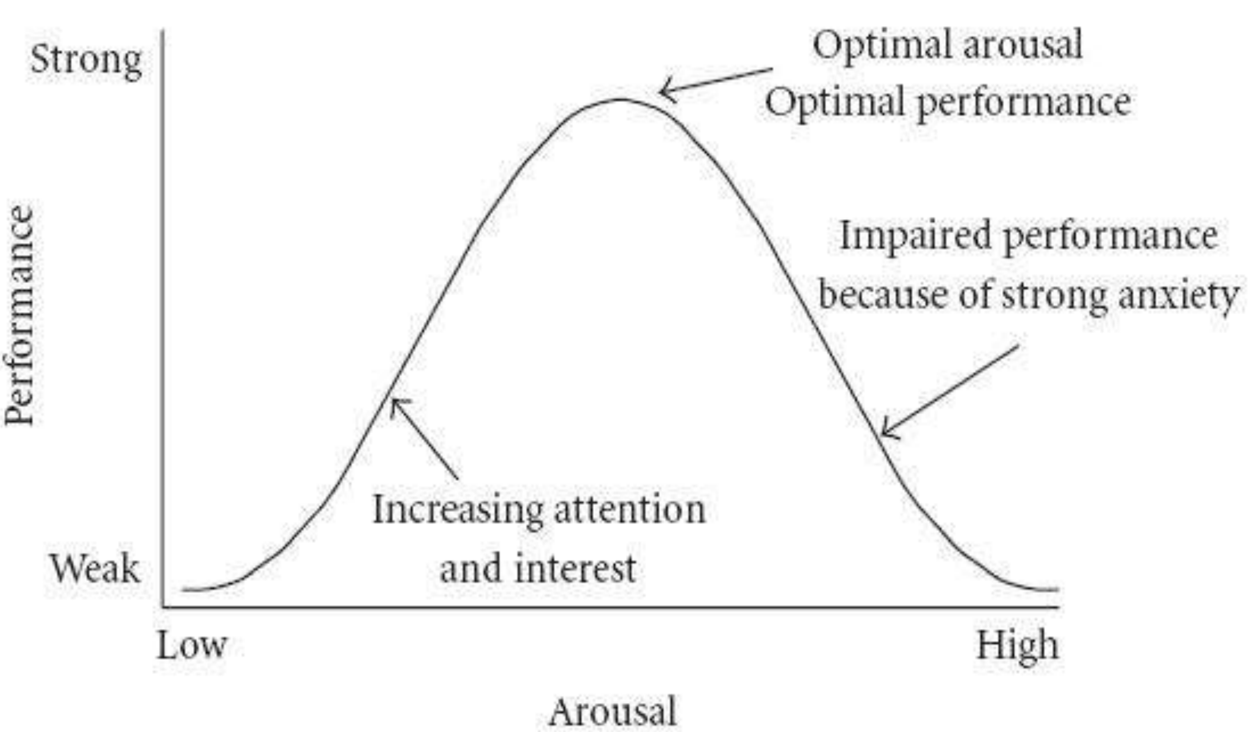
- Facilitates practice in various types of techniques, allowing rehearsal of skills and improved performance
- Rapid and direct feedback
- Includes consideration of non-verbal or emotional responses
- Enables supervisee to empathise with patients
- Promotes new insights

Discussion in small groups

- Given this why are these methods underused by supervisors?
- Why might you not use them as much?
- Why might supervisees prefer it if you didn't use them so much?

- Consider what the approach / avoid framework might have to say about this.
- How might we socialise supervisee to the idea of doing this?

Stress in supervision is not all bad
(the Yerkes-Dodson law)



Can we formulate reluctance to use active methods

- Avoidance?
- Safety behaviours?
- Internal focus of attention on body symptoms and thoughts?
- Overestimation of the likelihood of being negatively evaluated?
- Underestimating own ability to cope?
- Worrying?

Active methods are unnecessary for experienced staff

- Does this apply in other fields?
  - Musicians?
  - Athletes?

- Lifelong learning
  - Just reflective / conceptual or can it be experiential?

- How might you socialise a supervisee to this idea?

Exercise

- Role play in pairs
- How might you introduce active methods in supervision:
  - With ROSHNI-2 teams
  - With someone you have been supervising for some time

What works for whom

- What did you notice working in each scenario?
- What were the main barriers to using these methods?
- What seemed to get you (as supervisor or supervisee) stuck?

Things that might help

- Be in approach mode rather than avoidant mode – look for opportunities
- Consider any anxieties you might have about using them
- Be mindful of the anxiety provoking nature of the techniques
- Agree to their use collaboratively – in your contract / your agenda
- If the supervisee is reluctant to use them make this an agenda item

Things that might help

- Start with the least anxiety provoking methods
- Help your supervisee to tolerate the uncertainty of using them at first
- Provide a clear rationale
- Say that 'sometimes it helps learning if you start with doing something intentionally wrong to see what happens' – then model doing this as the therapist
- Provide clear framework as to what you will do and for how long

Things that might help

- Give specific and immediate feedback
- Either can pause the role plays for reflection at any time
- Use Kolb explicitly
- Make it stimulating and fun

Things that might help

- Formulate the reason either party might be reluctant to change their behaviour
- You can use whatever model you like
- See if this formulation gives you any useful clues as to what can be done
- How useful would it be to share this?

Exercise

- Work in groups of 3
- 1 Supervisor, 1 supervisee, 1 observer
- Practice using an active method
- Experiment with ways of introducing and carrying out this method
- Observe, reflect and plan

Personal action plans

- Write down 3 learning points from this session
- Write down 3 things you will do differently in supervision
- Write down how you will review how this has gone

Power in supervision

- There is always a power difference in supervision
- The supervisor may be responsible for evaluating the competence of the supervisee
- They may have power through their social role (gender, age, ethnicity)
- They may be more senior in the team or service
- They may also have line management roles

- In pairs:
- How might this impact negatively on supervision?
- What is unhelpful & helpful about power differences?
- How can supervisors address this power difference?

Power inequality

- Supervisors are in an inherently powerful role, not necessarily a bad thing
- This can be exacerbated by ethnicity, gender and social class.
- If we are supervising in a culturally reflective and thoughtful way what factors do we need to consider as part of an ongoing process?

Reflection

- Develop your personal goals for developing supervision skills
- Goal 1
- Goal 2
- Goal 3

- What would you like to improve or change about your supervision?

____

The Supervisory Alliance

- Especially significant during earlier stages, where supervisees reported that they would elicit a ‘deeper level’ of supervision, if they were honest and open in their reflections about their clinical practice.
- Supervisees reported they were more able to do this when their supervisors also adopted an open, honest and inquisitive stance, because this facilitated the development of mutual trust and empathy
- Supervisees not open and honest about their needs when they perceived the supervisory alliance to be weak and/or when they feel unsafe.

Facilitating this alliance

- Supervisees need to feel there is
  - a minimum level of mutual respect,
  - agreement regarding a joint responsibility for the relationship,
  - clear roles.
- Factors influencing respect supervisees had for their supervisors.
  - Preference to be supervised by clinicians who were professionally and personally credible.
  - Personal credibility included supervisors' human qualities eg being approachable, honest, warm, empathetic, and supervisee-centered.
  - Professional credibility was discussed in terms of ability (i.e. as a supervisor, colleague and clinician).
- Supervisees emphasized the importance of having the opportunity to directly observe their supervisors work

Boundaries

- Supervisees expressed a need for professional boundaries and for clearly delineated supervision time and space.
- Supervisors who were either unboundaried or excessively rigid were seen as lacking professional credibility.
- Trainees described high levels of anxiety and a need to put extra time, effort and energy into trying to understand unboundaried supervisors.
- Notably, in each case cited it was a supervisor who had imposed a psychodynamic model (inflexibly) onto trainees:
  - ‘With this placement it has been very boundaried in the sense that you can contact me if there is risk, an emergency, but supervision is one hour, a regular time, and really that’s supervision, and we will stop bang on the hour, regardless of whether I’m in mid-thought, mid-conversation ... The practical stuff I want to know, kind of sometimes gets left behind.’
- A poor supervisory alliance was identified by almost half of trainee mental health staff as the reason they would not bring clinical mistakes or difficulties to supervision.

Supervision contracts

- Do you have these?
- When and how are they negotiated? Renegotiated?
- How do you ensure they are being used?
- Contracts should include:
- Practical arrangements – day, time, tape review etc
- Line management arrangements – who to contact if there are concerns
- Discussion about preferences for supervision styles, what has gone well / badly in the past
- This is a good point to introduce ideas like active approaches or thinking about diversity

Discussion

- So how do we enhance trust?
- Particularly with the challenge of supervising over Skype / WattsApp?

When new learning occurs

- Hogan and Pressley (1997): learning occurs when information is integrated into a learner's existing knowledge base.
- Bransford, Brown and Cocking (2000): "the contemporary view of learning is that people construct new knowledge and understanding based on what they already know and believe"
- These implication is that paying attention to what the supervisee brings to supervision is a sensible first step, it also enhances their self-efficacy and the supervisory relationship

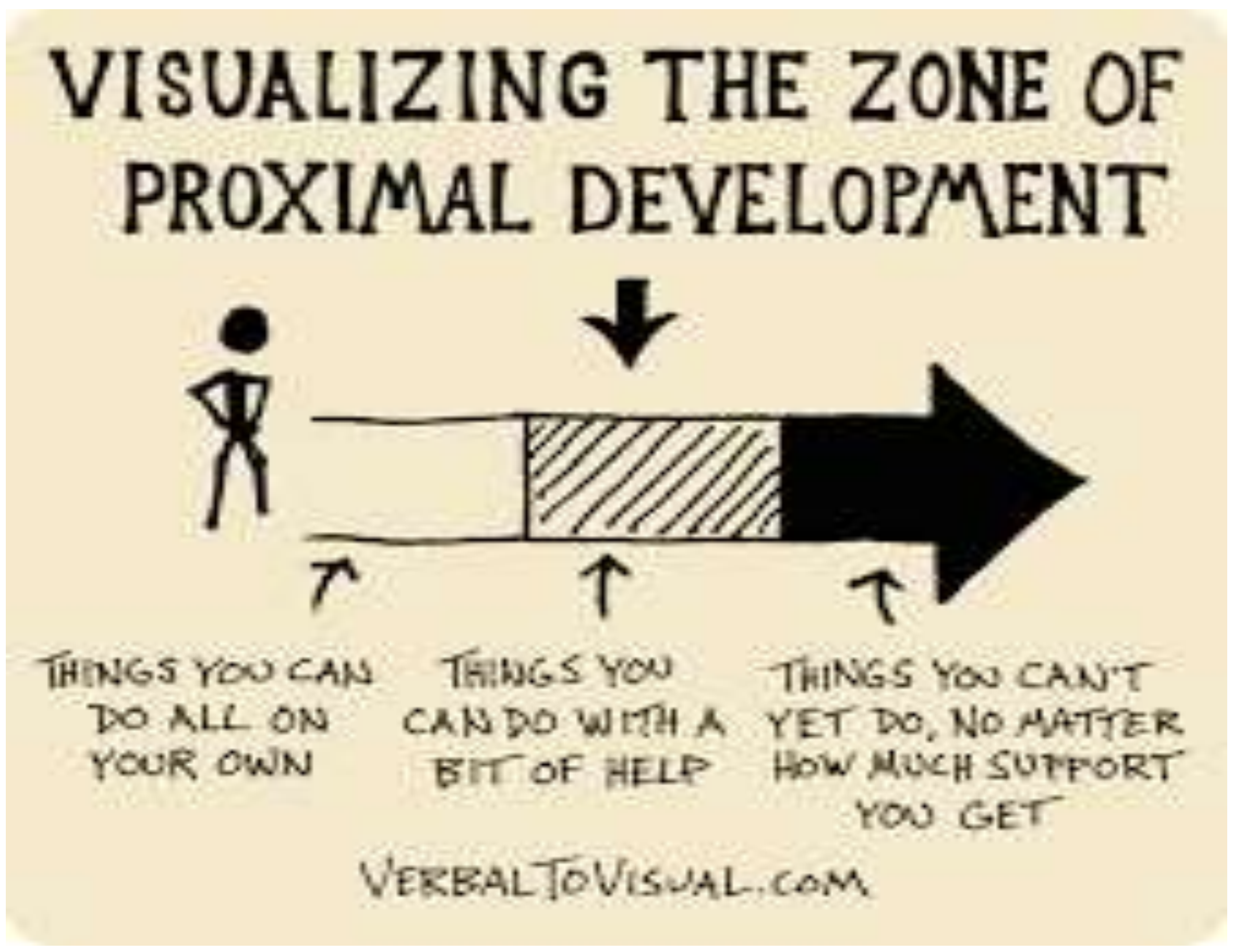
The Zone of Proximal Development

- The distance between what a person can do independently with respect to a skill versus what he/she can potentially achieve with maximum supervisory assistance.
- For example, at the beginning of a CBT course, a supervisee might score 28/72 on the CTS-R, and realistically by the end of the course the best he/she is likely to achieve is 38/72; this 10-point range would therefore be his/her zone with respect to these competencies.
- It can help identify those aspects of the skill “yet to be developed” and enable the learner to perform the skill independently.

The Zone of Proximal Development

- Vygotsky likens the early stages of skill development to "buds" which need to be identified and nurtured.
- These features are highlighted in Tharp and Gallimore's (2002) 4-stage model, which describes how a learner progresses through the ZPD.
  - Stage 1– Performance is assisted by a more capable person;
  - Stage 2 – Performance is assisted by self;
  - Stage 3 – Performance becomes automatized;
  - Stage 4 – Performance can become de-automatized.

The Zone of Proximal Development (Vygotsky)



The developmental stage of the supervisee

- One useful framework is to consider where your supervisee is at in terms of their development as a therapist.
- As with a child you want to provide a learning environment that stretches them but does not overwhelm them.
- An overwhelmed child feels too anxious to learn as does a therapist

Maslow’s 4 stages of learning
(though probably developed by Noel Burch)

- **Unconscious incompetence**
  - The individual does not understand or know how to do something and does not necessarily recognize the deficit. They may deny the usefulness of the skill. The individual must recognise their own incompetence, and the value of the new skill, before moving on to the next stage. The length of time an individual spends in this stage depends on the strength of the stimulus to learn.
- **Conscious incompetence**
  - Though the individual does not understand or know how to do something, he or she does recognize the deficit, as well as the value of a new skill in addressing the deficit. The making of mistakes can be integral to the learning process at this stage.
- **Conscious competence**
  - The individual understands or knows how to do something. However, demonstrating the skill or knowledge requires concentration. It may be broken down into steps, and there is heavy conscious involvement in executing the new skill.
- **Unconscious competence**
  - The individual has had so much practice with a skill that it has become "second nature" and can be performed easily. As a result, the skill can be performed while executing another task. The individual may be able to teach it to others, depending upon how and when it was learned.

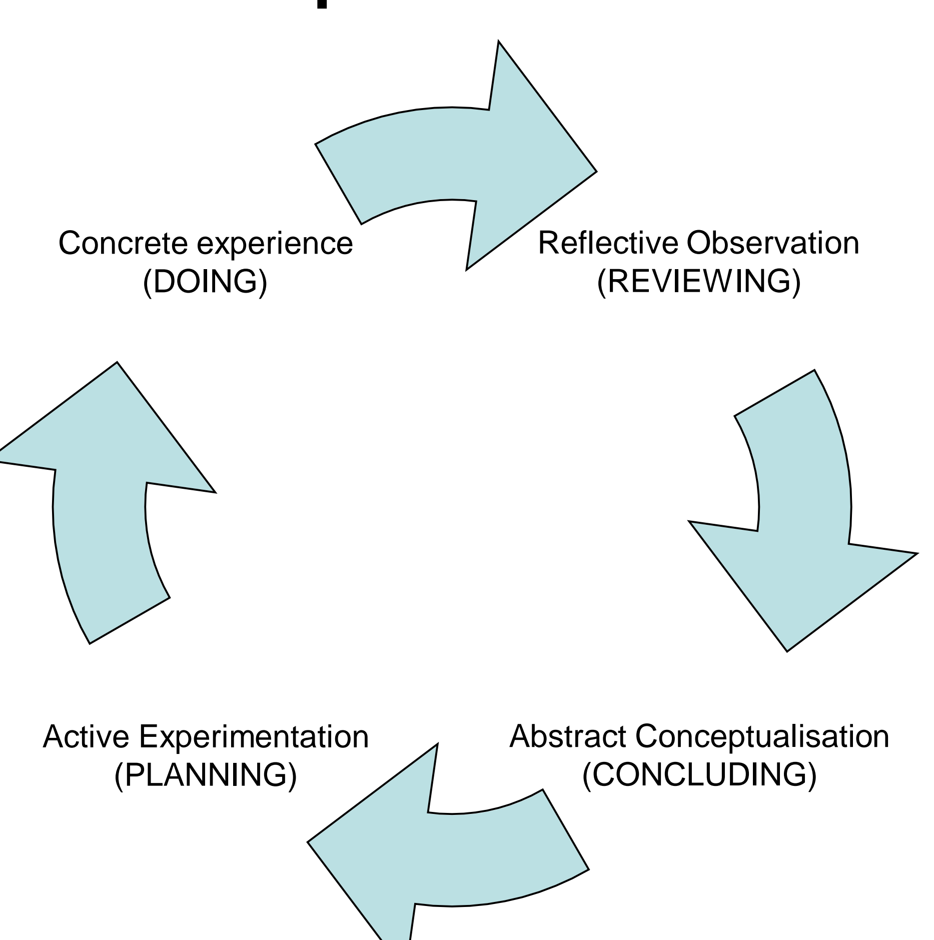
Exercise – in pairs

- Not all supervisees will be at the same stage of expertise
- How can you theorise what stage your supervisees are at?
- What are the ways you would begin to map this?
- To what extent should your model be shared with your supervisee?

The Kolb cycle is the cornerstone of learning

- In therapy and supervision
- Doing things alone not enough to learn effectively
- You need to go through the cycle several times to really benefit and consolidate
- The most effective way is through role play
- But going off, trying something and reflecting next supervision can also be helpful

Effective Learning within Supervision



Top 10 effective supervision methods

Milne (2013), mean 3.7 methods / study, reports % of studies

Feedback (praise, constructive criticism)	81%
Observation and outcome monitoring	79%
Discussion (rationale, q&a, setting objectives)	75%
Written / verbal prompts (inc guidelines)	48%
Encouraging autonomy (time management)	21%
Formulation (including written / drawn)	13%
Modelling skills (live video / live supervision)	13%
Behavioural rehearsal (role play)	10%
Homework assignment	4%
Other (eg alliance building)	21%

Cognitive Therapy Supervision
Padesky, 1996

Mirror of therapy process:

- Establish supervision problem list
- Set goals
- Agenda set
- Skills taught
- Guided discovery employed
- Homework assigned

Cognitive Therapy Supervision
Padesky, 1996

Teaching methods employed

- Clinical demonstrations
- Role plays
- Didactic instruction
- Socratic questioning
- Behavioural experiments
- Case conceptualisation

Cognitive Therapy Supervision Padesky, 1996

Guidelines for supervision

- Build on the supervisees strengths
- Choose modes & foci which help with next stage of competence
- Build conceptualisation skills so supervisees can help themselves
- When difficulties occur, use supervisory road map to pinpoint problem
- Pay attention to what is not discussed in supervision

Giving feed back

- Feed back should be justifiable and relevant.
- Given in a way that it sensitive to the supervisory alliance.
- Negotiate the process of giving feed back as part of the contract.
- Feed back should be predictable and respectful. Ensure the supervisees feels 'safe in receiving it'.

Giving feedback

- CORRBS.
- **Clear:** if your supervise can not interpret what you are saying , they will not be able to action it.
- **Owned:** your comments should be framed as opinion not 'truth'
- **Regular:** frequent enough to for it to be practically useful
- **Reviewed:** Balanced: feed back should reflect strenghts
- **Balanced:** feedback should reflect strengths and achievements and be as affirming as possible. Remember challenge and support are equally important in enhancing learning and good practice.
- **Specific**: use examples to illustrate your point.

But feedback models assume it is about where someone has gone wrong

- All of us need to feel we are competent in our jobs
- If you only bring stuck cases to supervision you spend a lot of time talking about the limits of your skills
- Make sure you notice and praise what has gone well in a difficult case
- And ask your supervisee to bring examples of successful cases
- Look at what went well
- Use Kolb to generalise from this learning

What might or might not be specific to CBT supervision

- **Structural components**
  - Focus & aims; Agenda; Review; Summaries
- **Theoretical underpinnings**
  - How client is understood;
  - How therapist is understood;
  - How client-therapist processes are understood;
  - How supervisor is understood;
  - How supervisor-supervisee processes are understood
- **Tasks in supervision**
  - Nature of reflection; Use of specific strategies – guided discovery, experiments, types of self reflective tasks

Role Play Exercises

- Take turns to be supervisor and supervisee
- Bring a treatment dilemma
- Start with:
  - Establish problem list
  - Set goals
  - Set agenda
- Outline to one another the core presenting problem with some background information
- Use these cases in the role-plays throughout the session

Guided discovery in supervision

- Didactic ⇦ ? ⇨ Socratic
- Discovering for yourself:
  - is a better way to learn,
  - has more face validity,
  - increases likelihood insights are used in therapy
  - mirrors therapeutic processes.
- Less experienced supervisees seem to prefer supervision to be didactic

Guided Discovery and Socratic Dialogues in supervision

- Definition: Padesky (1993)
  - Questions which supervisee can an answer
  - Drawing attention to relevant information which may be outside their focus
  - Move from concrete to abstract
  - Supervisee can apply new information
- Stages
  - Informational questions
  - Listening
  - Summarising
  - Synthesising

Rational Analysis - Socratic Dialogues

- Conversations to aid guided discovery with aim of restructuring of rules, assumptions, beliefs
- Two core elements:
- **Test of Evidence**
  - What is the evidence in favour of the thoughts? What facts support them?
  - What is the evidence against the thoughts? What facts contradict them?
- **Decatastrophising**
  - What is the worst that could happen? Could I live through it (problem-solving)? What is the best that could happen? What is the most realistic outcome?
  - What alternative ways of viewing the situation are there?
  - What would I say to a friend? What would a friend say to me? How would I have thought before I was depressed/on a good day?

Socratic Questions

- Memory questions – develop a shared factual understanding
- Translation questions – identify the meaning attributed to events
- Interpretation questions – Explore the relationship between events
- Application questions – Identify helpful knowledge of experiences
- Analysis questions – promote logical evaluation
- Synthesis questions – encourage creative/alternative thinking
- Evaluation questions – promote re-evaluation and reflection

Role Play: Socratic Dialogues

- One supervisor, one supervisee
- Bring a clinical dilemma or real case you are struggling with
- Supervise using **only** Socratic questions

Scaffolding and Socratic Method

- Supervisees see Socratic Method as supervisee-centred and developmentally sensitive.
- Aids processing of learning and ensures that learning is motivating.
- Learning in this way enhances self-efficacy (Bandura, 1997), positive affect and intrinsic motivation (Ryan & Deci, 2000).
- Socratic Method important part of educational scaffolding
- This changed developmentally from task-focused scaffolding to process-focused scaffolding.
- Recently, James et al (2008) highlighted the value of scaffolding as a key micro-skill within supervision.

Reflective practice

- This is enhanced when certain things were in place.

1. adoption of a Socratic approach with appropriate educational scaffolding facilitated their ability to understand and remember supervision because they felt more engaged in the process.
2. when trainees allowed themselves time and space immediately after their supervision session they were able to think about and process the material more effectively.
3. the emotional climate engendered within the supervisory alliance had a strong impact upon what was received and reflected upon.

- Trainee reflection depends on the way the information is transmitted, their ability (and willingness) to process and understand it, and the perceived salience (value judgment) attached to the information.

Role play

- Think about how you might use a Socratic approach to a supervisee expressing strong beliefs about whether a SU will be able to use a particular therapy approach based on assumptions about the gender, social class or ethnic community of the Service User.
- Think about how a direct challenge might increase arousal levels and what impact this might have on learning
- Think about the degree to which the supervisee is able to think about other explanations

Models of supervision

- Can be very useful and help to clarify the overall aims, processes and methods of supervision. Use of a recognized supervision model is recommended and several based on a CBT approach have been developed within the last few years.
- Here are some examples:
  - The “Tandem Model” (Milne & James, 2005)
  - The “Declarative-Procedural-Reflective (DPR) Model” (Bennett-Levy, 2005)
  - The “Newcastle Model” (Armstrong & Freeston, 2006)
  - “Prepare Undertake Refine Enhance (PURE) Supervision Flower Model” (Corrie & Lane, 2015)

- All of these models have strengths and limitations and it is recommended that when a model is used an open conversation between supervisor and supervisee takes place to negotiate which model is preferred.

The tandem approach to supervision

The "Tandem Model" (Milne & James, 2005)

- There are two parties involved, necessarily, one steering the tandem (the supervisor, as he/she must exercise some leadership & have appropriate power to discharge responsibilities) and a supervisee who follows
- The tandem is travelling on a path of learning and development (and both parties learn as they journey).
- There are many ways to learn and develop within the model.
- This "developmental" approach underpins many models of clinical supervision, and the metaphor of travelling is one of the most popular theories of experiential learning
- The journey is effortful and the results will depend significantly on the approach that is taken to the travelling (e.g. 'apprentice-master' or 'therapist-client').
- The front wheel, being under the immediate control of the supervisor, represents the wheel (or 'cycle') of supervision. This essentially involves the inter-related steps of needs assessment, agreeing learning objectives, the use of supervision approaches to facilitate learning, and evaluation.
- In turn, the back wheel represents the experiential learning cycle, being closest to the supervisee's sphere of operation.
- Following this model (Kolb 1984), the supervisee makes progress down his/her path of learning by a combination of experiencing, reflecting, conceptualising, and doing.

The "Declarative-Procedural-Reflective (DPR) Model" (Bennett-Levy, 2005)

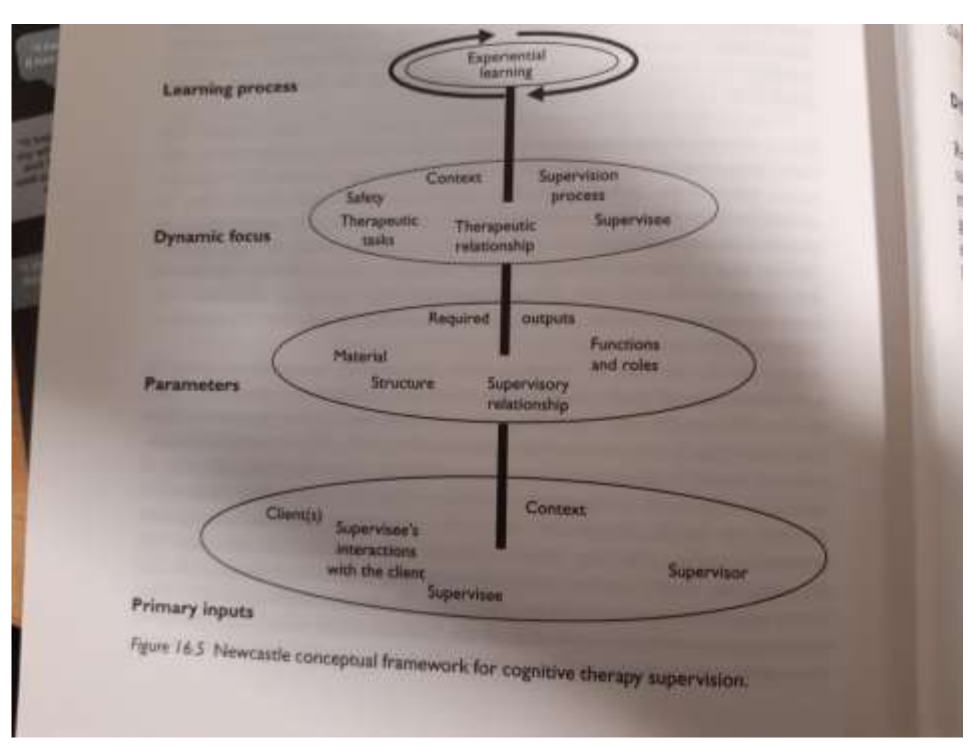
- Model to describe use of self-reflection in CBT supervision and skill development
- Based on 3 interacting information processing systems
- The Declarative System – what do I know?
- The Procedural system – how should I put my knowledge into practice?
- The Reflective System – how can I understand my own role in this process?

The "Newcastle Model" (Armstrong & Freeston, 2006)

- Level 1 is concerned with describing what each of the participants (i.e. supervisee, supervisor, client, and their respective contexts/management structures) bring to the supervision.
- Level 2, the model highlights the key characteristics underpinning the delivery of the supervision, such as clarifying the goals, outputs, roles, structures, relationship issues and the resources required to conduct the supervision.
- Level 3 the model maps out the types of discussions occurring during the supervision. This level recognizes that the process is dynamic and that topics wax and wane. It contains topic foci such as: therapeutic task, therapeutic relationship, supervisory relationship, supervisee, context, and safety issues.
- At the top level of the framework is a cycle that reflects the supervisee's learning process. This level essentially outlines Kolb's model of learning, which suggests that effective learning occurs when the learner engages in iterative cycles of reflection, experiencing, experimenting and conceptualizing

- The NCSM is particularly helpful at identifying the various components involved within the supervision process.
- It is also evident from such mapping that the supervision process could be enhanced if many of the elements identified at the various levels were clarified at the outset and recorded in a learning contract by the supervisor and supervisee.
- For example, at their first meeting the supervisor and supervisee could establish goals, boundaries, resources, disciplinary procedures, and assessment criteria

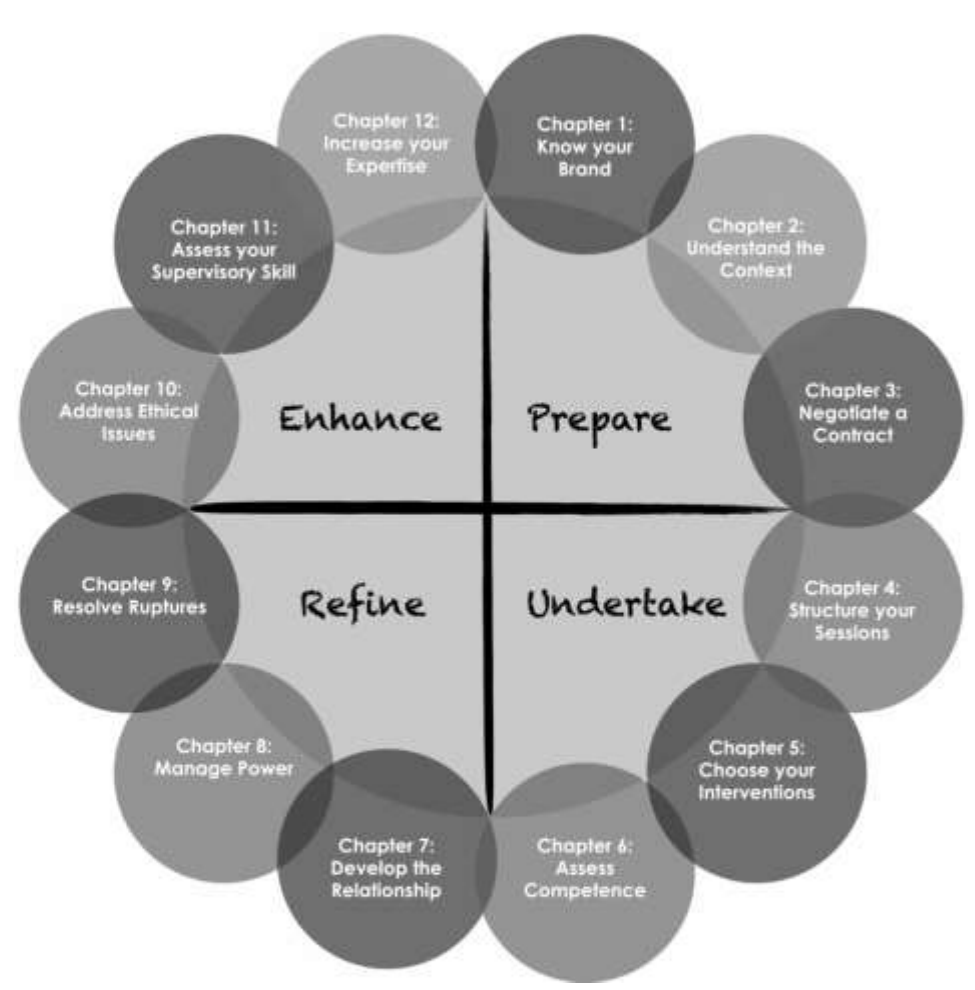
The "Newcastle Model" (Armstrong & Freeston, 2006)



“Prepare Undertake Refine Enhance (PURE) Supervision Flower Model” (Corrie & Lane, 2015)

- Preparing for Supervision explores how to establish an effective and ethical base from which supervision can occur
- Undertaking Supervision focuses on the practical delivery of CBT Supervision
- Refining Supervision offers insights into managing the supervisory process and relationship
- Enhancing Supervision hones competencies by considering complex ethical challenges and CPD.

“Prepare Undertake Refine Enhance (PURE) Supervision Flower Model” (Corrie & Lane) 2015)



Supervision: Adherence & Guidance Evaluation (SAGE)

- What is supervision?
  - ‘The formal provision, by senior / qualified health practitioners, of an intensive, relationship-based education and training that is case / work focussed and which supports, directs and guides the work of junior colleagues (supervisees)’

Milne (1997)

Supervisory competence

- How do you know if you are a competent supervisor?
- How is competence measured within your modality of supervision?
- What systems are in place to monitor supervisee satisfaction with your supervision?
- We have an idea that there are core skills common across all modalities
- We have been testing this out with Parenting / Systemic and CBT supervisors over the past few year
- But we wonder what you will make of it…

Context for SAGE

- 'One of the most pernicious problems confronting supervision researchers is the dearth of psychometrically sound measures specific to…clinical supervision'

  Ellis & Ladany 1997
- Serious deficiency for clinical services too.
- Competence at the heart of modern professional training and licensing.
- Includes the commissioning of:
  - training
  - services
  - supervision
- Supports developing accountability

The case for direct observation

- An established method, part of CBT / Parenting and Systemic therapies
- Used to check therapist adherence to the model
- Core component of CYP-IAPT therapist training
- Affords multi-method approach to enhancing skills
- External and objective as a way to demonstrate competence

How do you know if supervision is competent?

- Observation of supervisor
- Knowledge / attitudes base (quiz, interview etc)
- Feedback from supervisee
- Supervisees performance (eg on CTR-S, and perhaps on whether this changes over the course of supervision)
- Patient improvement
- **Ideally all these would be utilised to give 360 degree picture**

So…the need for SAGE

- Part of a balanced evaluation, complementing self-report data
- Affords a supervision profile (strengths and weaknesses) enabling focussed feedback and development
- Builds on effectiveness of observation as basis for feedback and supervision
- Consistent with CBT model and academic conventions
- Currently the best available tool
- Has been adapted for Systemic Therapy but not for others as yet

Kruger and Downing (1999)

- Main problems with self-rating of competence:
  - Most people rate themselves as above average at most things
  - Novices are the least accurate self-raters (often unaware of what competence looks like)
  - Experts also poor but more likely to underestimate their ability
  - Novices are doubly compromised – unskilled and unaware – so unlikely to improve – so need for an objective measure
- Training can quickly rectify these problems

Using SAGE

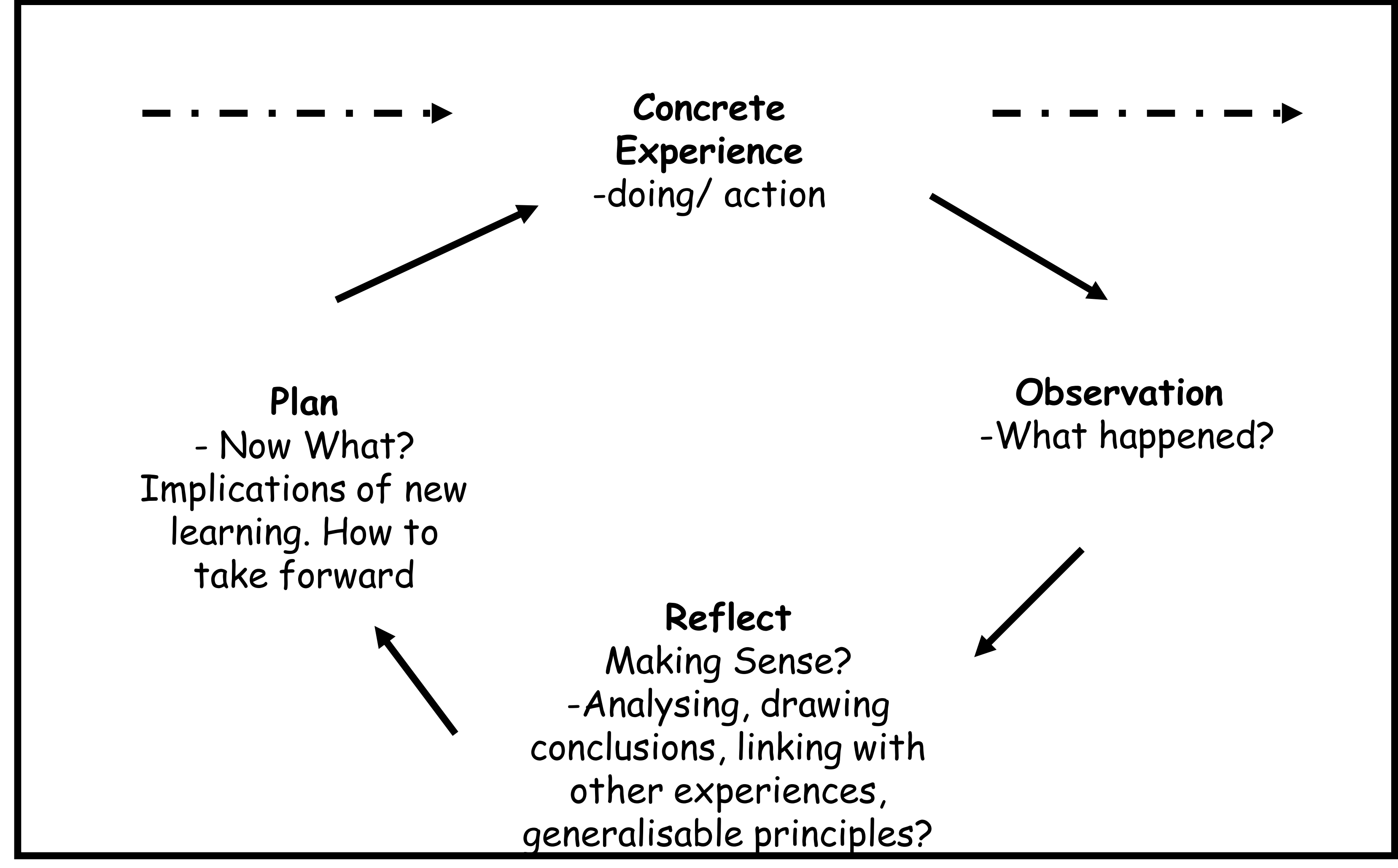
- Look over the SAGE manual
  - Discuss pros and cons in pairs
  - Complete the SAGE self assessment tool

- What do you think?
  - Are the items appropriate and complete?
  - Does the general structure seem right?

Self-rating using SAGE

- How accurate is your rating likely to be?
- What biases might be present?
- How will these effect self-rating?
- What could be done to rectify ratings?
- Compare your ratings with the review by Kruger and Downing (1999)

Integrated into the Experiential Learning Cycle



(Kolb 1984)

Competence rating scale

- Each dimension of the SAGE scored from 1-6
  - 0-1 – novice
  - 2-4 – competent
  - 5-6 expert
- Reasonable reliability and validity (Milne and Reiser 2011)
  - R = 0.815 (p = 0.001)
- Also used to distinguish between 3 types of supervision when blind rated (CBT, systemic, psychodynamic)

More on the scoring

- 0 – absence of feature or highly inappropriate performance
- 1 – inappropriate performance with major problems evident
- 2 – evidence of competence but numerous problems / lack of consistency
- 3 – competent but some problems and / or consistency
- 4 - good features but minor problems and / or inconsistencies
- 5 - very good features, minimal problems and / or inconsistencies
- 6 – excellent performance, even in the face of patient difficulties

The full set of dimensions 1

- Common factors
  - Relating (interpersonally effective)
  - Collaborative (active partnership)
  - Managing (well structured / scaffolded)
  - Facilitating (gentle questioning to develop supervisees grasp, creative perplexity)

The full set of dimensions 2

- The supervision cycle
  - Agenda setting and adherence (inc goals)
  - Demonstrating (modelling competence)
  - Discussing (reviewing, challenging)
  - Evaluating (monitoring / checking understanding)
  - Feeding back (giving provisional general summary)
  - Feeding back (receiving supervisees understanding)
  - Formulating
  - Listening (summarising, genuine and authentic)
  - Observing (live / recording)
  - Prompting (reminders / cue)
  - Questioning (open / closed, reconceptualising)
  - Teaching (information giving, self-disclosure)
  - Training / experimenting (role play)

The full set of dimensions 3

- The supervisees learning
  - Experiencing (recognises own affect)
  - Reflecting (supervisee reports and expresses own ideas)
  - Conceptualising (advice assimilated)
  - Planning (decision making)
  - Experimenting (enacting plans, in session rehearsal)

Discuss – pros and cons of using SAGE as part of your clincs

- Work in pairs:
  - Generate 3 pros and 3 cons when applying SAGE to your own supervision

Now lets see some supervision in action

- To support your learning use the SAGE to rate the supervision
- Consider what works well and what could be improved
- Use the Kolb cycle afterwards to observe, reflect and give feedback about what could be changed to improve things

Supervisory Dilemmas First steps

In therapy, what would you do?

- Observe
- Collect information
- **Formulate**

- How you formulate a challenge in supervision will depend on your theoretical orientation

Dilemmas in supervision

- Supervisee does not bring any recordings
- Supervisee does not bring cases they are struggling with
- Supervisee is under-confident in their abilities
- Supervisee is over-confident
- Supervisee is becoming overwhelmed / not coping with the work
- Supervisee does not write anything down and does not seem to be taking things very seriously
- Supervisee whose recordings suggest a marked interpersonal skills deficit
- Supervisee does not understand fundamentals of model being used

Skills practice

- Novice therapist
- Novice supervisor
  - Therapist has run group for 4 sessions and not managed to stick to the programme
  - They say the group is too challenging and they are always getting lost in conversations that are off topic
- Help us formulate what is going on from a variety of perspectives

At what point do you take the problem further?

- Hopefully you will have had a chance to discuss with your supervisee
  - Do you need to discuss this with the supervisee each time you do this?
- These discussions remain confidential
- If changing what you do as a supervisor cannot resolve the problem it might be necessary to discuss with a line manager
  - How have you set this possibility up in contracting?
  - How can you put this in a supportive way?

Recording your supervision sessions?

- Are you currently using session recordings in your own supervision?
- If not, think about what combination of factors is stopping you e.g. technological difficulties, lack of confidence, particular beliefs about what might happen etc.
- What is going to help you to bring recordings of your supervision for SoS?

Consolidation exercise

- Thinking about Supervision of Supervision
- Do you need it for your clinic?
  - What might we do to set this up?
  - What would make it work?
  - What are the key three ingredients of SoS?

Consolidation exercise

- In pairs:
  - What 3 things will you take from this to your next supervision?
  - How could you know if they were helpful?
  - How could you continue to work towards a healthier workforce through clinical supervision?

Andrew.beck@bthft.nhs.uk

References;

Hubbard, L. , Donoghue K, (2014) Oxford Health NHS Foundation Hospital. Charlie Whaller Institute. Slides 55' to 59'.

Kolb, D (1984). Experiential Learning: Experience as a Source of Learning and Development, Englewood Cliffs, NJ; Prentice Hall.

Latham, M. (2008). Experience of Supervision questionnaire (ESQ) Unpublished paper. University of York.

Milne, D.L. and James, I. (2002). The observed impact of training on competence in clinical supervision, British Journal of Clinical Psychology 41:55-72

Vygotsky, L.S. (1962). Thought and Language. Cambridge, MA. The MIT press. In J. Scaife (ed) Supervision in Clinical Practice. A Practitioners guide 2nd edition Routledge, East Sussex. 21-40

Yerkes, R.M. Dodson, J.D. (1908). The relation of strength of stimulus to rapidity of habit –formulation. Journal of Comparative Neurology and Psychology, 18, 459-482.
Milne, D.L. and James, I. (2002). The observed impact of training on competence in clinical supervision, British Journal of Clinical Psychology 41:55-72.

Padesky, C.A. (1996). Developing cognitive therapist competency: teaching and supervision models, in Salkovskis, P.(ed), Frontiers of Cognitive Therapy. New York, NY :Guilford Press

Vygotsky, L.S. (1962). Thought and Language. Cambridge, MA. The MIT press. In J. Scaife (ed) Supervision in Clinical Practice. A Practitioners guide 2nd edition Routledge, East Sussex. 21-40