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ORIGINAL ARTICLE

Imagery in cognitive behavioral supervision

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Abstract

OBJECTIVE: This article describes the role of imagery in supervision which is a part of the work of both the supervisee and the supervisor. Imagination bears outstanding importance in psychotherapy and supervision.
METHOD: The relevant texts for this narrative review were identified through the Web of Science and PubMed databases, within the period 1990–2019. The search terms included: Supervision, Cognitive behavioural therapy, Imagination, Imagery, Imagery rescripting, Therapeutic relationship, Supervisory relationship. The report also includes information from the books referred to by the articles. The supervisory experiences of the authors were also incorporated. The theoretical part is supplemented with case vignettes of strategies using imagination in CBT supervision.
RESULTS: Working with imagery can be used in transformative experiential learning. It can help to better map the situation with the patient, including its emotional components and basic psychological needs, to realise how the therapeutic relationship is set up, as well as to rework own therapist attitudes, schemas and emotional – behavioural responses, and plan future steps in the therapy. Many therapy steps could be learned during imagery exercises. Imagery also helps to understand and regulate the supervisory relationship.
CONCLUSION: It is useful to integrate imagery to the supervision. Using imagery can help to understand the patient, the therapeutic relationship better, and to plan optimal therapeutic strategies, as well as reflect/self-reflect and train difficult skills which promote professional and personal growth.

INTRODUCTION

Supervision can be understood as a cooperative effort in which the supervisee devotes themselves to their patients and themselves in the context of relations with patients, and with the connection with a broader context. Supervision increases the quality of the supervisee's work, improves their relationships with patients, and continuously develops therapeutic skills (Hawkins & Shohet 2006). Supervised therapists learn how to use their own experiences as a springboard for further learning. In addition to helping the therapist to better understand and work with their patients, the supervisor also helps the supervisee to realise how he/she is immersed in their work through experiential learning (Zachary 2000). After describing how to lead a supervisory session (Prasko *et al.* 2019a), how to assist the therapist in conceptualising the case (Prasko *et al.* 2019b), how to supervise the therapeutic relationship (Prasko *et al.* 2020a) and how to use guided discovery in supervision (Prasko *et al.* 2020b in press), this text is focuses on how to use imagery during the supervision.

The experiences generated by multisensory real-life experiences with emotional content are processed at a deeper and more memorable level than factual, verbal, rational/logical information that lacks meaningful emotional content (Holmes *et al.* 2009). According to Epstein's cognitive-experiential model (Epstein 1998), a rational system of understanding is analytical, logical, cause- and reason-oriented, has no direct link to the emotional system. On a rational level, things can be changed by logical arguments; the change is intellectual. The experiential system that is intuitive, automatic, and narrative has a direct link to the emotional systems. Such an experience is deeply encoded, a person "trusts" their knowledge, mostly in situations which are difficult to change with rational arguments. The experience is more profound because one not only believes it but feels it. Imagery work helps to improve at the level of the experiential system and change dysfunctional core beliefs and maladaptive schemas.

One of the essential skills of modern CBT therapist, especially who working with complex cases, is capability working with images and use imagery, to enhance cognitive change and get a more profound therapeutic effect. These skills can be learned experientially, and supervision is the most suitable place to do it. Latest advances in CBT shows the use of experiential strategies of imagery and role play can be invaluable in changing unhelpful cognitions and schemas (Hackman *et al.* 2011; Pearson *et al.* 2015; Arntz 2011). Imagery work becomes a standard tool working with PTSD, nightmares, simple phobia, social phobia, depression, personality disorders, eating disorders etc.

Supervisors can facilitate the learning of the supervisees by creative approaches such as imagery work. Through the imagery, supervisee becomes students and learn from their own experience, own practice and cooperative efforts with the supervisor or group (group supervision). The role of imagery in supervision is substantial. Both the supervisor and the supervisee automatically imagine most of the topics discussed during supervision and their imaginative activity discovers cognitively unrecognised layers of therapeutic work, for example, new features of conceptualisation or relationship. Imagery can help better map the situation with the patient (diagnostic part of imagery), including the emotional components, realise how the therapeutic relationship is set up, and also rework their supervisees attitudes and emotional responses or plan necessary future therapy steps. Imagery can help to understand and regulate the supervisory relationship.

METHOD

Studies used in this narrative review were identified through the Web of Science and PubMed databases, including resources within the period 1990–2019. The search terms included: Supervision, Cognitive behavioural therapy, Imagination, Imagery, Imagery rescripting, Therapeutic relationship, Supervisory relationship. The search was limited to the English language. The search was completed by repeated use of the words in different combinations. Supplementary references were found using references of the acquired papers. The report also includes information from the books referred to by the articles. The articles and book chapters were collected, organised by their importance, and critical texts itemised in reference lists were investigated. Also incorporated were our supervisory experiences. Our supervisory experiences were also incorporated. The theoretical part is supplemented with case vignettes of strategies using imagination in CBT supervision.

IMAGINATION

People can evoke sensory information about stimuli that are not physically available (O'Shea & Moran 2019). This cognitive ability, known as mental image creation, is a complex multisensory process that uses internal representations of perception and behaviour in working memory (Keogh & Pearson 2017). The mechanisms of imagination are essential for the evaluative functions of the brain as well as for predictive processing (Bubic *et al.* 2010) and management of future behaviour (Seligman *et al.* 2016). If appropriate mental representations underpin the presented options, an action can be successfully planned and implemented (Seligman *et al.* 2016), but if not, this effort may be in vain (Van Bentum *et al.* 2017). Memories contain real events as well as situations that were only imagined. Actual events and events that take place in a fantasy story conclude using the same cognitive apparatus (Means *et al.* 1987). The ability to imagine the past alternatively and in different ways can help to cope with the past and then to use this original mastering for future solutions

(Gopnik *et al.* 2004). Being able to imagine what might happen in the future can benefit planning and making decisions. Imagining behavioural scenarios then affects the expectations of ourselves and motivation for future behaviour (Anderson & Godfrey 1987). Positive contact with another person in imagery corrects the attitudes towards them and the desire to engage in further contact (Crisp *et al.* 2010). The idea of communication arouses the interest in participating in this connection before it is realised (Means *et al.* 1987).

Imagination can haunt people or protect them, motivate to a conflict, prepare for demanding tasks and joyful moments, and calm and soothe (Bravesmith 2008). Attitudes towards oneself and others and self-reflection can help to understand the background of this process, correct the maladaptive expressions of imagination, and strengthen those that are creative and adaptive. The emerging importance of imagery in psychopathology get imagery work in standard tools box of therapist and supervisor and use it in supervision becomes routine.

Imagery in psychotherapy

Imagery as a source of mapping and diagnostic tool

Imagery work in therapy as well in supervision is important because many patients find difficult to remember and describe the situation clearly: to describe the feelings, thoughts, images, memories, body sensations, sensory information, behaviour (own and others) and their consequence – essential data needed for the case/situation conceptualisation and later interventions. Nevertheless, when the patient asked to visualise the situation and explain their idea as if they were watching a scene in a movie, use another imagery method to revoke memories, they can make their actions, body sensations, feelings and thoughts very vividly present. Patients respond emotionally and physically to these ideas as if they were a fact (Di Rienzo *et al.* 2016). More profound beliefs about themselves, others, and the world are usually linked to the experience of specific adverse events (e.g. abandonment, bullying, excessive punishment, emotional, sexual or physical abuse, traumatic events, etc.) that have not been sufficiently emotionally processed (Veal *et al.* 2015). However, these events are present in memories, often in complex images associated with multiple sensory experiences and emotional reactions. The imagery of the past experiences enables these complex images and emotional responses to be present, coped with and, if they are associated with maladaptive patterns in current behaviour or knowledge, also they could be reworked into new, more adaptive patterns. In such a case, imagery work can serve as diagnostic – assessment and conceptualisation tool, later help to guide interventions more precisely according to the patient's context.

Emotional bridge

Another imagery practise, the "affect bridge" (now called "emotional bridge"), frequently used as a diagnostic tool, was developed by Watkins (1971). The "affect bridge" is a procedure whereby a patient is moved experientially (in imagery) from the current to a past event over an affect (emotions, body sensations) common to both events rather than through an overlapping "idea". The therapist asks the patient to describe what is currently triggering the discomfort, identifies the emotions, bodily reactions and thoughts of the event, and then links them to a childhood event where the patient experienced similar feelings. Emotions, body sensation and meaning, are coordinated to focus imaginative immersion effectively. If the therapist takes the "bad" feeling described as a nominal value ("Stick to this bad feeling and look for where you had a similar one in childhood or adolescence"), patients gain access to several "uneasy" early experiences. More specific alignment of both events permits for a more explicit link. For example, "You felt as if you were not important to anyone, as if they were ignoring you and nobody cared... Try to keep this feeling that nobody cares and look for a memory in your childhood where you felt the same ...". Farrell *et al.* (2014) suggest two steps:

(1) The *image activation*: The therapist asks the patient to access the current emotion (or the emotion of a situation in which he/she was vulnerable (the Vulnerable Child Mode).
(2) The *emotional bridging*: The prevailing emotion is then used as an affect (emotional, body reactions) bridge back to a childhood image. Once the patient is in the childhood image, help the patient make the image emotionally vivid. The language is, therefore kept in the present tense, and the therapist asks the patient to describe any feelings, body reactions, other sensory sights, thoughts, and needs, the patient is aware.

Later in exercise, in schema therapy approach, typically psychotherapist does not let the patient describe trauma or a painful experience ultimately, because it is not necessary to re-experience the whole traumatic situation. Instead, they stop the memories and rescript, when in other imagery work approaches, for example, imagery exposure it is possible.

This technique can be successfully used for assessment, enhancing self-reflection, and as first part for imagery or other intervention (imagery rescripting, transforming problem images, rational response, role-playing, exposure, etc.).

Imagery rebuilding - transforming problem images

One of the most innovative techniques in the CBT is imagery rebuilding combined with rational, more functional responding. This method is often connected with trauma work (Deblinger & Hefl 1996; Layden *et al.* 1993; Resick & Schnicke 1993; Young *et al.* 2003). Rebuilding problem images can be useful. The horror of repeated nightmares can be lessened through repeatedly imaging a new and different (bearable, pleasant) ending (Krakow *et al.* 2011). The projected negative

social encounter could be changed to a more positive prospect (Hirsh *et al.* 2003). Traumatic recalls can be rescripted and the threat removed (Leyden *et al.* 1993, Ehlers & Clark 2000). An aggressive self-image can be substituted into compassionate one (Gilbert 2005); Kabat-Zinn (1982) uses imagery in the Mindfulness-Based Stress Reduction program to increase mindful awareness; a simply unpleasant mental picture can be changed into one that is tolerable, acceptable or even pleasant and patients can develop calming, comforting, suiting images (e.g. safe place imagery) that can help them calm themselves and fulfil needs.

Imagery rescripting

Imagery rescripting of memories uses imagery and visualisation to identify and change the traumatic experiences from the past, which helps with transforming the present mental states and behaviour in similar situations. This way, it addresses current problems (Arntz 2012). Clinical applications were reviewed in Morina *et al.* (2017) meta-analysis. The technique of imagery rescripting focuses directly on the emotional processing of past negative experiences (Prasko *et al.* 2012). During rescription, the therapist's task is to help the patient (at least in part) pass through the memory of a stressful event, express their emotions, realise unfulfilled needs, and then help them rework the experience so that its impact is less painful and more empowering. The rescription of painful memories leads to a different emotional experience of the situation, which in turn changes significant beliefs about oneself, others, and the world (Nilsson *et al.* 2012; Arntz 2015a). Arntz (2015b) shows that imagery offers a chance to change the meaning of painful memories by creating an "unconditional reassessment of stimuli". New information, a satisfaction of needs, and a new perspective are obtained through imagination which leads the patient to change the meaning of memories. The mechanism is not grounded on the principle of systematic desensitisation, and then it is not required to "playback" the traumatic memory, in place of the rescription can be done at the very beginning of the stressful incident. Imagery rescripting is typically used with patients with post-traumatic stress disorder (Ehlers & Clark 2000; Smucker *et al.* 1995; Brewin *et al.* 2010; Arntz *et al.* 2015b), nightmares (Krakow *et al.* 2001, Hansen *et al.* 2013), simple phobia (Hunt & Fenton 2007), depression (Wheatley *et al.* 2007; Brewin *et al.* 2009; Moritz *et al.* 2017), eating disorders (Somerville & Cooper 2007), personality disorders (Weertman & Arntz 2007; Arntz 2011), social phobia (Wild & Clark 2011; Frets *et al.* 2014), obsessive compulsive disorders (Veale *et al.* 2015; Fineberg *et al.* 2018; Fink *et al.* 2018), body dysmorphic disorder (Ritter & Stangier 2016), suicidality (Van Bentum *et al.* 2017), bipolar disorders (Hales *et al.* 2018), or dissociative disorders (van der Hart 2012; Bichescu-Burian *et al.* 2017). However, the range of applicability of the technique is extensive – we have successfully used imagery rescripting with patients with delusional disorder, paranoid personality disorder, bulimia, or obesity. Imagery rescripting sometimes can be as complete treatment (e.g. nightmares, PTSD), but usually, it is the part of treatment package (CBT, schema therapy). Arntz (2018) rescripting childhood memories suggest an underlying protocol of 3 steps:

(1) Patient images the memory (get a memory – let the patient experience the memory perceptually and emotionally (present tense, as a child): *What do you see, hear, smell, experience, what is happening? What do you feel (emotionally, body reactions)? What do you think? What do you need?*
(2) Therapist (or patient in later phases of therapy) steps in the image and stops the threat.
(3) Therapist (or patient) directs attention to further needs of the child.

Role-play, rehearsal and dialogues in imagination

Imagery can be successfully incorporated in role-play, routine CBT technique. Beck *et al.* (1979) described patient and therapist speaking on critical and supportive inner voices and forming dialogue to reinforce the supportive voice. Padesky (1994) using "historical role play" to restructure past unhelpful interpersonal exchanges; Gilbert (2005) described using the two-chair method as the base for building up an image of a compassionate self and weakening inner critic. Rehearsal of new behaviour can be carried in imagery, and this increases the perceived likelihood of the event happening (Szpunar & Schacter 2013). It can improve self-confidence, and mental images can evoke comparable emotional and bodily responses to the real situation (Pearson *et al.* 2008). We can practically integrate imagery into treatment to build self-confidence, substitute when it is not possible to practice in the real-time and prepare or encourage to take the challenge (Kennerley *et al.* 2017). Imagery can be part to develop behavioural experiments.

Imagery based exposure

Imagery based exposure involves recalling a memory that provoked strong negative emotions, body reactions; then patient remembers a lot of perceptual details (a situation, sequence of events, sensory information), attempt to accurately label the emotions, body reactions, thoughts, images he/she experienced during the interaction, behavioural urges. In prolonged imagery exposure, the patient would keep visualising the image in detail until his/her level of distress decreased to about half its initial level. E.g. supervisee being given critical feedback by a supervisor can be reworked during exposure.

Some commonly used exposure techniques: imaginal desensitisation in which a feared stimulus is held in imagery until the patient habituates (Wolpe 1958). Such strategy is imaginal flooding in which a feared stimulus is repeatedly presented in imagery at high

intensity without reinforcement and any counterconditioning process (Stampfl & Levis 1967); Cognitive restructuring within reliving ('Enhanced reliving') is used for PTSD, where patients are helped to insert new and incompatible information into memories of peritraumatic 'hotspots' (Grey *et al.* 2002). Eye movement desensitisation and reprocessing (EMDR) is a strategy, where imagery of distressing events is combined with bilateral stimulation to help 'processing' of traumatic events (Shapiro 2001). Reliving' of traumatic memories in PTSD is exposure strategy, where patients with PTSD are requested to 'relive' an upsetting event and to recall details as vividly as possible (e.g., Foa & Rothbaum 1998); The rewind technique or visual-kinaesthetic dissociation is used by practitioners of NLP and is frequently taught as a standalone treatment for trauma/PTSD (Koziey & McLeod 1987).

Enhancing imagery effect with body-focused interventions

Body reactions always were in traditional CBT model, though body-focused interventions not used as much as cognitive, behavioural and emotions focused techniques. Emotions very closely linked with body sensations and most memories have their "body part". Some patients experience primarily somatic feelings and somatic memories with limited or no access to cognition or emotions. Usually, the therapist focuses mostly on the emotional and cognitive aspects of experience, but the experience itself has many somatic patterns. Body focused work can evoke or enhance imagery as well be a more profound and faster way to improve corrective healing imagery experience. Memories from pre-verbal stage first linked with physical aspects later come images and not associated with the narrative perspective. Evidence demonstrates the role of the body in maintaining trauma reactions and using mind-body techniques to heal (Miller 2005; Fisher 2017). The therapist can use body sensations and tool to enhance affect in emotional bridge and imagery rescription, as well during rescription or other imagery by body intervention we can add stronger self-regulating and self-caring aspect (e.g. warm blankets, soft toys, self-hug etc.) (Briedis 2018).

THE IMPORTANCE OF IMAGERY FOR SUPERVISION

Imagery is similarly significant in supervision as is in therapy. In supervision, imagery can help in all significant supervision points: conceptualisation, relationship, interventions, self-reflection, training and personal development. The imagery points to less consciously obvious facts, meanings and teaches a comprehensive response within a holistic experience. During supervision, supervisees become the observant practitioners who think about their work and learn it through reflections (Lewin 1947). Reflection itself is much more than a cognitive or abstract process because it involves emotions, feelings, motivating elements, and bodily experiences. This holistic experience is better learned by imagery than by logical thinking. When talking about clinical work, the supervisor draws the supervisee into complex, multi-layered interactions were emotionally or physically lived, meaning and imagination are as important as spoken words. Imagery is used in supervision in many ways. It could help with:

(1) a greater understanding of the patient;
(2) deepening the understanding of the therapeutic relationship:
   - by the imagination of a difficult therapeutic situation;
   - by bridging imagination;
(3) seeking alternative treatments:
   - by training in imagination;
   - by imagination based on resources.

Working with imagery in supervision includes:

(1) respect for the subjectivity and accepted natural nature of the supervised;
(2) providing space for the use of the senses and the ability to interpret;
(3) liberation from rigid thinking and action; and
(4) joint learning that develops understanding from different perspectives.

IMAGERY HELPING INCREASE UNDERSTANDING

Returning to a particular moment of a session or the typical appearance of the patient in a concrete situation and stopping this image helps the therapist to get deeper into the patient. The vision of the patient behind closed eyes, their facial expressions in a particular situation, and full awareness of the situation from the session allows perceiving the emotional impact that the therapist is experiencing but also to realise how the patient may feel in that situation (Stimmel 1995). For example, the image of the patient trying hard to explain what she did indicates not only her hyper-compensation but also the pleading need for acceptance. Another picture of her embarrassed smile, which repeats itself and then may point to the disappointment that the therapist misunderstood her. With more in-depth reflection on this image under the supervision, the therapist may realise that a patient, who has sought to be accepted by her father all her life, feels inadequately accepted by the therapist.

Therapist: I had been working with her for ten sessions, we were doing well at first, but now she is stuck.
Supervisor: How does it look like?
Therapist: I was trying to work with her on a core belief. We began to make evidence against it every three years on the time axis of her life. She worked well in the session. Then I let her do her homework for looking for an alternative view. She came to the next meeting, added some evidence to the three-year periods, then said she did not believe it, that she was confused, that

she did not understand anything…. She did not look for an alternative view on herself…. She looked kind of soulful….

Supervisor: Can you try to remember how she looked? Maybe best behind closed eyes….

Therapist: (closing her eyes) I see her, smiling awkwardly as if she really did not know… she was disappointed… and alone…

Supervisor: Do you have any idea what happens ...?

Therapist: As if she had no contact with me, she retreated into herself… she smiles, but she is alone….

Supervisor: She is alone ... What can happen to her?

Therapist: She feels misunderstood… I did not praise her for the homework…. I was annoyed that she had not finished the task… She felt like with her father with me. He did not praise her at all, only had high demands and criticised her…

A parallel process is a term used to denote what is happening inadvertently in the relationship between the therapist and the patients or the supervisor and the supervisee, e.g. the transference or countertransference. It is not easy to realise the parallel process because the transference and countertransference reactions are often outside of awareness. Imagination, however, can help to understand transference or counter-transmission, so it can play a significant role in recognising the parallel process. The tendencies of a therapist, which are projected into the patient or the supervisor, sometimes lead to maladaptive behaviour towards the person being treated. E.g. a therapist who is dissatisfied with the controlling partner tends to lead her patient to confront her partner, yet she does not dare to face such a confrontation in her own relationship (Stimmel 1995).

Metaphorical imagery

As mentioned in the Oxford Guide to Imagery in Cognitive Therapy, "working with metaphorical imagery may seem a considerable distance from the territory of cognitive therapy. However, it can be useful to evoke and use metaphors in various circumstances where traditional methods of accessing and transforming meanings may be difficult to apply" (Hackmann *et al.* 2011, p.165). It could be useful not only for patients but also for the supervisee and the supervisor. Evoking metaphorical imagery and reflecting upon it can be helpful if:

(1) affect is overwhelming;
(2) feelings are painful to put into words;
(3) an impasse is reached in the relationship;
(4) feelings are not entirely understandable to the person experiencing them,
(5) a therapist feels 'stuck';
(6) a person cannot quite understand the strength and nature of the feelings they are having about something;
(7) it is necessary to get new perspectives and new ways of dealing with potential obstacles. It can help to understand different perceptions of the situation and what needs to happen to deal with it.

Therapists can utilise metaphorical imagery to examine their own problematic emotional reactions to patients during supervision or in self-reflection (Bennett-Levy *et al.* 2009). Suggested steps are (Hackmann *et al.* 2011):

(1) The therapist brings to mind a patient with whom there is some recurrent impasse.
(2) Having a typical example, the therapist reflects on how this makes them feel in their body and what associated emotions are present.
(3) Then they are asked to allow a metaphorical image to arise for the way they feel in this situation. *Important:* When an image has been selected and fully evoked, the supervisor could encourage to be aware of bodily sensations and other sensory aspects of the image, including colour, texture, sounds, smells, tastes, weight, size, etc. Then they reflect on how it might look from different angles (above, below, from the side, etc.), or various distances.
(4) The metaphor can then be explored for its meaning, including any assumptions.
(5) The therapist can be asked to reflect on its possible history in the therapist's own life: why this particular patient situation evokes such a strong emotional reaction and inflexible, 'stuck' behaviour in the therapist.
(6) At the end of imagery, the supervisee is asked to reflect on what this image may mean (the meanings about the self, other people, the situation, a troublesome symptom, and the world in general).

The next steps after evoking stage could be the *transformation of metaphorical images*.

After reflecting on meanings of images, the supervisor could ask what the supervisee feels they need to change in the image to get a broader or more realistic perspective, which afterwards can be put to the test in real life. This process is very close to Socratic questioning or guided discovery and helps to reach a new perspective (Hackmann *et al.* 2011):

(1) Having the metaphorical image in all its aspects, the patient is asked to reflect on what would need to be different about the image to make them feel better.
(2) They are then asked to imagine these changes taking place.
(3) Several attempts can need to be made to change the image satisfactorily. It is also possible that a new metaphorical image may arise and need to be dealt with.
(4) When the image is finally transformed, there will be a shift in the associated affect and the meanings ascribed to the image. These meanings should be identified and reflected upon. The new perspective can then be tested out in real life (Hackmann *et al.* 2011).

Artmaking in supervision has been adjusted as a method to promote deep insights about countertransference and the therapeutic relationship, self-awareness, etc. (Deaver & Shifflett 2011). Drawing can be helpful to express what can seem like the inexpressible or unacceptable (Hackmann *et al.* 2011). For example, Johles (2005) invites to

make a drawing to symbolise problems and their potential solutions. In this technique, the patients are asked to consider their current situation, and make four drawings, in response to the questions:

- How is your life at the moment?
- What is your next step: what is emerging for you?
- What barriers or obstacles are there?
- What qualities do you need to help you deal with these?

Further drawings can be made to represent the potential transformation of assumptions, behaviour and emotions: "How I would like things to be" (Hackmann *et al.* 2011).

The imagery of a difficult therapeutic situation

The supervisor asks the supervisee about a difficult therapeutic situation. He suggests to the therapist to describe the situation in detail, including the description of the environment, the appearance and behaviour of the patient and his own experience. The imagination of a difficult therapeutic situation allows to return:

(a) the memory of the patient (how he/she looked, how he/she faced, what he/she said);
(b) to remember the therapist's own experience (emotions, thoughts, bodily reactions, behaviour, modal involvement).

After the imagery, it is possible to discuss how the imagined situation relates to the conceptualisation of the patient's story and whether the patient does not get into similar situations in relationships outside the therapy. It is also pointing to the therapist's transference experience. Supervision then discusses to what extent this transference has been predominantly induced by the patient's behaviour (since the patient can induce similar experience in other significant people in their life) and to which extent it is connected with therapist´s transference).

Therapist: I have to admit that the patient annoys me. He still sees a mistake in others, externalises guilt, and is unable to understand that he is responsible for the way others treat him.

Supervisor: You say he is annoyed because he sees the mistakes of others and does not see how he is responsible for the behaviour of others.

Therapist: Yeah, he feels like a victim ... now his wife has found a lover and left him ... I understand he is troubled ... However, somehow, he does not realise... that he is responsible for how he treated her before ... he does not want to think about it at all...

Supervisor: Can we present a situation with him ... to better understand it? ... you can close your eyes and try to recall it... How are you sitting together in a session… he says how bad someone is treating him…?

Therapist: (closing her eyes) Yeah, she is sitting against me complaining that a woman has another guy… as he always tried to make enough money, the family was well, and she was like that…

Supervisor: How do you feel?

Therapist: I am annoyed… he repeats it about three sessions now … I am angry at him…

Supervisor: I understand, you are angry with him that he happens the same subject… that it is not moving anywhere… How does he look….

Therapist: Unhappy ... and urgently ... as if he wanted me to change something ... However, I cannot change it ...

Supervisor: And how do you feel… when you say, you cannot change anything…

Therapist: Helpless….

Supervisor: I understand that your feeling is that you cannot change anything, and he is unhappy and urgent…. What do you think now that you are with these yours and his feelings…?

Therapist: I realised I was angry with him because I am helpless, and I cannot help him with the situation with a woman….

Supervisor: What else can you think of when you understand that ...

Therapist: Maybe I do not have to solve anything; he needs to hear and know that I feel with him ... maybe even tell him that the wife has gone to a lover is a fact that remains to accept, also if it is complicated... that I understand him how it hurts… only then to find out together what he can do for himself in this situation… I was impatient….

Supervisor: I like the way you think about it ... you understand your impatience ... you get a picture ...

Therapist: Yeah... I remembered the army service time ... my girlfriend left me ... I suffered terribly ... it reminds me ... that is why it is hard to talk to him...

Imagery rescripting in supervision

Imagery rescripting helps in supervision when dealing with a difficult situation that the supervisee brings from therapy with the patient. The supervisor leads the therapist to visualise the problematic situation with the patient and to describe what they see, feel, and experience. The imagery focuses on where they are, what the room looks like, which things are there, then how the patient looks, what they do, and what they say and how they feel. The supervisor asks the therapist's needs and the patient's needs. They then break the imagination and find out what the alternative reactions to the patient might be and what the consequences would be. Together they select an "optimal response". The therapist closes their eyes again, imagining that they have responded to the optimum scenario. The supervisor encourages and appreciates them.

Emotional bridge

The bridging imagination can also help in reworking the countertransference situation by returning to the memories of the emotions experienced by the therapist with the patient in a particular case, then looking for a situation in which the therapist experienced similar emotions in the past. After the rescription of a childhood event, the therapist returns to the current situation and reacts in a new way. A brief description of the structure of rescription in imagination under supervision is given below:

(1) Find strong emotional reactions of the therapist during the therapy session.
(2) To ask the supervisee, *"How did you feel in this situation?" "Have you ever felt similar?" What body bodily reaction you have now? Please show where? Does this bodily reaction was earlier with you? In childhood?"* Somatic response let us go deep to childhood memories. *"Have you ever experienced similar feelings in a situation from childhood?"*

(3) Find related situation from the past. "*What was happening? How the therapist felt? What were their needs?*"
(4) Perform imaginal rescripting. "*Who could help? Who might enter? Who could be a helper? What could they do? Enjoy new emotions after rescription.*"
(5) Bring with the new feeling to the current patient situation.
(6) Ask the supervisee, *"How do you feel now?" "What emotional need have you received in the rescribed situation?", "What do you feel in your body where show me". "What does it tell you about the patient's needs? What needs does the patient have?"*
(7) Ask the supervisee: *"What you want to say to the patient?" "Ok, so, now you can leave with the feeling in the body, and come back with the answers which will help you with the patient"*. (Usually feeling in the body is warm, so they go out with warm feeling and comfortable in minds)
(8) Build a bridge from the actual situation to the future - with a new sense of how the supervisee will speak to the patient to feel good.
(9) Discuss together and play in a role where the supervisor plays the patient and the supervisee themselves.

Therapist: I feel like I do not work well with this patient. Even when he comes, I feel tense, dislike him, and am angry with him that it will be useless again. I do not want to be angry with him or resign on the treatment. Unfortunately, it automatically robs me.
Supervisor: Looks like you want to help him, but at the same time you do not believe that the job will be successful… when he comes, you are dealing with him, and you have ambivalent feelings….
Therapist: Yes, that is right, but actually, I feel mostly helpless… probably because I do not know how to help him when he keeps saying that nothing helps him… that he feels worse… I have been doing it for two months… Nevertheless, he does not do homework, and he repeatedly says he forgot about it and he does not remember what we were doing last time… he looks as if he was not blaming for anything, but I am annoyed that I think he is doing it, he is not doing anything and playing as a victim….
Supervisor: Can I play him for a while ...? How do I behave? Describe it a bit, what it looks like in session with him in such a situation ...
Therapist: He just comes to the session, looks annoyed. To my question how things are going and what has happened since last time, he faces annoy and says that he has not done anything well and feels worse, that our therapy does not help him at all.
Supervisor: Okay, thank you. I will try to play it now and watch your feelings…. We can try it?...
Therapist: Definitely…
Supervisor: in the role of a patient: (looks annoyed) … The therapy does not help me. Whatever I do, I am getting worse… (in a moment). How do you feel now? What is going on with you?
Therapist: Helplessness, vanity, rage… I want to yell at him…
Supervisor: So the first feeling is that you feel helpless… when you try, and he does not…?
Therapist: Yes, first I feel helpless, then I get angry…
Supervisor: Perhaps it would be a good idea to look more at the helplessness… is that something you have ever experienced in your life…? Do you remember any childhood situations where you felt similar… that you are trying, it is not what you want and then you feel helpless?
Therapist: Yeah… I had that with my dad sometimes… I tried very hard, for example when I was skiing, I was pretty good, but he did not care… when I won the championship… I said it at home… he had looked like nothing and asking mom, where we are going for the weekend. However, my mom also said without much enthusiasm that I was smart and how good I was at school ...
Supervisor: How did you feel? You won the regional championship ... your father was interested in weekend, and your mom asked for school ... How did you feel about it?
Therapist: Suffering… I was very sorry… Moreover, I also felt their disinterest… I was alone, helpless… to feel hopeless that whatever I do, it makes no sense anyway, because they do not care…
Supervisor: What did you need most at the moment?
Therapist: Interesting in what I am doing, and also to praise me for how good I am…
Supervisor: Is there anyone who could tell them…? To hear it…?
Therapist: I do not know, only my grandmother, my mother's father… she was a doctor and had a significant influence on both…. they appreciated her… Furthermore, they were also a little afraid of her. Nevertheless, she always liked me… she believed me… However, she was no longer alive…
Supervisor: What should she tell them to help you? What would you need…?
Therapist: To tell them that you are not ashamed, you have such a clever son, and you do not care ... he is smart in school and excelled in sports ... I am proud of him ...
Supervisor: What would it be like for you if grandma said that?
Therapist: Nice, she would be standing behind me and actually praise me, they would watch…
Supervisor: Anything else you need at the moment ...
Therapist: Daddy says, "Mom's right, he is very clever, and I am proud of him too, I am just not telling him not to get too proud himself, but I am proud of him…"
Supervisor: How would you feel…?
Therapist: Great (his eyes shine).
Supervisor: Close your eyes and try to go through this whole scenario in the image as a movie.… What do you think can we try it?
The therapist visualises the whole created scene and describes how he feels in it
Supervisor: You have done it very well… try to hold on to the emotions you have, and with them, we will return to the situation with your patient. He sits in front of you and says, "The treatment does not help me at all. I feel worse ..." How would you react when you have the emotions you have from that situation with your grandmother who is cheering for you?
Therapist: I understand you, Mr Kapil, you are not experiencing a great deal of relief so far ... you are saying you are feeling worse ... can we further investigate what is going on? And then look for a way together, what to do to make you feel better? Can we do it?
Supervisor: I liked what you said ... how do you feel about it now?
Therapist: Well, calm… I accepted what he said and offered another search… I was not irritated at all, nor felt helpless… I actually realised I was too many focused-on strategies and less on how he felt… maybe I saw more of my goals to be a successful therapist than paid attention to him. Almost like my dad with me...

IMAGINATION OF THE ALTERNATIVE TREATMENT APPROACHES

Supervision draws on the past but is heading for the future. The purpose is to enable the supervisee to return to their work with more knowledgeable, skilled, smarter

and more creative and thus more beneficial for those they work. Supervision prepares for the future.

Training in imagination

Practice in imagery increases the willpower to undertake the task, especially if it is difficult or evokes negative emotions (Anderson & Godfrey 1987). Training in imaging is part of the basic approaches in cognitive behavioural therapy (Hackmann *et al.* 2011). In supervision, it may be appropriate to practice the imagination in three successive steps:

(1) In the first stage, the therapist and the supervisor discuss the problematic situation the therapist is experiencing with the patient and, in the discussion, create a scenario for the therapist's appropriate course of action;
(2) In the second phase, the supervisee imagines themselves in the situation with the patient, how they proceed, and how they managed to complete the appropriate step with the patient successfully. At the same time, they are an observer – as if watching themselves in the film as they perform the task. When they succeed in accomplishing the task, the supervisee should boast and be pleased that they have done it. The supervisor sometimes must help with this positive self-evaluation by asking what was done well. This notion of self-success weakens the usual thought patterns aimed at anticipating failure and failure. The supervisees should practice this idea first in a session, while the supervisor makes sure that the therapist not only imagines the situation after completing the task but also emotionally experiences it and feels good about his intervention.
(3) At the end of the training in imagination, the therapist may imagine possible problems that might arise in the performance of the task and ways in which they could cope with them. The therapist must finish the training with a pleasant feeling that they have mastered the task.

Therapist: I have one problem with one of my patients. I want to discuss today. Actually, my patient is dallying payments for sessions very often, and I feel uncomfortable with it. I understand that I should discuss it, but somehow, I do not have time and ideas on how to do it nicely.

Supervisor: Well, it sounds like a good question for supervision. Maybe you could explain more about the situation? Moreover, after that, do you mind if we will try to make imagery work for it – to construct in imagery right way how you would like to solve this difficulty with a patient?

Therapist: Sounds well! I could tell you that my patient is a 34-year-old man, and we work for 11 sessions with anxiety issues; he was actually afraid to fly. Furthermore, I think we are doing well. However, in the last four sessions, he forgets to take money for payment. He is apologising, but even in the next meeting, he is forgetting. I could understand once everybody could forget, but so many times it sounds like a topic for conversation.

Supervisor: Let me understand better – your patient did not pay for several sessions?

Therapist: Now he had pay at the last session, but it was with delaying, and we did not discuss it.

Supervisor: Let us put this situation in a blank for circus vicious, where we have a place for thoughts, emotions, body sensations and behaviour. With what you would like to start?

Therapist: I think: "Again? Come on, is it really so difficult to remember? " and I feel helpless and irritated, maybe a little bit angry. Body feelings not so explicit. Some warm feelings in the face. What am I doing? Doing nothing. Let us say I 'm avoiding and postponing to talk about the situation.

Supervisor: Thank you for sharing and you did very nice work describing your thoughts, feelings and actions. Let us think next step, what are your ideas what and how you would like to do differently? Maybe we could make a positive circle from it.

Therapist: I would like to have enough time for this topic. At the end of the session, it usually homework discussion time, and there is no space for other questions. I do not want to be in a hurry; I would like to feel calm. I want to start the next session on this topic.

Supervisor: Perfect idea to have enough time for conversation. Do you have particular thoughts about the conversation?

Therapist: I could openly tell that we had some trouble with payment last several times, and I want to discuss it for both of us to feel comfortable. Maybe I could remind her about our contract rules and ask what the patient thinks about his difficulties to remember? Also, I could ask about possible help and solutions to overcame situation?

Supervisor: I could find your ideas very useful. Let us try to do imagery work, where you imagine yourself in this conversation. If you want, you could close your eyes to really fell the situation. Moreover, try to describe me in real-time what you see, feel, and what is going on in the situation, but I will follow with some questions, ok.?

Therapist: Let us try/closes her eyes/. I see myself sitting in my practice. My patient Tom is coming. We are saying hello and taking tea. After that, I am telling him: "Tom, I feel that I need to discuss with You situation with payment at the beginning of our session. That we have enough time for it. I would like to understand you better and open this question as an important part of our agreement. What do you think?". He does not look surprised and told me that he agrees to discuss it.

Supervisor: How do you feel now?

Therapist: Relieved. I feel that finally, I told what I want! So lovely relaxing feeling.

Supervisor: Maybe you have some physique feelings?

Therapist: Yes, much less tension. Actually, I did not feel before how tensed I was!

Supervisor: You are doing great. Maybe some other feelings, sensations, ideas?

Therapist: I am not angry any more. I really calmer. Moreover, I have space in my head. Oh, I wanted it (smiling). It really sounds like a positive vicious circle.

Supervisor: Yes, it sounds good. Let us try to continue our work and imagine that you could see this conversation from a side like you are watching a small video about these new situations at the session.

Therapist: O.k. I could see it. It goes fast.

Supervisor: If I could ask you to take a pause on this imagery video and tell me what is done well, what it will be?

Therapist: I am calm and honest. It is suitable for safety at the therapy. Safety is a big issue for my patient. I think it is a crucial topic overall.

Supervisor: I could agree with you and add that you are brave.

Therapist: (smiling).

Supervisor: What are your feelings now?

Therapist: I feel strong and encouraged.

Supervisor: Is there any bodily sensation for these feelings?

Therapist: Yes, nice warm feeling in the chest.

Supervisor: Well, please keep these feeling and try to imagine - could be here any problematic point in this conversation?

Therapist: Yes, if he will tell me that he has financial problems. I do not know how to help.

Supervisor: If you keep a nice warm feeling in your chest and feel secure, encouraged, calm and honest, what kind of ideas you have how to overcome this problematic turn in conversation?
Therapist: … Maybe I could ask my patient what he thinks about the situation, solutions. Actually, the Socratic dialogue could help me; I do not need to fix all problems of my patient I could explore together with him (smiling).
Supervisor: I could agree that it is a brilliant idea. Dou you have any other possible difficulties?
Therapist: No, I do not think so.
Supervisor: You did a great job, and before you are returning from imagery work, can I ask you again about your feelings?
Therapist: Yes, I feel calm and satisfied.

Resources based imagination

Supervision often focuses on the problems the supervisor has, their causes, negative emotions, failures or fears about the future. The primary focus on the problems of the supervisee is understandable. Usually, the therapist brings cases where therapy is stuck. The supervisor and the therapist work together to solve the problem. As in therapy, an active approach to the strengths of the supervisee can create a stable supervisory relationship and can improve the quality of supervision work and its outcomes. Focusing on the resources also represents an easy way to increase the self-confidence and feeling of a supervisee´s mastery. Resource-based imagination focuses on what the supervisee needs, positive emotions, benefits, resources, achievements, and preferences for the future. This supervision focuses on creativity, flexibility, and resilience (Bannink & Jackson, 2011). In terms of time, resources can be divided into historical (what the supervisee managed in the past, what external resources they have available), current (internal and external resources available now), and potential in the future (what the supervisee can learn, etc.) (Ociskova *et al.* 2019). Some resources are largely inherited (e.g. temperament, intelligence), others are acquired (e.g. therapeutic skills, social skills, professional skills). However, most resources can be improved, changed, or built up. Many resources are relatively universal, i.e. they can be effectively used in various situations and problems (Ociskova *et al.* 2019). The induction of positive imaginations and metaphors helps to increase resilience. The imagination of positive events is associated with a significantly higher mood improvement than positive thoughts (Holmes *et al.* 2009). Imagination can help the supervisees to build their resilience model. It is possible to directly create an image on how to manage the future situation, how to behave optimally, and to mentalise possible reactions of the patient (Holmes *et al.* 2009, Holmes & Mathews 2010).

Therapist: I am considering whether to continue therapy, whether it is better for me to do psychological examinations, even if I earn less….
Supervisor: Hm… you wonder what to do …. tell me more about it….
Therapist: Patients who have started going to therapy come 2-3 times and then stop…. This has happened to me for the third time this year… I cannot do it… I am doing something wrong…
Supervisor: You seem to be disappointed ... three patients have stopped attending therapy ... so you wonder if you're doing the therapy well ...
Therapist: Yes, it is. I am disappointed in myself… I cannot keep them…
Supervisor: So, three dropped out… Furthermore, how many patients do you have who come to you regularly…
Therapist: Now about 15….
Supervisor: Hm, 15 people go regularly…. Furthermore, how are you doing with them? ...
Therapist: Most of the time, it goes… of course, with some, it is harder, and with some, it is going well…
Supervisor: You say, some are doing well…. Describe me a bit of what you do and how you feel about those you are doing well.
Therapist: Normally… I take routine steps… I assess them; we do conceptualisation, work with a vicious circle, work with thoughts, behavioural experiments and exposure, work with diagrams, then do problem-solving… normal… Moreover, now I put schematherapy with mods, rescription, working with chairs, stuffed animals… I am happy about that…
Supervisor: It looks like you are using a wide range of approaches…. Are you doing well with more challenging patients ...?
Therapist: I do not know what you mean… Nevertheless, now I have one patient with severe OCD in care. When he started, most of the day, he thought he would kill somebody ... someone in the family, or a child on the street ... I had him under supervision if you remember ... we talked about him twice.
Supervisor: Yes, I remember, this is the man who, in addition to the aggressive obsessions, was also depressed and had suicidal thoughts… it seemed to be really difficult… Nevertheless, from the way we talked about him, I had a good feeling that you had a good relationship you understand….
Therapist: So, he is no longer depressed, not suicidal and obsessions are rarely attacked him, almost rarely… now we are discussing his marital relationship, where he acts submissively….
Supervisor: So much progress ... you have already come to the solution of the problem ... as far as I can remember, he said he had a good marriage before ...
Therapist: She had reassured him many times a day that she would not do anything to anyone ... so he was grateful to her ... However, now, as the obsessions have decreased, he realises how critical she is, and it bothers him ...
Supervisor: We can deal with it later ... I want to go back to your thinking about whether or not to do therapy ... now we are talking about one of the patients where you are doing well, despite being a challenging patient ... Try to close eyes and recall some situation with him when you felt good…. When did you do something ...?
Therapist: (closing his eyes) … the last session… in the beginning, I still have an exposure in the session… we stand in my office; he has a knife in his hand and holds it in front of my neck… he is calm and smiling and says… "I would never believe I can stand like this with a sharp knife, be close to your carotid arteries and be completely calm ... Doctor, you have done a miracle ... I am a completely different person ... "
Supervisor: How do you feel?
Therapist: I am happy…. That he is doing… he has done it…
Supervisor: Perfect…. Think of him… Furthermore, how do you feel with yourself?
Therapist: I am kind of proud and also touched… I feel I helped him… it is a perfect feeling.
Supervisor: I also have it when you say it… I like how courageous you worked with it… Moreover, how sensitively you talk about him…. I think you did an outstanding job …… I can think of it even when your eyes are closed… can you recall another patient where you were doing well or…
Therapist: Yeah, I got Veronika right now. She suffered from anger outbursts, self-harm, repeatedly returning from her partner

and returning to it… we have been working together for a year, and she is doing well… she returned to school, stopped cutting herself, and even the relationship with her partner improved… Moreover, with mother, it is not entirely OK, but they are talking to each other… I feel like it is on the right track….

Supervisor: And how do you feel about it?

Therapist: Nice ... that we are working well together ...

Supervisor: And about yourself, how are you feeling ...

Therapist: Well yeah, I am proud of the work, before she was with two therapists, one dynamic and one Gestalt, and it did not work, and now it works with me…. I am almost arrogant … but no… I feel that the work was not in vain….

Supervisor: Are you happy about that?

Therapist: Very much, I just do not want to be arrogant….

Supervisor: What is it more, pride or arrogance…

Therapist: Well a bit of both… Nevertheless, rather the satisfaction and joy that she is doing… Nevertheless, a little arrogance is there too…

Supervisor: I understand ... However, you have to be proud of your work... we can go back to the beginning ... when you hesitated if to continue doing the therapy or if rather be more diagnostic... as a reason you said that this year the three patients stopped going after the beginning of the treatment... now what you can say?

Therapist: That I often have doubts about myself, and that if somebody stops attending, those doubts will increase… However, in fact, I do well with many people, and I enjoy working very much…. Actually, I like it very much… it was just such a grim idea… Nevertheless, maybe we could discuss those drop out cases… so I could understand a little more if and what role I have in their stopping therapy prematurely.

CONCLUSION

It is necessary and useful to incorporate imagery work in the supervision process. Using imagination can help to understand the patient, the therapeutic relationship better, and to plan optimal therapeutic strategies, as well as reflect/self-reflect, train difficult skills, promotes personal growth. It also helps to realise mental processes that can be hidden from rational thinking by engaging the multi-layered processes of our experience, including emotionality, bodily reactions, motivation, memories, and sensory processes. The supervisor needs to remain open to new learning and have the courage to bring creative skills to the supervisory space. Creation positive imagining future behaviours in supervisee mind can increase the effectiveness of supervisee and his/her patient.

CONFLICT OF INTEREST STATEMENT

The authors declare that the article was done in the nonappearance of any commercial or economic relationships that could be understood as a potential conflict of interest.

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