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Clinical, Research, and Policy Implications for Psychotherapy Training and Supervision in the 21st Century

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Despite technological advances for providing mental health services, our practices of training and supervision have changed minimally across the last 50 years. Adding to this irony, there is a dearth of evidence for the effectiveness of training and supervision, even though they are core to the way we, as psychologists, transmit our knowledge and practical expertise to future practitioners.

In the pursuit of reevaluating and gathering new evidence about how to train and supervise the next generation, we urged the authors of this book to think outside the box and envision bold new directions. We hope that this final chapter serves as a convenient summary of where we stand in this area and as a stimulus for further developments.

UNDERLYING ASSUMPTIONS

In the sections that follow, we begin by outlining our underlying assumptions. We then discuss specific empirically based conclusions from the evidence presented in this book, along with implications for practice, research, and policy.

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Becoming Better Psychotherapists: Advancing Training and Supervision, L. G. Castonguay and C. E. Hill (Editors)

Training and Supervision Are Lifelong Endeavors

Rather than thinking of the basic communication skills that undergird training and supervision as occurring solely in professional graduate programs, we recognize that people learn many such skills during childhood through interacting in their families and the outer world. Indeed, many students have told us that they were considered "natural helpers" when they were younger. Some students learned such skills as a way of handling stress and family dysfunction, but others learned to be good, empathic listeners through having effective role models. This early-acquired "natural" helping ability that we view as critical to both doing therapy and supervision (see Stahl & Hill, 2008) is likely due to both biological predispositions and socialization, although we do not have good estimates of the relative contributions of each. Relatedly, Heatherington et al. (Chapter 15, this volume) reminded us that we often look for these traits in those we select for graduate training.

During undergraduate and graduate training (see Chapter 3, this volume), we often see large increases in listening skills, clinical capabilities, and the incorporation of professional identities. Certainly, from the perspective of those of us who have had the pleasure of working with students, it is amazing to see the transformation of trainees across time (see Hill et al., 2015), although these changes are not well documented. In addition, learning and maintaining such skills probably continue well beyond graduate work (Chapter 4, this volume). Indeed, although we believe that therapists become better as they gain experience, proving the impact of such experience on client outcomes has been challenging (Hill et al., 2017; Tracey et al., 2014).

Training and Supervision Are Complex Human Endeavors

As with psychotherapy, training and supervision relationships are complex, influenced by personal reactions, personal likes and dislikes, moods, and external events. What works for one trainee/supervisee at one time will not necessarily work for another, or even for that same trainee/supervisee at a later time.

We are thus reminded throughout the chapters of this book that not all forms of training or supervision work for all trainers/supervisors and students/trainees/supervisees, and that we need to be mindful of individual differences, trainer effects, trainee effects, and situational variables (see Chapters 3, 5, 8, and 10, this volume). We cannot say that any given training model or supervision style is "the best," but rather that some approaches work sometimes for some trainees/supervisees when delivered by some trainers/supervisors under some conditions. In addition, the complexity and effects of any given supervisory dyad or practicum class is compounded by the fact that every trainee is embedded in multiple learning experiences at any given time and that studying the interaction among these systems is exceedingly difficult.

Relatedly, we are reminded that the influence of culture is ubiquitous. What works in one culture might not work in another. Models of training and supervision developed in the United States, for example, might not be effective in Asia and Africa. Indeed, one study (Joo et al., 2019) showed that Korean students modified what they learned in Western-based helping skills training to fit their Korean clients (e.g., less focus on insight) and we suspect and hope that trainees modify what they learn to fit their own and their clients' cultures.

We stress that this complexity, while wonderful and inherently human, makes it difficult to empirically investigate training and supervision. Our research designs and statistical models are not really suitable for studying unpredictable and complicated events, and instead work better with variables that can be easily counted and rated. Given that the typical results of any investigation are "it depends" and "more research is needed," a general caveat when thinking about the training and supervision literature is to avoid being overly simplistic.

Because one size does not fit all in therapy, training, or supervision (see Chapter 8, this volume), we need to teach the principles of responsiveness and personalization in our curricula. To guide such teaching, in Chapter 8, Stiles et al. offered a theory that emphasized three central distinctions: (a) *responsiveness to* (attention to external circumstances and to internal voices addressed by those circumstances) versus *responsiveness with* (actions and intentions, including their therapeutic goals and their interventions using semiotic tools, such as words and gestures); (b) *fast processing* versus *slow processing*; and (c) *emerging context* (perceived events) versus *internal context* (voices of previous experiences). In addition, Constantino et al. (Chapter 5, this volume) articulated a framework for teaching both *first-step* responsiveness strategies to meet patients with diverse needs where they "begin" and *if–then* responsiveness strategies to effectively navigate where patients and therapy relationships may "end up" at given moments in treatment.

Personal Growth Is Our Aspiration for All Therapists-in-Training

Many authors in this book have emphasized trainees' personal growth (e.g., see Chapters 12 and 17, this volume) in the context of supervision relationships. We know that trainees often pursue psychology as a field to learn more about themselves and to become more fulfilled human beings. In our view, increasing self-knowledge not only leads someone to become a more satisfied person but also to become a better therapist; as such, we value and attempt to foster such growth in our trainees.

One of the most important tasks in graduate training is for trainees to develop a sense of what they are comfortable with, excited about, and good at as therapists, as well as exploring their existential concerns related to faith and doubt. To navigate this complex pathway of personal and professional actualization, we believe that trainees need to learn to tolerate ambiguity vis-à-vis the various orientations to which they are exposed and to develop their own theoretical approach (see Chapter 17, this volume). Thus, rather than training students to adhere to a particular manualized approach, they need to think for

themselves about what works for them as a therapist and what is helpful for different clients. There is obviously tension, however, between on the one hand learning principles, theories, and case conceptualization, and on the other hand "finding one own voice." Similarly, there is also tension between trainees finding their own voice/comfort zone and the preferred/emphasized theoretical orientation of their training program or individual supervisors within the program.

We encourage trainees, then, to strive for personal growth, and note that one of the options for doing so is personal psychotherapy. By engaging in their own journey as a psychotherapy client, we hope that trainees become more self-aware, self-compassionate, authentic, culturally humble, open, reflective, and responsive to others who are similar to and different from themselves. We also hope that trainees learn to acknowledge their own limitations and feel able to question authority. More specifically in terms of psychotherapy, we hope that trainees reflect upon, become aware of, and manage personal reactions to individual clients, value inevitable existential angst, and think critically about what they are taught in their training programs. We hope they become more aware that doing therapy is difficult and complex and involves lifelong learning. Finally, we hope that trainees maintain an appropriate balance between work and life, remain open to different perspectives in supervision, and stay attentive to what they disclose about their clinical work to anyone other than formal supervisors (see Chapter 14, this volume).

Likewise, we encourage supervisors to strive for the previously mentioned qualities that can foster self-growth. They have to be comfortable in their own skins in order to serve as role models for trainees/supervisees. Importantly, supervisors need to achieve a delicate balancing act between relying on their own therapeutic expertise and clinical knowledge to train therapists to become competent in the conceptualization and implementation of treatment interventions, and at the same time encouraging students/trainees to critically reflect on and develop their own integration of theory and practice. One way to strive for such balance is for supervisors to be aware of their own biases and philosophical/theoretical perspectives, and to be clear with students about goals and expectations for supervision (e.g., "This is what I can teach you, and this is what we will work on together in order for you to learn this competently and in your own way"). While attempting to master this balancing act, they also have to be aware of trainees' developmental levels (e.g., beginner, advanced) and aim training and supervision to that level. Training directors then have to monitor how effectively the supervisors perform these tasks.

Power Dynamics Influence Training and Supervision

We must always remember the power structures in play when we provide training and supervision, and when we conduct research on these endeavors. Trainees are often not fully transparent about their reactions in training and supervision because they fear offending their supervisors and the possible consequences of such disclosure (see Chapter 12, this volume). They also

may be motivated to agree with their trainers and supervisors because of the evaluative nature of training and supervision.

And we, as trainers and supervisors, often want to validate and promote our own closely held and cherished beliefs. Such "trainer/supervisor allegiance" surely influences the results of our studies, much as researchers' theoretical allegiance influences the results of psychotherapy studies (e.g., Miller, 2011).

Training, Supervision, and Personal Psychotherapy Overlap

We define training as organized education applied in a group setting, whereas supervision tends to be implemented on a more individualized basis for trainees working with specific clients. The boundaries between training and supervision, however, are often blurred. Training can involve some individual feedback, and supervision can involve some didactic instruction.

Similarly, the boundaries between training/supervision and psychotherapy are often permeable. A student put it well when describing differences between psychotherapy and supervision: Supervision involves examining your personal issues related to your work with specific clients but talking about the origins of these personal issues should be reserved for one's own psychotherapy. Similarly, in their psychotherapy, trainee clients might explore personal issues that are stirred up by seeing clients but helping the trainee work with that particular client should be reserved for supervision.

Consider Different Views of How Training and Supervision Work

Frank and Frank (1991) boldly stated that the transmission of the therapist's beliefs and expectations about therapy to the client is what brings about change rather than the specific ingredients of the treatments themselves. Similarly, it well could be that supervisors' beliefs and expectations are what underlie the effectiveness of training and supervision. For example, rather than skills themselves being the crucial element of helping skills training (e.g., Hill, 2020), it could be that training students to become and think of themselves as professionals and then the students acting accordingly is what actually helps them become better therapists. Certainly, after putting in many years of learning to become therapists, it is not surprising that most of us think that our training and supervision were crucial. However, we need to remind ourselves to entertain alternative hypotheses for how people learn to become excellent therapists.

EVIDENCE-BASED CONCLUSIONS AND IMPLICATIONS

We start with conclusions for which we have the most evidence and end with those for which we have minimal evidence but often believe based on personal experiences. After briefly summarizing the evidence for each conclusion for

training and supervision in psychotherapy, we provide implications for practice, research, and policy.

Predoctoral and Doctoral Training Seem to Be Effective

We have a fair amount of evidence that the Hill model of helping skills training is effective for undergraduate and beginning graduate students, especially in terms of facilitating self-efficacy for using the skills and for actually using more of the appropriate skills (e.g., restatements, reflections) and fewer of the less appropriate skills (e.g., interruptions, premature advice and self-disclosure) in sessions with volunteer clients (see Chapter 3, this volume). In addition, a number of other positive outcomes of helping skills training have been found (e.g., increases in multicultural empathy), but these have yet to be replicated. We do not know whether such outcomes are due to the specific skills that are taught, the behaviors students are taught to avoid, the opportunity to practice, or being treated as budding professionals, but evidence suggests that such training is helpful for novice trainees. Furthermore, although as yet we have no specific evidence, it seems important for helping skills trainers to focus on critical thinking in terms of teaching students to reflect about when and when not to use particular skills, to understand the theory behind each skill, to focus on being responsive to client needs, to be aware of internal reactions and how these influence the therapy process, and perhaps most importantly, to observe how clients react to the various skills. Thus, we are not just teaching the skills in isolation, but are instructing trainees how and when to use these skills.

We also have some preliminary evidence that alliance-focused training is helpful in facilitating learning about alliance ruptures, particularly in the context of group supervision of ongoing cases for advanced doctoral students (see Chapter 6, this volume). This training is probably most effective once therapists have learned basic skills and have started seeing clients, but we lack evidence about the timing of such training. Other types of training (e.g., psychodynamic, cognitive-behavioral) have received some attention, but results have not been replicated sufficiently to develop conclusions. Here are some evidence-based recommendations:

- Practice implications:
  - Offer helping skills training as a foundation course(s).
  - Include alliance-focused training at later stages of training.
- Research implications:
  - Examine the outcomes of training for clients, trainers, and trainees.
  - Examine trainer and trainee effects on the outcomes of training.
  - Compare different training programs and investigate the components of training programs.
- Policy implication: Rethink our curricula to determine what courses and clinical experiences are needed to train students to become good therapists.

Components of Training

In their review chapter of the helping skills training literature, Hill and Knox (Chapter 3, this volume) reported evidence for the four components of Bandura's (1969, 1977, 1986) social cognitive theory of learning: instruction, modeling, practice, and feedback, with students especially noting practice as the most important component. In the studies reported in this book, we found additional evidence for these components, again with practice receiving the most attention and support. Thus, we start with this component.

Practice Seems to Be an Effective Component of Training

We have increasing evidence that practice is helpful and is perhaps the most helpful component of training and supervision (see Chapters 3 and 9, this volume). There is lively debate, however, about the effects of different types of practice. For example, some regard practice with real volunteer clients as best for learning skills. Others advocate for using standardized stimuli (e.g., having therapists respond to videorecorded client stimuli and then rating their interventions on the Facilitative Interventions Task, Anderson et al., 2016). Others suggest using avatars or machine learning to help trainees learn how to respond more effectively to clients (Chapter 11, this volume). We note that some of these training methods can be viewed as more modern versions of decades-old practices of having trainers respond to written stimuli or watch and respond to video stimuli. We suspect that all forms of practice could be helpful, with perhaps the more standardized forms, such as written or video stimuli, being useful early on, before trainees work with volunteer clients simulating real problems. Following or in conjunction with these kinds of instruction, trainees of course mostly need to work with actual clients.

Deliberate practice has received a large amount of attention in recent years as an effective addition to supervision for particularly difficult cases (see Chapter 9, this volume). In deliberate practice, supervisees bring in a difficult case, talk with a supervisor about their personal reactions, think about different options about how to handle the situation, systematically practice these different options with the supervisor and on their own until they feel comfortable, and then try the new behaviors in session with the target client. They receive feedback from the supervisor about what went well and what they can continue to improve. A study by Kivlighan and Kivlighan (Chapter 9, this volume), along with the data from Hill et al. (2020) using the same data set, provided evidence that some trainees (and their clients) profited from deliberate practice (especially trainees with more experience and who had been with their supervisors longer), whereas others did not profit as much.

Relatedly, Hayes et al. (Chapter 7, this volume) provided preliminary evidence that it is not just practice alone but reflecting about the practice that is important. They described a method whereby reflective practice can be integrated within supervision. Specifically, a trainee can use a log or journal to record their reflections, and this log or journal can be used to communicate directly with the supervisor (e.g., about one's personal reactions). When a reflective practice

log is used to manage personal reactions, trainees might find it helpful to reflect first on the most obvious aspects of their reactions (manifestations), then the triggers for them, then their origins, then the effects on the session, and finally, their strategies for managing their reactions. As a result of sharing their reflections about personal reactions with supervisors, trainees could learn how to better manage these reactions with the support from their supervisors.

Hence, we note that practice can take many forms. It seems likely, however, that it is not just practice alone, but practice combined with feedback (and perhaps instruction and modeling) and reflection about the experience, that helps trainees/supervisees change their behaviors. Here are our recommendations:

- Practice implications:
  - Encourage practice with different types of stimuli (written, video, computer, volunteer clients) prior to seeing actual clients.
  - Use deliberate practice (by identifying specific problematic situations and then role-playing better interventions).
  - Teach reflective practice (by reviewing therapy events and seeing what worked or did not work).
  - Teach trainees to be present in session and to reflect afterward, and then to improve at reflecting while doing therapy.
- Research implication: Examine both the process and the outcomes (for clients and therapists) of different types of practice.
- Policy implication: Rethink how our prepracticum and practicum courses, as well as externships and internships, are designed to ensure that students are engaging in different types of practice and reflecting about their experiences.

Feedback May Be an Effective Component of Training

Two types of feedback have been investigated in training. First is the feedback provided in regular supervision by trainers or supervisors about the quality of the skills trainees used. The second, provided by clients, is based on routine outcome monitoring (ROM), allowing therapists to receive data about how clients are progressing in treatment. Obviously, clients also provide feedback during sessions (e.g., in response to the question "How has the session been for you?") but this type of feedback has not been investigated.

We have surprisingly little evidence about the role of supervisor feedback that is typically associated with practice (see Chapter 3, this volume). Although trainees attain feedback directly by observing how clients respond, we suggest that it is probably helpful for supervisors to give more direct feedback about how students are implementing what they are taught. In particular, watching trainees' videos allows trainers and supervisors to provide feedback on what took place during sessions, rather than relying only on trainees' report of what they did and the seeming impact it had on clients, which may or may not be accurate (e.g., overestimating or underestimating the effects of their interventions).

As presented in Lutz et al.'s (Chapter 10, this volume) chapter, we have evidence about the effectiveness of feedback based on ROM. These authors advocated for psychotherapy training and practice to follow a transtheoretical and transdiagnostic approach focusing on empirically based processes and strategies. They argued that scientifically trained therapists need to be able to interpret and make use of ROM data. They suggested that such training requires a high degree of therapeutic flexibility and competence. In order to close the persistent research–practice gap, they further recommended that research findings and feedback tools be implemented in daily practice and training. Here are some recommendations regarding feedback:

- Practice implications:
  - Have students play video excerpts from their sessions rather than relying solely on their self-report so that supervisors have firsthand awareness of therapist behaviors and can thus provide better feedback.
  - Where possible, provide trainees with feedback about client progress, either through providing client-reported data about progress (ROM) or by asking therapists to systematically ask clients about their reactions.
  - Have clients and therapists routinely complete satisfaction and outcome measures so that data may be used to assess the effectiveness of therapy/supervision.
- Research implications:
  - Investigate the effects of different types of feedback regarding client outcomes and treatment processes (e.g., alliance) for trainees at different levels of training.
  - Investigate to what extent confirmation bias and social desirability factors influence the validity of client and therapist reports of progress.
- Policy implication: Ensure that our prepracticum and practicum courses, as well as externships and internships, are designed to provide students with feedback about their performance.

Instruction Might Be a Beneficial Component of Training

Throughout all our schooling, we receive didactic instruction. Although we all see such instruction as foundational, we have less evidence about how students make use of such instruction when they are practicing psychotherapy. Aafjes-van Doorn and Barber (Chapter 4, this volume) noted the lack of evidence that continuing education for practicing professionals has any salutary effect on practicing therapists. In the review of training undergraduate students in helping skills (see Chapter 3, this volume), students rated instruction as helpful, but less so than practice.

In this book, we speculate about two types of instruction. The first is related to instruction regarding specific skills to use in the context of specific client markers. Indeed, we have increasing evidence for the efficacy of specific therapist interventions when certain client markers appear—whether

at outset of therapy (e.g., when a client may have a preference for a particular style of therapy), or during therapy (e.g., when a client may become resistant to the current direction of the work; see Chapter 5, this volume). These findings suggest the relevance of teaching trainees about these marker–skill combinations and helping them to practice and implement these skills. The second is related to the ethical need to instruct about possible harm that can occur in therapy. Strauss and Frenzl (Chapter 16, this volume) argued that given that harm does occur (5%–10% of psychotherapy cases end in deterioration), therapists need to know what to look for and how to minimize harm. Such instruction also interacts with the need for therapists to engage in ROM so that they know when harm has occurred (see Chapter 10, this volume). Here are some recommendations regarding didactic instruction:

- Practice implications:
  - Provide didactic instruction about important client or dyadic markers to recognize and specific skills to address them, along with opportunities to practice the skills when such markers appear (perhaps using role-playing).
  - Teach therapists different theory-driven and evidence-based pathways to clinical change in order to maximize their ability to offer flexible treatment frameworks that a given patient finds most *personally* suitable (e.g., preference-compatible, hope-inspiring).
  - Instruct trainees about potential harm to the client and how to avoid it in psychotherapy.
- Research implications:
  - Delineate frequently occurring markers that disrupt psychotherapy outcomes and therefore require targeted therapist responsiveness.
  - Examine the effectiveness of current and new marker-intervention combinations for different kinds of therapists and clients.
  - Compare marker-driven responsiveness training with other training methods, such as training-as-usual on adherence to a sequentially ordered treatment manual.
- Policy implications:
  - Rethink how our prepracticum and practicum courses, as well as externships and internships, are designed to ensure that students are provided with instruction that they can use (i.e., instruction focused on the changing needs of clients rather than on learning the specific skills associated with one theoretical approach).
  - Monitor the effectiveness of practicum instructors, and have the courage to make changes, including requesting that less effective instructors, some of whom may have taught practicum courses for years, step aside for new instructors with new ideas and awareness of clinical research.

Modeling May Be an Effective Component of Training

We have some limited evidence that modeling is effective (see Chapter 3, this volume), although most of the research on modeling is old and flawed, and thus needs to be updated (Hill & Lent, 2006). Certainly, trainees talk about the benefits of observing master therapists doing therapy (and many sessions are commercially available), research assistants note that they learn more directly about what they like and do not like by participating in research studies where they observe therapists and attend carefully to what they do, and researchers have stressed the benefits of students learning to code using process measures for research to learn what works and what does not work in therapy (see Pascual-Leone & Adreescu, 2013; see also Chapter 10, this volume). Here are some recommendations regarding modeling:

- Practice implications:
  - Trainees could observe sessions of master therapists conducting psychotherapy and practice coding process variables in psychotherapy sessions.
  - Practicum instructors could also see a client and have students observe live and then ask questions.
- Research implications:
  - Compare the effects of instruction, modeling, practice, and feedback.
  - Compare different types of modeling (e.g., just observing sessions or observing sessions while coding research measures).
- Policy implication: Make demonstration sessions by master therapists readily available at minimal charge.

Predoctoral Supervision Is Effective in Terms of Supervisee Outcome

The existing literature provides evidence that supervisees find supervision helpful and satisfying, but we have less evidence about the impact of supervision on clients and only limited data on supervisor effects, that is, whether or not some supervisors are more effective at helping supervisees help their clients (see Chapter 3, this volume). Interestingly, we have preliminary evidence that doctoral students engage in informal supervision and that such supervision can be particularly helpful in providing support (see Chapter 14, this volume). These new findings expand our thinking about what supervision entails and raise important concerns about setting guidelines for such practices.

Also from recent studies, it appears that at least sometimes, supervisees find supervision to be very effective in helping them work with specific clients with whom they are having difficulty (Hill et al., 2016; see also Chapter 12, this volume). Two suggestions for helping trainees work with difficult clients flow from the work presented in this book about supervision. First, based on the chapter by Friedlander et al. (Chapter 12, this volume), supervisors can use interventions characterized by the acronym *DEEP*: *Describe* the supervisee's concern, *Explore* the therapeutic process and the supervisee's associated thoughts

and feelings, *Expand* the supervisee's understanding of the difficulty, and *Plan* an alternate approach to the clinical work. Second, based on the work by Kivlighan and Kivlighan (Chapter 9, this volume), supervisors can use deliberate practice as a component of supervision, especially if they provide adequate explanation of the theory, principles, and application of deliberate practice, and tailor it to the needs of the trainee.

Here are further recommendations for predoctoral supervision:

- Practice implication for trainees: Engage in supervision, get feedback about skills, read about different theories, and practice using as many different formats as possible (e.g., deliberate practice, role-playing).
- Practice implications for supervisors:
  - Use good basic skills (e.g., open questions, interpretations) and advanced skills (e.g., managing ruptures, handling termination) when interacting with supervisees.
  - Provide supervisees with clear expectations about supervision, given that some supervisees become demoralized when they learn that they are not conducting therapy perfectly.
  - Practice mindfulness (i.e., being calm and present).
  - Exhibit cultural humility.
  - Provide supervisees with feedback data about how clients are progressing.
  - Attend to the supervisory relationship, as it has been linked not only to supervisees' satisfaction but also to the supervisory working alliance.
  - Attend carefully to supervisees' expression of negative emotions, for beneath what is overtly expressed to supervisors may lie even more troubling concerns that supervisees should be invited to share in supervision.
  - Not only listen to trainees' verbal descriptions of what transpired in therapy sessions, but also watch videorecordings of their therapy with clients to directly assess the quality of the therapeutic interactions and client engagement.
  - If supervisees are seeing more than one client, attend to which clients are focused on and which are not.
  - Use case notes wisely to help students become more reflective about their work with clients.
  - Consider the advantages of live supervision (i.e., being present behind a one-way mirror or over Zoom while the session between the therapist and client is taking place) to intervene immediately.
- Research implications:
  - Examine the effects of supervision on how supervisees/therapists work with clients and on client outcome.
  - Further examine supervisor effects.

  - Investigate the impact of different types (formal, informal, peer, individual, group) and lengths (brief, long-term) of supervision, supervisor and supervisee effects, and the mechanisms by which supervision has an impact on various outcomes.
  - Study how supervisors become responsive to supervisees' needs, how messages are relayed from supervisors to supervisees to clients, and how supervisors can best work with supervisees who have very different identities and political views.
  - Study the effects of deliberate practice using more experimental designs, larger samples, and comparative designs with supervision/training-as-usual or alternative training approaches (e.g., helping skills training).
  - Investigate the effectiveness of matching supervisor–supervisee based on gender, racial identity, and theoretical orientation.
  - Study the association between effective supervision (according to the perception of trainees) and clinical outcome (according to the perception of clients).
  - Examine the temporal aspects of supervision, that is, optimal length of time of supervisory sessions, optimal frequency (per dyad), optimal number of all supervisory sessions.
- Policy implications:
  - Continue providing formal supervision at the postgraduate level.
  - Allow informal supervision but only under clear and prudent guidelines (e.g., the conditions under which it should and should not occur, and the ethical and legal implications involved).

Postdegree Training and Supervision Are Modestly Effective

As described by Aafjes-van Doorn and Barber in Chapter 4, the empirical findings on the effects of training and supervision for experienced therapists can be summarized using the six levels of the therapist training evaluation outcomes framework (Decker et al., 2011). Most therapists appear to be satisfied with their training and supervision experiences postlicensure (Outcome Level 1). Following training and supervision, therapists tend to report perceived increases in levels of competence (Outcome Level 2). Training and supervision result in acquisition of knowledge and skills, especially following multicomponent trainings (Outcome Levels 3 and 4), although transfer of therapist skills to new practice settings appears to be minimal (Outcome Level 5). Finally, there is not enough evidence to suggest that self-identified improvement translates into changes in client outcomes (Outcome Level 6).

In addition, preliminary findings suggest that peer consultation within routine clinical practice was perceived as helpful in terms of professional development and in handling specific situational issues, such as the COVID-19 pandemic (Chapter 13, this volume). Advantages of peer consultation in contrast to formal individual supervision are that peer consultation is less formal,

clinicians may feel more comfortable opening up with peers, and there is less (if any) formal evaluation. In addition, peer consultation can be free and allows therapists to serve in both the supervisor and supervisee roles. Because group members choose what they are interested in exploring, peer supervision can focus on case materials that participants are willing and able to share, and that the specific feedback group members would like to receive. The findings also suggest that creating a contract between participants may entail discussing examples of and responses to problematic group behaviors, and forming explicit agreements on confidentiality within the group—both of which may facilitate adaptive risk-taking and deepen engagement across group members.

- Practice implication: Engage in ongoing formal supervision or peer consultation while seeing clients at every experience level.
- Research implications:
  - Examine the outcomes (for therapists, clients, and supervisors) of different types of supervision, including peer supervision and consultation.
  - Investigate under what conditions, for which kind of clients, and in what settings different forms of supervision are most helpful.
  - With regard to formal supervision, develop and test training models that have been established in the fields of education and cognitive psychology (e.g., more emphasis on procedural knowledge in addition to acquisition of declarative knowledge).
  - Use large-scale, methodologically rigorous trials that include representative clinicians, clients, and follow-up assessments to provide sufficient evidence of effective training methods and materials (Herschell et al., 2010). Multimethod, multi-informant assessment at multiple time points is also recommended to fully explore training capacity to change therapist behavior and treatment outcome (Beidas & Kendall 2010; Decker et al., 2011). In addition, large-scale naturalistic studies are needed.
  - Investigate questions related to therapists, such as whether there are qualitative differences between individuals who elect to receive clinical supervision after training and those who do not; whether therapists benefit more from supervision when supervisors are assigned versus selected, or trained versus untrained; how to assess therapist competence and expertise as a result of posttraining supervision; and the effects of personal therapy on supervision.
  - In terms of peer consultation, conduct studies with large and heterogeneous samples to enhance generalizability of results and to determine what works and what does not, and to see whether peer consultation reduces therapist burnout.
- Policy implication: Develop guidelines for formal, informal, and peer supervision for different levels of training (predoctoral, postdoctoral, practicing therapists).

Desirable Characteristics of Potential Doctoral Student Therapists

A number of characteristics have been identified by directors of clinical training as either "green flags" or "red flags" in the selection of potential graduate students in a number of training programs (see Chapter 15, this volume). These characteristics focus on aptitude for therapy training, although we are aware that, especially for heavily research-focused PhD programs, research aptitude is an equally important criterion for selection of graduate students. A tension that exists in the field, and especially in selection practices, involves the extent to which potential as a therapist and as a researcher overlap. Here are recommendations regarding desirable and undesirable characteristics of applicants:

- Practice implications:
  - Stakeholders (directors of clinical training, faculty members, supervisors) might pay particular attention to selection of trainees.
  - In terms of negative characteristics, be alert to indications of emotional instability, narcissism, limited intelligence, coldness, rigidity, arrogance, lack of self-awareness, multicultural insensitivity, defensiveness, being judgmental, high anxiety, lack of grit or resilience, and poor boundaries.
  - In terms of positive characteristics, assess for openness, warmth, intelligence, socially skill, empathy, self-awareness, curiosity, grit, mental health, multicultural sensitivity.
- Research implications:
  - Examine the extent to which ratings of incoming candidates on specific personal/interpersonal skills predict their progress/problems in clinical training, research training, and career choices (e.g., clinical practice only, research only, combined practice and research).
  - Investigate which skills can and cannot be improved with training.
  - Develop methods (e.g., having applicants respond to standardized clients; Anderson et al., 2016) to assess skills before, during, and at the end of graduate and postgraduate training.
- Policy implications:
  - Develop guidelines for selection criteria.
  - Have discussions among faculty about the competing demands of selecting students who will make good therapists and/or good researchers, depending on the nature of the program (e.g., scientist/practitioner vs. scholar/practitioner).

Competencies in Therapy Are a Desired Part of Training

Castonguay et al. (Chapter 2, this volume) surveyed trainers from around the world to develop a sense of what competencies are currently taught in

training/supervision. These competencies were clustered within three categories: generic, theory-specific, and metacompetencies. It is clear that competencies categorized in each of the three domains have potential value. Some generic skills, for example, explain why some therapists are better than others; several theory-specific skills are core interventions in treatment manuals that have been shown to be effective for diverse clinical disorders; and a number of metacompetencies (e.g., responsiveness, metacommunication, emotion regulation) are aimed at providing trainees tools to help individualize treatment to particular clients and to address challenging issues during therapy.

Castonguay et al. (Chapter 2, this volume) also presented a diversity of methods that are currently used to foster the acquisition of skills attached to the three domains of competencies. These include didactic methods (courses, reading) and experiential methods, such as supervision, various procedures aimed at providing feedback (e.g., ROM, deliberate practice, interpersonal process recall), and personal therapy.

Although we recognize the need to have some way to assess our training and supervision, we are concerned that many of the identified competencies are not empirically based. Given that ours is a scientific field, we call for research that seeks to establish an empirical foundation for these competencies. In addition, they should not be viewed as a constraining set of skills to be uniformly prescribed by supervisors and trainers. Rather, they should be taught in ways that are responsive to the individual variations among students and that help them find their own theoretical and clinical style in conducting therapy. Here are our recommendations regarding competencies in therapy:

- Practice implications:
  - Expose trainees to diverse competencies and their respective empirical basis. Many programs, at least in North America, focus on a restricted range of theory-unique techniques attached to a particular type of empirically supported treatment, such as cognitive behavior therapy. However, there is substantial support for the efficacy of other major orientations (humanistic, psychodynamic, systemic) for various clinical problems (Barkham et al., 2021) to justify the teaching of their theory-specific competencies.
  - Include in training those metacompetencies that have received empirical evidence (e.g., metacommunication skills, see Chapters 5 and 6, this volume; Norcross & Lambert, 2019) in the curriculum of all scientist–practitioner training programs.
  - Expose trainees to different methods of learning (didactic, modeling, practice, feedback) and do not restrict training to fidelity to treatment manuals.
- Research implications:
  - Establish the effectiveness of the various competencies, both in terms of trainees' and clients' outcome.

  - Assess what programs are actually implementing, as well as stakeholders' (such as faculty, supervisors, clinical staff, students) evaluations of the components and teaching methods of training.
- Policy implication: Base competency criteria on empirical evidence about effective components of training and supervision.

Technology Can Be a Useful Adjunct to Training

Lutz et al. (Chapter 10, this volume) provided a model of how empirical knowledge, computer technology, and statistical analyses can be integrated into a training program for therapists. Trainees learn about psychotherapy research, use a computerized feedback system that helps them personalize treatment for their clients, and implement session-by-session monitoring of process and outcome data. Similarly, Bugatti et al. (Chapter 11, this volume) described new technology that they have developed to facilitate the learning and deliberate practice of helping skills. Here are our recommendations regarding the use of technology in training therapists:

- Practice implication: Incorporate more technology in training and supervision in ways that might enhance them.
- Research implication: Investigate the effects of technology on training and supervision.
- Policy implication: Develop guidelines for how and when technology should be used.

CONCLUSION

When we combine what we know from the existing literature (Chapters 3 and 4, this volume) with the innovative studies presented in this book, we can see that there exists an impressive foundation of knowledge about psychotherapy training and supervision. We hope that we have inspired trainers and supervisors to conduct more research and base training and supervision on empirical data. We recognize that research in this area is messy, difficult, and time-consuming, and that programs and systems in general tend to be resistant to change even when research indicates that such change would be beneficial. We hope, however, that we have provided some models of how such research might be conducted. Much remains to be done, of course, but we feel confident that we are on the right path.

The field has moved, probably for the foreseeable future, into far greater use of teletherapy. Questions and research, then, need to be focused on whether changes in the way that therapy is conducted have implications for the way that supervision is conducted. For example, is there research on whether tele-supervision is more or less effective than in-person supervision? More generally,

there is so much we do not yet know about the parameters of supervision: optimal length of time, optimal frequency, potential for matching, group versus individual supervision, different supervisory formats for different orientations (e.g., live supervision for family therapy), benefits of supervisors being "on call" for between-session questions, and learning from "failed" cases. Perhaps most important, we know little about the barely examined question of greatest significance: What is the association between supervision, especially therapist-perceived good supervision, and client outcome?

We also note that there are many areas of training and supervision that we have not covered in this book that nevertheless are important. As one example, we could consider individualizing the training for every trainee, just as we individualize psychotherapy for every client (Caspar, 1997). As another example, students clearly need to be trained in case formulation and conceptualization (Eells, 2022).

In conclusion, we note that a considerable amount of research has shown that psychotherapy is effective (Wampold & Imel, 2014). Yet, there are still a number of clients who do not fully benefit from therapy, some who do not benefit at all, and even others who get worse during or as a consequence of therapy. The overall goal of training and supervision, and efforts to study these practices, then, should be to enhance the current degree of effectiveness that has been reached in psychotherapy.

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