

Therapist and supervisor competencies in cognitive behavioural therapy

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Abstract

HYPOTHESIS: For cognitive behavioural therapy, acquisition and maintenance of psychotherapeutic and supervisory competencies is crucial.

METHODS: The PubMed, Web of Science and Scopus databases were searched for articles containing the following keywords: cognitive-behavioural therapy, competencies, therapeutic relationship, intervention, technique, training, supervision, self-reflection, empirically supported, transference, countertransference, scheme of therapy, dialectical behaviour therapy. The search was performed by repeating the words in different combinations with no language or time limitations. The articles were sorted and key articles listed in reference lists were searched. In addition, original texts by A.T. Beck, J. Beck, C. Padesky, M. Linehan, R. Leahy, J. Young, W. Kuyken and others were used. The resources were confronted with our own psychotherapeutic and supervisory experiences and only most relevant information was included in the text. Thus, the article is a review with conclusions concerned with competencies in cognitive behavioural therapy.

RESULTS: For cognitive behavioural therapy, four domains of competencies in psychotherapy are crucial – relationship, case assessment and conceptualization, self-reflection and intervention. These may be divided into foundational, specific and supervisory. The foundational competencies include recognition of empirical basis for a clinical approach, good interpersonal skills, ability to establish and maintain the therapeutic relationship, self-reflection, sensitivity to a difference and ethical behaviour. The specific competencies involve the skill of case conceptualization in terms of maladaptive beliefs and patterns of behaviour, ability to think scientifically and teach this to the patient, structure therapy and sessions, assign and check homework, etc. The supervisor's competencies include multiple responsibilities in supporting the supervisee, identification and processing of

the therapist's problems with the patient, continuous development, increasing the supervisee's self-reflection, serving as an example and being as effective as possible in the role of a clinical instructor. **CONCLUSION:** Both the literature and our own experiences underline the importance of competencies in cognitive behavioural therapy and supervision.

INTRODUCTION

Acquisition and maintenance of professional competencies is one of the basic values of a psychotherapist's education, irrespective of the therapeutic approach he or she was trained in. In cognitive behavioural therapy (CBT), there is increasing evidence of a significant association between the level of therapeutic competencies and treatment outcome (Grey *et al.* 2008; Kuyken & Tsivrikos 2009; Trepka *et al.* 2004). During their training, therapists are expected to acquire knowledge and skills to help them better understand patients' signs and problems, clearly conceptualize the association between internal and external aspects of problems, and competently use the acquired knowledge to guide patients towards solving their problems in order to relieve them from the signs of their mental disorders. High levels of their competencies are psychotherapists' duties towards both individual patients and the entire society which has the right to request the competencies from them. Apart from psychotherapy training itself, containing the theoretical, practical and supervisory components, it is the therapists' duty to maintain their competencies through continuous lifelong education (Newman 2010). Competent psychotherapy requires, among other things, the ability to incorporate into therapy up-to-date knowledge of diagnostics, assessment methods and therapeutic interventions, interpersonal relational and communicational skills, sense of timing, ethical judgement, self-awareness, acumen in collaborating with clients and colleagues, sensitivity toward diversity issues, a respect for scientific methods of inquiry, etc. (Kaslow 2004, Kaslow *et al.* 2008). Competencies in psychotherapy are usually defined in several areas: good knowledge of theory, professional conduct towards patients, ability to use specific therapeutic strategies, skills needed to maintain a therapeutic relationship, skills aimed at achieving a change, adherence to ethical norms, etc. (Beitman & Yue 1999, Beck *et al.* 2008). In a questionnaire distributed to 120 experienced CBT therapists, Bennett-Levy *et al.* (2009) asked which training or supervision methods in their experience had been most effective in enhancing different types of therapy-relevant knowledge or skills. It was found that different training methods were perceived to be differentially effective. For example, reading, lectures, talks and modelling were perceived to be most useful for the acquisition of declarative knowledge, while enactive learning strategies (role-play, self-experiential work), together

with modelling and reflective practice, were perceived to be most effective in enhancing procedural skills. Self-experiential work and reflective practice were seen as particularly helpful in improving reflective capability and interpersonal skills. In CBT, self-experiential work and self-reflection lead to increased empathy (Bennett-Levy *et al.* 2003).

THE CUBE MODEL AND ITS APPLICATION IN CBT

The need to clearly delineate the psychotherapist's competencies resulted in formulation of the so-called cube model (Rodolfa *et al.* 2005), which examines expertise in conducting psychotherapy across three basic dimensions. These include: (1) foundational competencies, (2) functional competencies, and (3) developmental perspective. In each dimension, attitudes, knowledge and skills may be defined (see Table 1).

(1) Foundational competencies

Foundational competencies are necessary for all modalities of psychotherapy and comprise the broad concept of professionalism such as adherence to ethical standards, a willingness to self-reflect and self-correct, cross-cultural sensitivity and interdisciplinary collaboration (Havrdová 1999, Havrdová 2008, Newman 2010). Rodolfa *et al.* (2005) attempted to classify these competencies and defined 4 foundational competencies in psychotherapy that are also crucial for CBT. These are: (a) therapeutic/supervisory relationship, (b) case conceptualization, (c) application of therapeutic interventions, and (d) self-reflection.

- a. The psychotherapist's foundational competency is the ability to *establish, develop and maintain the therapeutic relationship* (Safran & Muran 2000; Young *et al.* 2003; Hardy *et al.* 2007). Sometimes, CBT is viewed as therapy typically having numerous therapeutic techniques available. However, this notion is misleading. In addition to individual case conceptualization, the prerequisite for applying any therapeutic strategy is also a well-established therapeutic relationship (Kimmerling *et al.* 2000; Leahy 2003; Hoffart *et al.* 2006; Hardy *et al.* 2007; Spinhoven *et al.* 2007; Gilbert & Leahy 2007; Prasko *et al.* 2010a). This has been recently shown in a research study of patients with avoidant and obsessive-compulsive personality disorders, where the most important predictor for successful therapy was a good therapeutic relationship (Strauss *et al.* 2006). It is also apparent in the treatment of depressive patients. When identical standard strategies were used, patients who established a better therapeutic relationship had better outcomes (DeRubeis *et al.* 2005). Therefore, practising skills potentially improving the therapeutic relationship is one of the cornerstones of CBT training and supervision (Praško *et al.* 2010; 2011). Without

establishing a therapeutic relationship, a specific therapeutic intervention is usually impossible. The ability to develop a therapeutic alliance is associated with the intrinsic ability of humans to establish high-quality relationships with individuals, groups or families. This ability gives rise to learned skills:

- To develop a therapeutic alliance – an atmosphere of safety and understanding (listen to the patient, express one's understanding, validate his or her emotional state, reflect, strengthen, maintain hope, etc.) (Rogers 1967; Patterson 1984; Bennett-Levy 2006; Greenberg 2007; Thwaites & Bennett-Levy 2007).
 - Respect and tolerance for and sensitivity to differences (cultural, value, racial, etc.). Understanding other cultures, values, expectations and attitudes is crucial for treating people with a cultural or social background different from that of the therapist. In various cultures, cognitive schemata may be adaptive or maladaptive to varying extents, depending on the others' expectations (Nisbett 2003; Tseng & Streltzer 2004). This sensitivity is also important when treating patients from generations far apart in age since attitudes to oneself and others are established in different ways in various generations.
 - To titrate the patient's anxiety in a way that enables cooperation but also mobilizes the patient for a change.
 - To help the patient relax, find the courage to face challenges, be patient even though the result is only apparent after some time, become authentic, open, trusting, withstand failure, criticism and disappointment without feeling a sense of injustice or as a victim.
 - At the same time, the therapist is an example of how to relate to other people in an active, authentic, positive, encouraging, kind and tolerant way.
- b. *Case conceptualization* is the ability to understand problems and signs from the point of view of the past and present context. This ability is based on studying the theory but it may only be developed through practical experiences of working with patients, most significantly developed by systematic supervision (Armstrong & Freeston 2003). Good conceptualization stems from understanding and respecting the scientific basis of therapy. A competent CBT therapist has sufficient knowledge of the scientific basis of the cognitive theory of mental illness but is also aware of the limitations of current scientific knowledge (Clark *et al.* 1999). It is important that he or she knows the latest developments in CBT, both in research and practical application, in order to be able to work with schemata, use behavioural experiments, work with imagination flexibly when processing traumatic emotions from childhood, trauma overwriting, work with attentiveness and meta-cognitions, etc. A competent CBT therapist also views his or her work, similar to scientific work, with healthy scepticism. Each case conceptualization is in fact a hypothesis and strategy selection is a method, the result of which is seen as a measurable outcome. In CBT, case conceptualization involves behavioural, functional and cognitive analyses, mapping current signs in the categories of antecedents, cognitions, emotions, behaviour, consequences and interpersonal relations, determination of predisposing and precipitating factors and mapping core schemata and conditional assumptions that are related to the current problems.
- c. Therapists' *interventions* should stem from case conceptualization. They are designed to relieve patients' suffering and promote their health, modify their conditions for the benefit of themselves, their families and those around them. Adequate selection of therapeutic interventions requires continuous growth of therapists' knowledge, such as learning about the latest discoveries in the field, advances in therapy, knowing ethical and legal norms, and resolving individual and cultural variations (Vargas *et al.* 2008; Koocher *et al.* 2008). Cognitive behavioural therapy is typically characterized by careful training of individual interventions by role-playing and their use in supervision with the help of audio or video feedback (Prasko *et al.* 2011a).
- d. *Self-reflection* is a complex process of realizing the therapist's own cognitions and attitudes, emotions and behaviours toward the patient, and how these are related to his or her personal core schemata and conditional assumptions, and their potential modification when working on oneself or in supervision. From the CBT perspective, self-reflection requires (Hoffart *et al.* 2002; Aubuchon & Malatesta 2003; Kaslow *et al.* 2008; Prasko *et al.* 2010b):
- developed ability to realize, observe and think about the therapist's own experiencing;
 - ability to maintain distance from oneself, knowing one's own emotions, ability to be true to oneself and to have no illusions, willingness to admit one's own limitations and blind spots, ability to withstand criticisms and learn from it, willingness to be supervised, desire for further understanding one's role in the treatment of a particular client;
 - ability to understand which reactions of the therapist are related to countertransference;
 - therapeutic use of one's own thinking, emotional, bodily and imaginative experiences in interaction with the client.
- (2) *Specific competencies*
- Specific competencies represent specific skills and knowledge such as diagnosis and assessment, guiding

Tab. 1. Competencies in CBT divided into foundational, functional and developmental for attitudes, knowledge and skills (adapted from Prasko *et al.* 2011).

	FOUNDATIONAL COMPETENCIES	FUNCTIONAL COMPETENCIES	DEVELOPMENTAL PERSPECTIVE
ATTITUDES	<ul style="list-style-type: none"> • Good relationship with people • Humanism • Optimism • Curiosity and need to understand • Respect for differences • Humanity, kindness, tolerance • Need for self-development • Regard for truth • Humility • Tenacity 	<ul style="list-style-type: none"> • Respect for scientific knowledge in the field; scientificity and objectivity • Purposefulness and planning • Analytical, systemic and holistic approach 	<ul style="list-style-type: none"> • Accepting unfinished business • Acknowledging changes over time • Accepting continued self-education
KNOWLEDGE	<ul style="list-style-type: none"> • Knowledge of psychopathology • Diagnosis and diagnostic criteria • Knowledge of psychological theories of personality and psychopathology • Knowledge of the main psychotherapeutic schools, their theories and practices • Case formulation • The patient's indication for psychotherapy 	<ul style="list-style-type: none"> • Understanding the learning theory and individual methods used to achieve changes in thinking, attitudes, behaviour, emotions and bodily reactions. • Understanding the CBT model in individual disorders (depression, individual anxiety disorders, somatoform disorders, eating disorders, psychoses, relationship problems, etc.) 	<ul style="list-style-type: none"> • Gradually increasing ability to understand in a more comprehensive way throughout both training and therapy
SKILLS	<ul style="list-style-type: none"> • Creating safe atmosphere • Empathetic listening • Expressing acceptance • Validation of the patient's emotional conditions • Strengthening of the patient • Congruence • Strengthening hope • Establishing and maintaining the therapeutic relationship • Conducting a supportive interview • Conducting a motivational interview • Titration of anxiety • Self-reflection 	<ul style="list-style-type: none"> • Working in a CBT model based on case conceptualization and the ability to share it with the client • Ability to guide therapeutic sessions in a structured manner (psychoeducation, evaluation, measurement, drawing up an agenda, feedback, assigning and discussing homework, etc.) • Ability to conceptualize a disorder in a CBT model and share the model with the client • Guiding the client in planning activities and structuring time • Identification of automatic thoughts and making them conscious with the patient, conducting Socratic dialogue. Cognitive restructuring, using recording of automatic thoughts • Preparing and guiding exposure therapy (education, making graduated steps, patient facilitation, flooding, exposure in imagination, interoceptive exposure, exposure with response inhibition) • Planning and performing behavioural experiments with the client • One's own communication skills and guiding the patient in training social skills, communication and assertiveness • Solving problems with the patient • Working with core schemata and conditional assumptions • Processing of traumatic emotions from the past • Trauma overwriting in imagination 	<ul style="list-style-type: none"> • Acquiring skills from simple to more complex and from foundational to functional

therapy and supervision, the ability to structure sessions, assign adequate homework to patients and use them to develop the patients' skills to solve their problems, conceptualize patients' problems in terms of dysfunctional attitudes and behaviour patterns. An integral part of competent cognitive behavioural therapy is the use of empirical approaches to therapy. Examples of such methods are behavioural activation (e.g. Dimi-

djian *et al.* 2008), rational meaning reframing (e.g. Strunk *et al.* 2007), gradual and interoceptive exposure in patients with panic attacks (e.g. Addis *et al.* 2006), exposure and ritual prevention for OCD (e.g. Wilhelm & Steketee 2006), repeated processing of trauma combined with a change of meaning of the event in PTSD (e.g. Resick *et al.* 2008) and a long list of others. These CBT procedures are most competently performed only

if the therapist is experienced and knows, based on his or her case conceptualization, when to use the skills and uses them sensitively, in the right time and with a high level of professionalism, uses adequate scales to assess the patient's condition prior to and after intervention to find out if it is beneficial for the patient, ensures generalization of what the patient learns during intervention by systematically assigning homework. Selection of an intervention or its preference to others may also be related to transference and countertransference relationships that the therapist should be aware of or should learn about in a beneficial way during his or her supervision (Linehan & Kehreer 1993; Beck *et al.* 2004; Newman & Beck 2009). Although extensive results of CBT studies paint a very encouraging picture (Butler *et al.* 2006), much work still has to be done to develop strategies that would help patients resistant to various therapeutic approaches including pharmacotherapy (Coffman *et al.* 2007). The fact that many very effective approaches are available in CBT does not mean, however, that an individual therapist is able to use them appropriately if needed by a patient. Especially in case of more complicated and resistant patients, the difference between therapists may be enormous. Some therapists directly refuse more complicated patients (borderline patients, those with hypochondriasis or personality disorders, etc.) and claim that CBT is not indicated in these patients although studies clearly suggest that it is indicated more than any other possible psychotherapeutic approaches. Also the fact that numerous very effective CBT methods for resistant patients have only been introduced in recent years leads to the fact that therapists who do not follow the latest trends and do not participate in additional workshops are usually unable to use them. The situation is even more serious in the Czech Republic and other former Eastern Bloc countries where routine tracking the latest developments worldwide by reading journal or internet articles in English is not a part of educational culture. On the other hand, it is impossible for every therapist to be able to deal with any problem, knowing all therapeutic options that could be used (Dobson & Dobson 2009). Nevertheless, the level of CBT therapist's competence is positively associated with the rate of improvement in therapy, as shown by several studies of depression (Kuyken *et al.* 2009; Trepka *et al.* 2004).

What interconnects the individual elements of effective and competent CBT is empirical thinking. The ability to arrange clinical data in a reliable and meaningful way, as well as the ability to formulate and verify hypotheses and select appropriate interventions resulting from the hypotheses are the most important characteristics of empirically oriented therapists. Additionally, one of typical features of CBT is that in its course, patients learn to think more empirically, how to distinguish subjective impressions from objective data, how to follow important aspects of their own functioning, how to decrease the tendency to ascribe causative

influences to accidental circumstances, and how to formulate hypotheses that they may systematically verify by behavioural experiments or other adequate means.

One of the most obvious examples of clinical empiricism is case formulation as a set of hypotheses (Beck *et al.* 1979; Kuyken *et al.* 2009) to be tested and revised if new information appears that rejects some of the hypothesis.

a. *Core techniques.* A CBT therapist needs to be proficient in several basic cognitive behavioural techniques and skills, to teach some of them to his or her patients. These include:

- self-observation – used to obtain data on the most important situations, thoughts, behaviour, emotions and consequences;
- guided discovery – asking questions that help explore alternative meanings and evaluations;
- creating new ways of behaviour by role-play during sessions or homework such as behavioural experiments;
- planning of activities rightly assumed to provide the patient with feelings of joy, success and meaningfulness;
- relaxation and controlled breathing to reduce tension, anxiety, anger or strong reactions in *in vivo* and interoceptive exposure or in imagination;
- performing and using the existing skills and homework in new situations to increase the chance to maintain the therapeutic effect.

Similarly, the CBT therapist must be able to reflect his or her own skills and maintain the ability to apply them naturally and continuously, at any time necessary for the patient's therapy (Bennett-Levy 2006). If a philosophy of cooperation is applied, the therapist should guide the patient in a structured manner by asking questions and formulating hypotheses, not only listen to him or her passively or, which is the other extreme, give authoritative orders. There are numerous other CBT techniques that may be derived from the above core techniques. An overview of these techniques is beyond the range of this text but may be found in some other resources (e.g. Leahy & Holland 2000; Freeman *et al.* 2005).

b. *Achieving and maintaining functional competencies in CBT.* The basic assumption for the therapist to master the necessary skills in an optimal way is a sufficient amount of work. A good cognitive behavioural therapist should attempt to apply his or her skills during every session with a patient. A necessary but not sufficient condition for achieving and maintaining therapeutic skills is an adequate number of actively treated patients. These skills, however, must have been previously learned by role-play during training and repeatedly improved

during supervision and rehearsed by their application to one's own problems (Newman 2010). Even experienced therapists stop using certain strategies actively. This phenomenon, referred to as therapeutic drift, is a certain form of safety behaviour, with the therapist gradually losing the courage to apply certain therapeutic strategies (Waller 2009). Alternatively, it is more comfortable for him or her to just talk with the patient and reflect empathetically than to be active. For a short time, the patient may feel better in such therapy but he or she usually does not change the important aspects of his or her thinking and behaviour. The therapist is concerned that the patient will not be able to manage certain CBT strategies (in particular exposure, role-play, work with schemata, work with trauma in imagination, etc.). This results in the therapist's mostly supportive, non-directive approach that prevents CBT from being effective. If the therapist does not use these active strategies, their application gradually becomes less natural for him or her and he or she is more concerned about using them.

(3) Developmental perspective

Developmental perspective focuses on which phase of training the trainee is, what the trainee may know at a specific phase of his or her professional growth and what the adequate supervision in that particular phase is (Newman 2010). There seems to be an agreement between individual therapy schools of thought that an issued training certificate may only guarantee the therapist's competencies for a limited period of time and these have to be developed throughout life (Lichtenberg *et al.* 2007; Kaslow *et al.* 2007).

COMPETENCIES FOR THE SUPERVISORY PROCESS IN CBT

The supervisor has numerous tasks and responsibilities to guide the supervisee, facilitate as autonomous professional growth as possible, teach him or her therapeutic skills, follow the ethical principles, help him or her avoid burnout, but at the same time, consider the patient's benefit to be most important (Linehan and McGhee 1994, Falender and Shafranske 2007).

Foundational competencies in CBT supervision

The CBT supervisor must have identical competencies to those of the CBT therapist. Moreover, he or she should be able to establish the supervisory relationship, different from the therapeutic relationship in many parameters (Praško *et al.* 2010a), must strengthen the supervisee and yet provide him with enough space for individual growth, understand well his or her influence on and power over the supervisee and clearly realize in which phase of his or her therapeutic development the supervisee is (Kaslow *et al.* 2007). The supervisor must be prepared to deal with cultural, ethnic or other

differences, be sensitive and respectful to them. The supervisor is also responsible for the supervisee's development and his or her entrances into the supervisee's work through his or her recommendations. He or she must realize both the supervisee's and his or her own countertransference and talk about it openly in a non-hurting manner (Praško *et al.* 2011b). He or she also needs to watch the borders of the supervisory process so that supervision does not turn into personal psychotherapy (Newman 2010). Additionally, the supervisor is an example for the supervisee of how to make clinical decisions, think ethically, communicate in a positive sense, strengthen, understand and guide another person, take care of one's own growth, protect oneself from burnout, cooperate in an interdisciplinary way and consider other options as well.

a. Specific competencies in CBT supervision. The supervisor discusses case conceptualization with the supervisee, guides the supervisee to further study, shows him or her resources, discusses alternatives to his or her approach, may teach him or her new skills and techniques, gives him or her an opportunity to practise these skills (e.g. when working in imagination or by role-play during supervision sessions) (Kuyken *et al.* 2009; Praško *et al.* 2011a). The supervisor's tasks are to teach the supervisee understand and treat the patient in a way ensuring the best possible therapy result, to support the development of the therapist's own style, to boost the supervisee's self-confidence, to help the supervisee better understand his or her work with the patient in the broadest possible context, including attitudes to oneself, others and the world, to teach the supervisee understand attitudes, thoughts, behaviours or emotions related to transference and countertransference (Armstrong & Freeston 2003; Waltz *et al.* 1993; Safranske & Falender 2008). Therefore, the supervisor should behave in the way that he or she requires from the supervisee, that is, show respect and empathy, create an atmosphere of security and acceptance, encourage and appreciate, be congruent, able to reveal hidden contracts in therapy and inform the therapist about them in an acceptable way, provide the therapist with other possible solutions to consider, be straightforward and optimistic when dealing with other people (Geben & Ruskin 1994). To provide supervision, the supervisor should be able to (Beck *et al.* 2008): (a) consult and stimulate, (b) monitor the administrative aspects of therapy (keeping records), set up a learning relationship, (d) teach, develop and strengthen, (e) strengthen the individual ability to discover and choose, (f) evaluate the decision process and alternatives, (g) monitor professional ethical issues, and (h) provide expertise. The supervisor's role, however, is not only to reassure the supervisee within the safe setting of the supervisory relationship and to facilitate the experi-

ence of acceptance and appreciation (the necessary foundation that further supervision steps are based on) but also to stimulate him or her to search and provide him or her with even a negative feedback in a manner that is stimulating rather than critical (Hawkins & Shohet 2004). The supervisor should regularly listen to recorded supervisee's sessions and provide him or her with highly specific feedback, aimed not at criticism but at further development of the supervisee's skills (Beck *et al.* 2008; Newman & Beck 2008). For qualitative and quantitative evaluation of supervision, supervisees may use the so-called Cognitive Therapy Scale (CTS, Young & Beck 1980), covering all important basic components of a CBT session (creating a session programme, setting up cooperation, focusing on key behaviours and cognitions, understanding the problem, used strategies for change, asking for feedback, checking and assigning homework, etc.) and assessing on a scale from 0 to 6. If regularly used, the scale may indicate the quality of sessions, ultimately related to therapy results (Trepka *et al.* 2004). During supervision, the supervisor deals mainly with the therapist's understanding of and behaviour towards the patient or with the therapist's attitudes and emotional reactions. It is important, however, that the supervisor also reflects a broader background of what is happening and realizes his or her own attitudes, emotional reactions and patterns of behaviour that interfere with the supervisory process.

- b. Developmental perspective in CBT supervision.* During the supervisee's therapeutic maturation, supervision gradually becomes more sophisticated, from simple case conceptualization and cognitive restructuring, through role-play, use of imagination and work with core schemata, to work with the therapeutic relationship and countertransference reactions. Gradually, the therapist learns to understand a wider context of the therapeutic relationship, with respect to the patient's past and social background, and to process his or her own countertransference reactions (Henry *et al.* 1993; Rodenhauer 1992). As time passes, the didactic role of supervision becomes less important and the main methods for discovering facts and case conceptualization are guided discovery, role-play, imagination and work with one's own attitudes. The format of advanced supervision is fully based on all participants' agreement. However, the most important thing is that the supervisee himself or herself comes with a clearly formulated order.

CONCLUSIONS

In psychotherapy, a need has recently emerged to clearly define the psychotherapist's competencies when providing psychotherapy. Cognitive behavioural therapists may complete their training only after they demonstrate both a high level of foundational therapeutic competencies similar to those in other areas of psychotherapy (ability to establish the therapeutic relationship, understand the patient, being empathetic, supportive and non-condemning, show interest in the patient, watch one's borders, etc.) and a high level of specific cognitive behavioural competencies related to specific cognitive behavioural case conceptualization with formulation and verification of hypotheses about what caused and what maintains the problem, the ability to assess and measure the achieved change, apply tailored therapeutic strategies based on individualized case conceptualization, guide the patient, demonstrate appropriate behaviour to him or her in both role-play and real-life situations, provide him or her with feedback, teach him or her to evaluate his or her behaviour, thoughts and emotions and plan strategies for controlling them, etc.

For good-quality acquisition of therapeutic knowledge, skills and attitudes, regular supervision is necessary to help the supervisee, gradually, step by step and in accordance with the stage of his or her therapeutic training and maturation, put everything into practice, consider this and other options, alternatives, ethical issues and his or her own power.

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