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A Different Type of Supervision: Training Clinical Mental Health Counseling Interns in Dialectical Behavior Therapy

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A basic qualitative study examined the role of supervision in learning dialectical behavior therapy (DBT). Ten master's-level clinical mental health counseling interns completed in-depth interviews regarding their experiences of supervision when providing DBT skills training groups to adolescents in an inpatient psychiatric setting. Supervision was described as an activity in tandem with observation and shadowing, with the supervisor functioning as a consultant and teacher. Themes highlighted the importance of structure in mitigating trainee performance anxiety, and a focus on skills training during supervision. Implications for supervising counseling interns in evidence-based practices such as DBT are discussed.

Competence and knowledge in using evidence-based practices (EBPs) has been reflected in professional training standards for master's-level clinical mental health counseling (CMHC) students. The American Mental Health Counselors Association (AMHCA; 2011) standards for the practice of CMHCs specifically require both faculty and supervisors to possess knowledge of EBPs and how to apply them in clinical settings. In 2009, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) required EBP training as part of the specialization area of study for addiction counseling, CMHC, and marriage, couples, and family counseling specializations (Standard I.3). In the recently-published 2016 CACREP Standards, the requirement for EBP training was moved from the specialization-area standards to the common core standards section for both helping relationships (II.F.5.j) and research and program evaluation (II.F.8.b), indicating that all counseling students must be trained in EBPs regardless of specialization. Yet the frequency of EBP training in master's-level counselor preparation programs is currently unknown. No studies currently exist that examine the frequency of EBP training in counseling programs. The reported underutilization of EBPs in clinical

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practice (Becker, Stice, Shaw, & Woda, 2009) could be conceptualized as a gap that begins to appear during training programs for many students, though further research is needed.

Training post-graduate practitioners in EBPs is not a straightforward process. Most trainings consist either of two or three day workshops that have not resulted in sustained implementation of EBPs in clinical practice (Oxman, Thomson, Davis, & Haynes, 1995). Learning an EBP is a complex endeavor, requiring supervised practice in addition to didactic training. Few studies currently exist into the training or supervision of master's-level CMHC students in EBPs. A gap in the literature therefore exists, to examine how to adequately train and supervise master's-level CMHC students when learning EBPs.

DIALECTICAL BEHAVIOR THERAPY

Dialectical behavior therapy (DBT) has been identified as an EBP by Division 12 of the American Psychological Association (Society of Clinical Psychology, 2015) and the Substance Abuse and Mental Health Services Administration in the treatment of borderline personality disorder, and is currently an emerging evidence-based practice for suicidal adolescents. DBT is currently one of the two most implemented EBPs in clinical practice, along with multisystemic therapy (McHugh & Barlow, 2010). DBT is a complex therapeutic treatment, incorporating four modes (individual therapy, group skills training, 24-hour phone support, and consultation team meetings), four modules (distress tolerance, emotional regulation, interpersonal effectiveness, mindfulness), and four treatment stages. A primary focus of the modality is teaching clients more adaptive coping skills to cope with emotional distress and dysregulation (Linehan, 2014).

DBT supervision has been described as resembling the therapy itself. DBT supervision follows stage models and prioritizes issues in hierarchies. The goal of supervision, as with DBT, is to increase skill acquisition such as moving from basic skills (e.g., group leadership) to advanced skills (e.g., mindfulness). Similarly to DBT, supervision balances acceptance and validation with problem-solving and change-oriented strategies (Fruzzetti, Waltz, & Linehan, 1997; Waltz, Fruzzetti, & Linehan, 1998). Supervisee competence develops from reviewing videotaped or live sessions of client work in supervision, to ensure supervisee adherence to the treatment manual (e.g., use of diary cards) while also identifying supervisee strengths and weaknesses in providing DBT. The professional relationship is given precedence and supervisees are described as "a person of equal status, due equal respect" (Fruzzetti et al., 1997, p. 89). Important skills for trainees to master during experiential training include therapeutic genuineness, distress tolerance, appreciation of diversity, and the ability to receive feedback non-defensively. Supervisees are also expected to develop the ability to maintain a dialectical position of accepting that two contrary positions can co-exist (i.e., there is usually not a single, "right" way). During DBT consultation meetings, supervisors monitor enthusiasm in addition to specific supervisee skill targets early in training. Supervisors are also tasked

with making the process enjoyable (Fruzzetti et al., 1997). Fruzzetti et al. (1997) acknowledged that very little information exists regarding what methods of supervision are most effective in fostering adherence to the manual-based protocol and supervisee competence. DBT supervision has been described as useful at all stages of counselor development, functioning as a support for therapists to prevent burnout in addition to enhancing therapist competence and effectiveness (Waltz et al., 1998). Whereas supervision is time-limited in most other psychotherapeutic models of supervision, DBT supervision is intended to last for as long as DBT is provided, with consultation teams meeting weekly, potentially for years.

In one of the few existing studies into DBT training, Dimeff et al. (2009) examined the impact of different training approaches on trainee competence. Three approaches were compared in a randomized controlled trial design: individualized reading of a treatment manual, a two-day instructor-led workshop, and a multimedia online training. Of note, none of these three approaches included supervised clinical practice as part of the training curriculum. Supervision was expected to occur afterwards during consultation team meetings that are a requirement of DBT practice. Thus, while information exists in the literature regarding how to approach DBT supervision, studies are needed that examine what constitutes effective DBT supervision.

The purpose of the present study was to address this research gap by exploring how master's-level CMHC students attributed meaning to their training and supervision in learning DBT as part of their internship experience at a child and adolescent inpatient psychiatric unit. The research question guiding this study was, "What is the role of supervision in learning DBT in an acute inpatient psychiatric unit for adolescents?"

Background of the Current Study

Over a 24-month period, master's level CMHC students in their internship phase of training participated in six to 12 months of supervised group leadership of DBT skills training groups (hereafter, DBT-STGs) for adolescents in an acute inpatient psychiatric unit located in the Southeastern U.S. Interns were all completing CMHC programs at two local-area graduate counseling programs. Both programs were accredited by CACREP at the time of the study's completion. Twelve months prior, the setting had recently implemented a comprehensive version of DBT for an inpatient setting, following the DBT manual for suicidal adolescents authored by Miller, Rathus, and Linehan (2007). DBT-STGs were provided daily, with daily review of diary cards during individual and family sessions with primary therapists. Adolescents aged 12 to 18 years attended the groups. These adolescents were hospitalized with a variety of mental health issues, though most predominantly for suicidal thoughts and parasuicidal behavior including non-suicidal self-injury. Adolescents could elect to attend the DBT-STGs or complete assigned worksheets and reading materials in their rooms during group time if they chose. Thus, group partici-

pation was somewhat voluntary even though many adolescents were admitted on an involuntary basis to the unit.

The DBT-STG supervisors consisted of two trained primary therapists working at the setting. At the time of the study, the primary therapists had implemented a 12-session DBT-STG curriculum one year earlier and had begun to supervise interns in leading DBT-STGs. These DBT-STG supervisors were themselves supervised by an experienced therapist with 30 years of experience throughout the study, who also served as the primary site supervisor for the interns. Interns were exposed to everything from pre-group planning to post-group clean-up and debriefing with staff members. The preparation required for the group was fairly time intensive and detailed, making the training experience complex and requiring methodical instruction. The supervisor provided live supervision through either leading, co-leading, or observing the group with the intern. Post-group supervision sessions were conducted immediately following DBT-STGs in a private room. Video recording capability was not permitted in the hospital, and thus was not available for supervision. Individual supervisees led anywhere from one to four DBT-STGs per week. Interns also completed rotations on other units in the hospital, including inpatient psychiatric units for adult, geriatric, and dually-diagnosed populations.

METHOD

Design

This study was conducted as part of a larger 24-month multiphase mixed-methods study. The present study utilized a basic qualitative design, following Merriam's (2009) guidelines. Basic qualitative research is defined by Merriam (2009) as a common approach to qualitative research in applied fields such as counseling. In basic qualitative studies, data are collected from interviews, observations, and/or documents. Data are analyzed to identify recurring patterns known as themes. Constructivism is the primary theoretical positioning of basic qualitative research, which seeks to understand how individuals make meaning of particular phenomena. Basic qualitative designs are distinct from other qualitative approaches because they do not include a further dimension to the research. For example, phenomenology seeks to understand the essence of a phenomenon, and grounded theory seeks to build substantive theory. Basic qualitative designs do not have this additional lens for approaching data collection and analysis.

Participants

A pool of potential participants was identified, based on intern willingness to participate in the research project. Ten intern supervisees were interviewed for the study. The intern sample was adequately represented by men and women (50% each), with a sizable minority of African-American participants (n = 2, 20%). Participants had been providing DBT-STGs for an average of nearly nine months by the time of the interviews (range = 5-19 months). Years

of counseling experience varied greatly among interns, with some interns new to the field and others already having five or more years of experience.

Procedure

The primary mode of data collection for this study was in-depth, semi-structured, face-to-face interviews. Interviews lasted for a maximum of 60 minutes. Interview questions were both a priori (i.e., determined before the study began) and emergent (i.e., determined after several interviews). All a priori interview questions were reviewed by peers and faculty at the author's university to ensure their relevance to the research question under study. Interviews followed a protocol that was approved by the Institutional Review Board of both the author's university and the hospital system where the inpatient adolescent psychiatric unit was located. All interviews were audio recorded and transcribed by a professional transcriptionist for the purpose of data analysis. The research was closely supervised by a dissertation chair, dissertation committee methodologist, and another dissertation committee member. For the purpose of bounding, which Merriam (2009) defined as placing limitations upon data collection activities to ensure that the focus of the research remains on answering the research question, in-depth interviews were only conducted with master's-level CMHC interns who were providing group leadership of DBT-STGs in the adolescent inpatient psychiatric unit during the second and third year (12-36 months) of DBT implementation in the setting.

Interviewees were selected using the theoretical sampling method. The primary researcher and dissertation committee methodologist sought adequate variation among participants, and selected the first five interviewees on the basis of length of time leading DBT-STGs, number of years of experience, gender, and race/ethnicity. Following the initial five interviews, a coding consensus team met at the author's university to review transcripts and code responses into categories using the constant comparative method (Glaser & Strauss, 1967). The constant comparative method is the most common form of qualitative analysis used to categorize codes into themes, and can be applied with different qualitative methodologies, including basic qualitative studies (Merriam, 2009). Codes were entered into a software program, NVivo 9 (QSR International, 2010), for the development of thematic analyses. The coding team reviewed their individual coding of manuscripts, and reached consensus on differences between coding team members. After initial themes across the five participants were identified, the primary researcher and methodologist met to review the potential pool of interviewees and made selections to provide support or contradiction to emerging themes (Merriam, 2009). Data collection and analysis continued until saturation and redundancy was reached (Lincoln & Guba, 1985).

Trustworthiness

To enhance the trustworthiness of findings, several techniques were used. First, member checks ensured the accuracy of transcripts and initial analyses, by sending these documents to participants via e-mail for their review.

Follow-up interviews were conducted with two intern participants, based on the need to understand specific responses. Second, an audit trail was maintained throughout the process. Third, a coding team of three trained doctoral students was used to code the qualitative transcripts and organize codes into themes. Fourth, the coding team consisted of one member who had *etic positioning* as a doctoral student in another unrelated discipline to counseling (speech and language pathology). This coding team member asked helpful questions to ensure that assumptions were avoided when coding data. In the results that follow, quotations are not associated with any particular respondent to protect participant identity.

At the time of the study, the primary researcher and author of this article was an employee at the inpatient adolescent psychiatric unit where the study was conducted. In qualitative research, having prior familiarity with the setting when the study is conducted is defined as *emic positioning* (Merriam, 2009). In contrast, etic positioning is defined as lacking familiarity with the setting at the time of the study. Emic positioning has benefits that include the potential for participants to be more open and forthcoming during interviews because of familiarity with the researcher. Drawbacks to emic positioning include the potential for the researcher to be less objective and detached. The use of a coding consensus team was especially important to this study, because of the primary researcher's emic positioning.

RESULTS

Emerging themes from the interviews were organized by the following categories: the training sequence, supervisee adherence to structure, supervisor developmental level, the role of supervision, responses to live supervision, supervisor characteristics, preference for experiential learning, and training outcomes.

Training Sequence

Interns reported that their training program comprised a step-by-step sequence. Interns shadowed and observed group leaders before serving as co-leaders and primary group leaders with the supervisor providing live supervision for each group session. After completing this sequence, interns were allowed to provide DBT-STGs without live supervision being provided each time. Interns described the training protocol and progression in a detailed and coherent manner, as if memorized. As one intern summarized, "it's clear that there is purpose in every step." Most interns reported that the inclusion of supervision into the training program was vitally important in learning how to lead such an "involved" structured group. However, one intern provided a contradiction, believing that the structure of DBT groups circumvented the need for supervision ("I don't know if supervision is required that strongly with DBT as much as with some other groups, because it is so structured").

Supervisee Adherence to Structure

For many interns, leading DBT-STGs was their first experience of leading groups. Interns initially felt that the manualized structure of DBT-STGs provided a "safety net" that reduced their feelings of being overwhelmed in performance situations for the first time. One intern believed that structure was especially important during the early phases of training, because trainee skills were "more feeble" when learning a new skill for the first time and the structure helped to "compensate" for this lack of mastery. Another intern shared that the structure of the group outline assisted her when the group became off-task or when a negative group dynamic existed in the room. An intern indicated that a preference for structure and skills-training was influenced by the intern's developmental level: "For me personally, I do better with that technique than sitting down and trying to talk about emotions, I guess. At this point in my career, anyways."

During their first experiences of leading groups, interns found themselves trying to follow the detailed directions of each group in a precise and literal manner, worried about forgetting to teach some of the content. DBT-STG supervisors had also observed some supervisees reading from handouts in a sterile lecture format instead of facilitating DBT-STGs in an engaging and experiential manner as the supervisors had modeled. When interns lectured, supervisors observed less engagement by adolescent group members. Supervisors attempted to mitigate this rigidity through feedback during supervision. As a result, interns reported that supervision was particularly beneficial in helping them "not get locked into my structure."

Consistent with counselor development models (e.g., the transition from Stage 1 to Stage 2 of Stoltenberg and McNeil's 2009 model), this need and preference for structure decreased as interns became more experienced during the course of their internship. Over time, their "fear of the unknown" diminished as they became more comfortable with the material and less reliant on rigidly following the group leader guides when facilitating the group. As an intern surmised,

> At the beginning of my internship, to feel more safe and confident in my internship, I wanted things more laid out. Very structured, and black-and-white. And then a couple of months in, say two or three months… I felt kind of like I made it my own, and I felt more accepted and more confident. For me, the structured nature of the manual is helpful at the beginning. But… after two or three times of me leading it, I would develop that sense of "I feel confident, I don't need a bullet-point outline like that."

Over time, interns reported feeling more confident in their group leadership abilities. Accordingly, they became less reliant on rigid adherence to structure than at first. As they gained confidence, some interns reported not following treatment protocols with fidelity.

Supervisor Developmental Level

It was evident from intern responses that supervision of DBT-STGs was highly structured, similarly to the structure of the DBT modality itself. Supervision meetings reviewed the intern's performance regarding leadership of DBT-STGs immediately following the group. Interns were asked to reflect on two prompts: "What did you do well?" and "what could you improve?" These two prompts were asked during every supervision meeting.

The coding team assessed the supervisors at Stoltenberg and McNeil's (2009) first stage of supervisor development, due to their preference for structure during supervision. As suggested by Stoltenberg and McNeil (2009), the developmental level of the supervisor was a fitting match with the developmental level of the Stage 1 supervisee, who also craves structure. An advanced intern reported during an interview that she had begun to use a similar structure during peer supervision of other groups at the hospital. This intern even used the same two questions that had been asked of her earlier during DBT-STG supervision. Supervisees may have been approaching Stage 2 of counselor development by the time they had completed their internships (considered by Stoltenberg and McNeil to be Stage 1 of supervisor development). It is therefore possible that the structured nature of supervision was congruent not only with the DBT model, but also with supervisee developmental issues such as the early preference for structure.

The Role of Supervision

DBT supervision was considered to be "very helpful," "invaluable," and "essential." Yet most interns (n = 8, 80%) considered supervision to be merely part of a training program along with observation and shadowing; it was not considered a separate activity. Indeed, interns experienced DBT to use "a different type of supervision" that was a competency-based activity (task-oriented, skills based). For example, an intern reported that in supervision he received feedback about how to improve his group leadership by using more humor to "relate more easily to kids." After being asked about what went well during the group, the intern became aware of "things that I did well that I might not have even thought about." He added that supervision assisted him to make sense of "puzzling" events that occurred during the group, a cognitive counseling skill. During post-group debriefings, supervision was usually described as involving the receipt of feedback and "getting questions answered" about leading DBT groups. Using the framework of Bernard's (1979, 1997) discrimination model, "getting questions answered" suggests a focus on *understanding* the intervention and adolescent response (cognitive counseling skills) while developing skills in *providing* the intervention (counseling performance skills). Thus, supervision was considered part of a skills training process rather than an independent activity outside of the intervention being provided. Less attention was given to topics unrelated to skill acquisition, such as the development of self-awareness or professional counseling identity. Consistent with the focus on skills training, several interns implied that the supervisor took a more didactic

role in supervision as a consultant and teacher. Interns did not characterize their supervisors as taking the role of a "counselor," as per Bernard's (1979, 1997) discrimination model.

Responses to Live Supervision

Live supervision was provided at the training site to interns leading DBT-STGs, since video recording was not allowed on the hospital premises. Most interns considered live supervision to be helpful in their development as group leaders because the feedback was more accurate and reliable than subsequent self-reporting. Having another "set of eyes" in the room was understood to help the supervisee appraise the group situation more realistically than their "one-sided representation of a scenario." Live supervision helped interns to become aware of what they may have missed during the group. Receiving feedback from a supervisor who was present during the group session also decreased feelings of uncertainty among interns regarding their performance. As one intern intoned, "Because I had feedback immediately following [the group], I knew where I stood. I knew what I needed to work on. It was a very tangible experience for me." One intern also felt that live supervision provided quality assurance. Without live supervision, interns may not have assessed adolescents accurately or engaged in appropriate leadership behaviors. Live supervision also ensured that interns were following the DBT-STG manual with fidelity. In short, live supervision seemed to be an important component of the training experience and a useful substitute in cases when video recording was unavailable.

While most supervisees reported preferring immediate feedback, reactions were mixed. Some supervisees preferred receiving feedback immediately after the group session, before memories of the group had faded. Other interns believed that if the supervisor was present for the session and took notes, then the feedback would likely still be helpful and reliable even if provided several days later. Furthermore, two interns wanted additional processing time before receiving immediate feedback. These interns explained that they had felt tongue-tied and overwhelmed by being expected to share before they had an opportunity to process the group.

Live supervision both mitigated and heightened performance anxiety for supervisees, depending on the intern. For one intern, live supervision "helped with my anxiety level," because "it was good to have someone there who knew what was going on." Another intern intoned, "as long as you have supervision… you're not going to drown in there." In contrast, one intern shared that live supervision was not her preferred choice because "the critique" felt "intimidating." In response, she attempted to impress the supervisor in the room rather than attending to the adolescents.

The frequency of live supervision was also discussed by interns. Surprisingly, a few interns felt that live supervision was essential at first, but soon became unnecessary after a handful of live supervision sessions, by which time they had mastered basic skills in the modality:

> I don't think you can do it without some type of supervision. At least for the first four or five times. For some people, it could become cumbersome after four or five times, because they may feel like they have it.

Intern experiences of supervision as "cumbersome after four of five times" runs contrary to typical DBT supervision models described by Fruzzetti et al. (1997) and Waltz et al. (1998), in which consultation groups (i.e., supervision) are required as an ongoing element of DBT practice. Without them, the practitioner is not providing DBT with treatment fidelity.

Supervisor Characteristics

When reflecting on what they valued most in their supervision of leading DBT groups, four interns (40%) stated that spending "quality time" with the supervisee was the most desired supervisor behavior. Other responses included clear communication, ability to have their questions answered, and supervisor competence. Knowledge of DBT was considered an important supervisor quality. As one intern explained, "if someone was to observe me and they really didn't know about DBT, I think it might be a difficult situation to have supervision."

Preference for Experiential Learning

Interns compared their experiential learning (i.e., on-site field experiences) with traditional methods of learning such as reading texts, and preferred the former. Some interns had previously read about DBT, though felt they did not fully understand the modality until their supervised practice in group leadership of DBT-STGs. Supervised training models may be more effective in assisting interns and other trainees to develop competence in providing DBT when compared to self-study of treatment manuals. Dimeff et al. (2009) had previously suggested that self-study was less engaging than other types of DBT training.

Training Outcomes

Overall satisfaction with the training experience was consistently high across interns interviewed. Most interns had only cursory knowledge of DBT prior to their training, and some interns were skeptical of its effectiveness at first ("it wasn't easy to buy-in and say 'This is valuable' at first"). The two interns who reported some degree of resistance towards learning how to facilitate DBT-STGs considered psychodynamic therapy to be their primary theoretical orientation. These interns were initially resistant to learning DBT on the grounds of theoretical objection. However, after learning the DBT modality, these interns believed they had gained another "valuable" approach to client care. As a result, they became more supportive of DBT, even encouraging peers to "keep an open mind" and "not knock something before you try it."

An unexpected benefit of DBT training was the finding that some interns reported "doing research" on DBT and its evidence-base during slow periods at their site. Materials were available for interns to review, including the Miller et

al. (2007) treatment manual for suicidal adolescents. It could be assumed that interns would have made a less concerted effort to review the evidence base of a non-EBP intervention, though further study is warranted.

DISCUSSION

Training master's-level CMHC interns in DBT had important benefits and drawbacks. One advantage was that EBPs such as DBT seemed to be a good fit during internship training. At this stage, supervisees have a developmental need for structure. This structure provides a "safety net" by mitigating performance anxiety and reducing the ambiguity of accomplishing a complex task such as facilitating group therapy for the first time. In the process of learning DBT, supervisees were given the opportunity to experience a different approach than the theoretical orientations from which they initial align. This expanded their skill set and built respect for different approaches. Learning DBT also seemed to facilitate independent inquiry into its evidence base.

Drawbacks of EBP training included the potential for interns at novice stages of counselor development to adhere too rigidly to the structure of treatment manuals and supporting materials such as leader guides and patient handouts. Supervisors can provide increased monitoring of supervisees during their initial experiences of leading structured groups such as DBT-STGs. Increased monitoring would encourage supervisees to take an interactive approach to group leadership and prevent supervisees from merely reading handouts in a rote manner. Once interns became more experienced, they seemed to have less preference for structure and some deviated from the treatment manual. Because treatment fidelity is important when providing a manual-based treatment, supervisors can assist interns to work within the structure of a treatment manual while also facilitating the development of a supervisee's own style of delivery. Balancing the two dialectical polarities of retaining treatment fidelity while also encouraging supervisee autonomy in developing their personal style requires supervisory skill.

Skills Training Model of Supervision

Supervisees experienced "a different type of supervision" in their DBT-STG training program. Supervision was considered to be a facet of a broader training experience. A supervision sequence was described by interns (i.e., shadowing and observing, co-leading, leading with supervision, leading without supervision). In addition, supervision was understood by supervisees to focus primarily on skills training and acquisition. This conceptualization of supervision as focusing on skills acquisition and being part of a training sequence rather than independent stand-alone activity had several important resulting effects.

First, supervision was considered to have less value as the intern became more experienced. Because supervision solely focused on assisting supervisees to provide the selected intervention effectively, interns may have felt that supervision was less of a necessity as they became more skilled at the

intervention. The focus of DBT supervision meetings was primarily counseling performance skills and cognitive counseling skills (Bernard, 1979, 1997), with far less attention focused on self-awareness and professional behavior. It is tentatively suggested that DBT supervisors should intentionally introduce a focus on supervisee self-awareness and professional behavior during post-group supervision sessions to keep supervisees engaged even as they gain skills and competence in providing DBT. Supervisors can therefore be mindful of the need to address self-awareness and the development of professional behaviors during CBT supervision and consultation sessions, in addition to the focus on skill development.

Second, supervisees valued the supervisor's level of knowledge and competence in providing the selected intervention. Using the lens of Bernard's (1979, 1997) discrimination model, the supervisor was typically in the role of consultant or teacher rather than counselor. Supervisor knowledge of the modality could have been considered more important to supervisees because of the supervisor's role of consultant and teacher rather than counselor. Supervisors with less knowledge and competence were deemed to have less useful feedback to give the supervisee. In other words, supervisees saw supervisors as models of skill acquisition, and preferred supervisors with higher skill levels. Supervisors of EBPs should ensure that they are skilled providers of the selected intervention before supervising students in the modality.

Recommendations for DBT Supervision Structure

Based on the findings of this study, interns could learn to lead DBT-STGs by following the following training sequence: (1) self-study of materials, (2) observing a trained DBT-STG leader, (3) co-leading with a trained leader, (4) leading under supervision, and (5) leading independently without supervision. A recommended supervision structure would include an initial meeting to orient the supervisee to the treatment modality. Direct discussions regarding the effect of live supervision and/or video recording on supervisee performance anxiety could be included as a topic during introductory supervisory meetings. It is suggested that the supervisor could also ask supervisees during introductory meetings about their preference regarding the immediacy of feedback, since some interns preferred immediate feedback while others felt tongue-tied and wanted more time to reflect on their experience. Supervisors could then individualize supervision to meet the preferences of each supervisee.

Early supervisory session (for the first four to five sessions) would focus on skills acquisition of both counseling performance skills and cognitive counseling skills. Supervisors should directly discuss and normalize supervisee performance anxiety and the tendency to rigidly cling to structure at first. As supervision continues past the fifth session, the supervisor could gradually introduce an increased focus on self-awareness and professional behavior into supervision as the supervisee develops their skill-set. By approximately the tenth supervisory session, the supervisor should have addressed the development of the supervisee's personal style in delivering the group material while

also maintaining fidelity to the treatment manual. Peer consultation could be useful after the tenth supervisory session, as the supervisee has likely developed enough skill to engage in productive dialogue with other supervisees providing the modality. The supervisor could facilitate these peer consultation meetings.

Integrating EBP Training into CMHC Preparation Programs

Most interns preferred to learn DBT through supervised practice rather than self-study of treatment manuals. It is possible that other EBP trainings would be more successful and well-received if provided during internships rather than self-study coursework in master's-degree CMHC programs. While further research is needed, it is suggested that counselor educators would better serve students by working collaboratively with site supervisors to arrange supervised EBP training experiences during internships rather than focusing their efforts on incorporating EBP training into coursework. When collaborating to arrange EBP training for students during internships, programs must be careful to not train all students in only one EBP (i.e., DBT) or to promote only one EBP during their program. Any favoritism would constrict student opportunity to develop a personal model of counseling, prohibited by the CACREP Standards (II.G.5.d, 2009; II.F.5.n, 2016). Ideally, students would be included in decisions about what types of EBP programs they would learn during internships. Pre-internship coursework in CMHC programs (both CACREP-accredited and non CACREP-accredited) should continue to primarily train students in foundational knowledge and skills. For example, students should possess foundational knowledge in group leadership approaches and group stages by the time they reach their internship, since leading DBT-STGs was the first group leadership experience for some interns in the present study. Consistent with the AMHCA (2011) Standards for the practice of CMHC, program faculty and supervisors in CMHC training programs should be knowledgeable of EBPs. However, it is suggested that CMHC program faculty do not need specialized preparation to train students in EBPs prior to internship.

Limitations and Directions for Further Study

As with all qualitative studies, findings are not representative of a broader population and thus findings cannot be reliably generalized to other settings. Further studies regarding EBP supervision and training would be useful to corroborate findings from this study. While data saturation and redundancy was reached, there is an ongoing debate regarding adequate sample sizes for qualitative research. Guest, Bunce, and Johnson (2006) proposed that only six to 12 interviews were necessary to reach saturation with homogenous subjects, whereas Charmaz (2006) suggested that 25 participants were required for "smaller projects" (p. 114). The primary researcher and author had emic status, which carries benefits and limitations. While emic status may have increased the trustworthiness of the investigator in the setting and thus potentially result in more open accounts by interviewees, it may also have resulted in less objective distance from the topic under study. Including a member of the coding

consensus team who was unfamiliar with the counseling profession (i.e., etic) was used to mitigate this potential bias. An audit trail, which included the bracketing of biases prior to the study commencing, was also maintained throughout the study.

Further studies could explore questions that arose from the coding consensus team's analysis of the interviews. First, it was wondered if DBT supervision was skills-focused because of the modality itself (behavioral), or because of the developmental level of the supervisor (Stage 1). To investigate this further, two studies could be useful. First, the supervision of other non-behavioral EBPs could be explored, such as the supervision of short-term psychodynamic therapy. Second, DBT supervision could be explored with more advanced supervisees or supervisors in Stages 3 or 4 of Stoltenberg and McNeil's (2009) model. Further studies could also examine differences between supervisee experiences of live supervision compared to videotape review in DBT training. Research examining whether supervisees review the evidence base for EBPs more frequently than other non-EBPs when providing those interventions could also be useful. Finally, future studies could also focus on supervisor experiences of providing supervision of DBT to master's-level CMHC interns.

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