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Building skills in cognitive behavioral supervision.

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Abstract

The purpose of supervision is to ensure that clients' needs are met and to monitor the effectiveness of therapeutic interventions and the therapeutic relationship. Cognitive behavioural therapy (CBT) supervision is the systematic cooperation of the supervisee with the supervisor, which aims at increasing the therapists' competencies when working with specific clients. The advantage of supervision is the possibility to shape and develop the therapist's practical skills through specific techniques. This paper aims to review currently available CBT supervision strategies that boost the development of therapists' skills and provide possible examples. Various techniques are discussed, including behavioural, cognitive, imagery and psychodrama methods that facilitate supervisors in enhancing therapists' skills. In addition, complementary approaches are discussed, such as role-playing, modelling, chaining, or imitation to present at a particular moment of the therapy, increase the insight into the client's perspective or the treatment itself, and search for an alternative approach to improve the therapeutic outcomes for the client. Overall, the article describes the supervisor's need to have a flexible variety of skills and know which learning methods might be most effective for boosting the supervisee's skill level and needs with a particular client.

REVIEW ARTICLE

INTRODUCTION

One of the supervisor's main tasks is to help the supervisee to hone their skills to ensure the best possible therapeutic outcomes. The skill-building also aims to support the development of the therapist's style along with their self-confidence, self-reflection, and reflection on the therapeutic process (Armstrong & Freeston 2003; Waltz *et al.* 1993; Safranske & Falender 2008). The supervisor assesses the individual level of the supervisee and adapts the case conceptualisation, suggests a further study of a discussed matter, explores alternative approaches, teaches new skills, and encourages its practice (Kuyken *et al.* 2009; Prasko *et al.* 2011a).

The process of supervision offers the opportunity to observe the supervisee's practical skills and the possibility to further develop them through role-playing, modelling, chaining, or imitation. Therefore, the supervisor's behaviour should contain elements expected from a therapist, such as respect, safety, acceptance, empathy, encouragement, appreciation, congruence, the ability to perceive matters in their complexity, straightforwardness, and optimism when dealing with other people (Greben & Ruskin 1994). Competences in four primary areas are essential for cognitive behavioural therapy (CBT) (Prasko *et al.* 2011b):

(a) shaping the psychotherapeutic relationship;
(b) assessing and conceptualising the patient's story;
(c) selecting and implementing therapeutic interventions tailored to the patient's problems;
(d) self-reflection and ethical reflection.

The supervisee masters specific approaches that allow for maintaining a good working alliance with the client while using standard-level strategies to enable therapeutic change (Henry *et al.* 1993; Linehan & McGhee 1994; Beitman & Yue 1999). The sensitive balance between safety and change is one of the most central skills of a highly skilled therapist, and it cannot be learned from a manual. Supervision plays a significant role here, as the supervisee learns to use standard skills in a specific situation with a particular client.

There are several important therapeutic skills:

- Self-experiential work and self-reflection, which increase empathy (Bennett-Levy *et al.* 2003);
- Nuanced and balanced application of the CBT skills. Technical skills in a clinical context, such as plans, rules, procedures, and when-then skills, represent a sophisticated, often seamless combination of inexperienced therapists' conceptual, technical, and interpersonal skills and the inability to tolerate uncertainty and doubts.
- Interpersonal perception skills. The ability to focus and capture the essential elements of the patient's presentation. This includes being attuned to the patient's condition "at the moment", focusing on verbal and non-verbal indicators that allow to create and gather evidence for the case formulation and being mindful of the therapist´s and the patient´s emotional states;
- Interpersonal communication skills. The therapist's active communication skills include expressing empathy, warmth, and compassion or implementing strategies that help bypass the patient's coping (defensive) modes.

CBT supervision is similar to other psychotherapeutic approaches in emphasising general therapeutic competencies, which include understanding the client, creating an atmosphere of safety, acceptance, and appreciation in the therapeutic relationship, and the ability to self-reflect. However, the emphasis on specific competencies differs from other psychotherapeutic approaches. Different psychotherapeutic approaches do not explicitly use the skills, such as Socratic dialogue, exposure therapy, imagery rescripting, or planning behavioural experiments. At the same time, CBT uses many strategies as the most important means of change. Supervision provides a suitable space for the evaluation and honing of these skills.

A CBT trainee typically acquires practical therapeutic skills during their training, where a variety of typical situations is acted out both in the role of a client and in the role of a therapist using role-playing (Prasko & Vyskocilova 2015; Prasko *et al.* 2022). However, the practice is rarely as smooth as the training. Clients may differ from the ideal, clear-cut situations in training. These struggles brought to supervision indicate a potential for further skill development.

An integral part of CBT supervision is the process of learning, asking inductive questions, supervising skills, conducting behavioural experiments, and learning self-reflection and ethical reflection in specific therapeutic situations, recognising transference and countertransference reactions. This learning takes place in a structured way following successive steps, learned theoretically by practising standardised situations during therapeutic training and then specifically with the help of role-playing to the needs of the client and the therapist.

There are several competencies of the supervisor essential in the effective delivery of CBT supervision (Shafranske & Falender 2008; Prasko *et al.* 2022):

- Ability to identify, prioritise, and assist in working through the supervisee´s problems with their clients;
- Skills that facilitate the supervisee's self-reflection;
- The ability to perform exercises in situations with the supervisee's client during supervision;
- Using creative approaches to present the issues and solve them;
- The ability to increase a supervisee's understanding of transference and countertransference in the therapeutic and supervisory relationship.

Although increasing evidence shows that higher therapeutic competence relates to better therapy outcomes

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(Grey *et al.* 2008; Kuyken & Tsivrikos 2009), evidence that practising therapeutic skills during psychotherapeutic training or supervision increases therapeutic competencies need to be clarified. Some studies report that training can improve therapist competence and patient outcomes (Milne *et al.* 1999; Sholomskas *et al.* 2005; Mannix *et al.* 2006; Westbrook *et al.* 2008), while others show only non-significant lasting effects for CBT client management (King *et al.* 2002; Walters *et al.* 2005). Given these differences, it is essential to develop a more systematic evidence base for skill training in CBT so that the effectiveness of the CBT training programs can be maximised (Jacobson *et al.* 1996; Salkovskis *et al.* 2006). In addition to practising therapeutic skills during the training, it is also necessary to practice specific skills with specific patients whose cases the therapist comes for supervision. Here the role of supervision can be irreplaceable (Prasko *et al.* 2023).

Bennett-Levy *et al.* (2009) surveyed 120 experienced CBT therapists to find which training or supervision methods they considered most effective for improving various therapeutic knowledge and skills. It turned out that different training methods differed in effectiveness. For example, reading, lectures, discussions, and model moments were perceived to be the best for acquiring declarative knowledge. In contrast, active learning strategies (role-playing, self-experiential learning), combined with modelling and reflective learning, were considered the most effective for acquiring procedural skills. Self-experience and feedback were particularly important for enhancing self-reflection and interpersonal skills. To facilitate the most effective training and supervision, it is essential to understand which methods are the most effective for learning specific skills (Bennett-Levy & Thwaites 2007; Bennet-Levy & McManus 2009; Milne 2008).

A better understanding can help to focus supervision or training more effectively. Role-playing (Milne 1982), reading/lectures (Sholomskas *et al.* 2005), modelling (Baum & Gray 1992), self-experiential work (Bennett-Levy *et al.* 2001), and reflective practice (Sutton *et al.* 2007) have been identified as proper supervision and training approaches. However, studies have yet to investigate whether different training methods are differentially effective in gaining specific knowledge/skills. There is still a debate about whether role-playing or modelling is more effective than self-experiential work for learning therapeutic approaches or whether it is the other way. What is more effective for acquiring interpersonal skills?

Another study by Bennet-Levy & McManus (2009) found that CBT trainees rated reading and lectures or discussions as sufficient approaches to learning declarative or conceptual knowledge but proved to be relatively insufficient strategies for learning procedural skills (Bennet-Levy & McManus 2009). Role-playing was most strongly associated with learning procedural skills, mainly technical and interpersonal skills. Modelling by CBT students was a highly rated strategy for declarative and procedural learning and for acquiring conceptual and technical skills and knowledge. Reflective practice and self-experiential work showed similar patterns of perceived effectiveness. Both were considered effective in improving procedural and reflective systems, particularly for learning interpersonal skills (Bennet-Levy & McManus 2009). In contrast, lectures and reading were perceived to have only a slight advantage for learning interpersonal skills.

BEHAVIORAL TECHNIQUES

Supervisees sometimes report that their clients need to accept basic behavioural approaches such as activity planning, exposure, problem-solving, or social skills training. Clients object that they seem too mechanical or machine-like and do not sufficiently consider their emotional state (Prasko *et al.* 2010). The problem in such cases often lies in that the supervisee needed to adequately understand why the strategy was important in the context of the patient's problem formulation (Linehan & McGhee 1994; Persons 2008; Kuyken *et al.* 2009). Another issue might be that the supervisee imposes too heavy or too many tasks on the client and needs to sufficiently explore the client's possibilities and limitations (Prasko *et al.* 2022). Therefore, the supervisor needs to ask the supervisee for a replay of the client's psychoeducation focused on the rejected strategy and then for a description of how the supervisee reacted to the client's communication that they did not complete the task. The good news is that better-tailored psychoeducation or motivational interviewing approaches can help (Westra *et al.* 2016; Beckman *et al.* 2022).

Providing positive and negative feedback during supervision is another important task of the supervisor (Newman 2013; Newman & Kaplan 2016). CBT students who practise behavioural skills tend to overestimate their performance after role-playing. Additionally, supervisors may be excessively complimentary to protect or please their supervisees (Milne *et al.* 2008). If positive or negative feedback is provided, it is often vague and needs to be more structured (Friedberg 2018). At the same time, feedback is essential because it influences behaviour, and the supervisees need to identify what they are doing well, what they still need to learn, and what they did not notice (Friedberg *et al.* 2009).

Positive reinforcement from the supervisor is crucial (Freeman *et al.* 2009; Prasko *et al.* 2019). The supervised individual usually finds the supervisor to be a person who is accepting and interested in them and their therapy. The supervisor also shows interest in the therapist by remembering their attitudes and preferences and what the therapist said in the joint conversation. One of the responsibilities of a supervisor is to look for opportunities for sincere praise. Praise,

appreciation, and encouragement can directly affect the therapist's self-confidence if the supervisor believes them. Direct positive statements can be very effective from the authority figure. Usually, words of encouragement can have a potent effect. Therapists want to believe that their efforts are worthwhile. Praise, recognition, and appreciation can reinforce more adaptive behaviour and cooperation if the supervisor deems them well-deserved (Westra *et al.* 2016). On the contrary, if they are perceived as undeserved, they can cause feelings of humiliation. The therapist perceives the praise as fake, which might disrupt the supervisory relationship, and insincere praise is worse than saying nothing.

Another critical skill is guiding the client to the meaning of embracing immediacy (Friedberg & Gorman 2007; Friedberg *et al.* 2013; Scott & Lewis 2015). The ability to be immediate includes addressing emotionally evocative moments in the here and now. The ability to have a real emotional experience in the present time helps avoid an emotionally sterile, intellectualised, and mechanical approach in CBT (Friedberg *et al.* 2013).

COGNITIVE TECHNIQUES

Cognitive techniques can be used in supervision to change the therapist's automatic thoughts or schemas that relate to the client's attitude or work with the client (Prasko *et al.* 2019).

Guided discovery is one of the essential approaches in supervision. It helps the supervisee better understand the client or, if necessary, change the supervisee's attitude towards the client and find suitable strategies to solve their problems (Linehan & McGhee 1994; Persons 2008; Praško & Vyskočilová 2010; Prasko *et al.* 2020). Guided discovery is based on hypothesis testing (Cummings *et al.* 2015). As a specific technique, it applies several therapeutic skills: empathic listening, Socratic dialogues, behavioural experiments, and homework. Teaching supervisees the basics of guided

Box 1. Case vignette – The patient who does not do homework, helping with cognitive reconstruction.

The supervisee states that he is having problems in his therapy with a client who does not do his homework.

Supervisor: You told me about the problem with the client who needs to do homework when we discussed the conceptualisation during our last supervision. If I remember correctly, he talks briefly, is depressed, and had a difficult childhood with an overly critical and punishing dad. So now that I know more about this, can you describe a specific example of how this manifests when he does not do his homework? Moreover, how do you react to that?

Supervisee: Yes, that is the client. He is 25 years old; he suffers from depression; he had a very strict father who had excessive demands, belittled and punished him. A psychiatrist sent him to me. We have had four therapy sessions.

This is what it looks like. We are doing cognitive restructuring now. We discussed it in the third session; he seemed to understand. For homework, he was given a recording of his automatic thoughts. He came to the next session saying he didn't complete the task because he couldn't do it and wasn't good at it. At the same time, he understood it well during the last session. He didn't want to do it. I told him that if he doesn’t do his homework, he won’t get better because even though it's incredible what we do together in the session if he doesn't use it at home, it won't help him much.

Supervisor: Okay, thanks for the description. We could try to re-enact it, I'll try to play you, and you will try to play the role of your client who came in without homework. What do you think?

Supervisee: Okay, we can try it.

Supervisor: Okay, you can try to be your client. You described him very well. Try to put yourself in his role.

Supervisor as a therapist: We can discuss your homework together. As I see in my write-up, you should have done at least two automatic thought entries during the week.

Supervisee as a client: I don't have it, doctor, I can't do it. I don't understand and can't do it at all. When you explain it to me during the session, I felt better.

Supervisor as a therapist: If you do your homework, your condition will improve. While what we do together in sessions is excellent, using it at home will help you a little...!

pause

Supervisor: How did you feel in the role of the client?

Supervisee: Stupid. I felt helpless that I was being criticised, and the therapist did not ask more about my issue to complete it. As if the therapist just assumed I was lazy.

Supervisor: Uhm. What would you need the most as a client in this situation?

Supervisee: I would need the therapist to understand and maybe even appreciate that I did well in the session.

Supervisor: Absolutely, I can see that you empathised with the role of the client. Can we try it again? This time I will be in the position of the client. What do you say, can we try it?

Supervisee: Sure, I'd like to try it differently.

Supervisor as a client: I don't have homework and do not understand it. I would feel better if you explained it to me during the session.

Supervisee as a therapist: I think you understood it during the session and were fine. I remember that well, but then it wasn't possible at home. What happened at home concerning this homework?

Supervisor as a client: As soon as I began thinking about the task, I started thinking I wasn't up to it. And then I put it off. I sat on it once, but nothing came to mind when I looked at the table.

Supervisee as a therapist: I see. You describe it nicely. Although you did well in the session with my support, you were surprised by the automatic negative thought, "I'm not up to it", at home, which is why you put it off. What thoughts went through your head when you sat at the task table?

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discovery is vital but relatively challenging (Alford & Beck 1997). Many supervisees consider guided discovery a frequent problem in their therapeutic practice (Waltman *et al.* 2016). Still, it is also possible to practice the cognitive approaches that the supervisee needs to use with the client through role-playing, where the supervisor plays both the therapist and the client and subsequently switches roles.

IMAGERY TECHNIQUES

Imagery work is used in CBT for transformative experiential learning. Imagery can help better understand the client's situation, including emotional components and basic emotional needs (Prasko *et al.* 2020). It also helps to realise how the supervisee's therapeutic relationship is set up and to process and accommodate the supervisees' therapeutic attitudes, schemas and emotional-behavioural reactions. They also learn to plan future steps in therapy. Many therapeutic actions can be understood in advance with the help of imagination. Imagery has many roles in supervision. Visualising the situation can help return to the supervisee's emotions in their session with the client. In imagery, they can also try to respond better to the client.

Moreover, the supervisor with the supervisee can imagine various brief interventions that could help a client. The bridging imagery can also help in rescripting the countertransference situation by returning to the memories of the emotions they were experiencing with the client in the session and then looking for a situation in which they shared similar feelings in the past. Using imagery techniques with their childhood situation, they experience emotional alignment, which they then translate into a problem with the client and react in a new way.

During supervision, supervisees become both in the experience and meta-position, where they think about their work and learn to reflect on it (Lewin 1947). The reflection of an imaginative experience can often yield

***Continued.* Box 1.** Case vignette – The patient who does not do homework, helping with cognitive reconstruction.

Supervisor as a client: It was the same. I told myself I was stupid and couldn't do it.
Supervisee as a therapist: I understand when you say to yourself that you are stupid and not up to it. What emotions did it evoke in you?
Supervisor as a client: I felt anxious, which blocked me. Like when my dad scolded me for not being good at math.
Supervisee as a therapist: Yes, you told me about that. Those are painful memories, and we will focus on them later. Now I'd like to return to that situation where you're sitting over that homework. Can we record it straight into the automatic thought record?
Supervisor as a client: Well, we can. (writes down the situation, thoughts, and emotions)
Supervisee as a therapist: I like that. What percentage of you believe in the idea that you are stupid and that you are not good enough?
Supervisor as a client: A lot. I think 90 %. My anxiety is an 8 out of 10.
Supervisee as a therapist: I understand that the task is not done well with such anxiety. Let's try it together further. What shows that you are stupid and not up to it?
Supervisor as a client: The fact that I am not able to write it.
Supervisee as a therapist: Anything else?
Supervisor as a client: My dad yelled at me that he would leave me if I was stupid at math...
Supervisee as a therapist: Hmm, anything else?
Supervisor as a client: Well, I sometimes have that impression at work...
Supervisee as a therapist: This is a kind of circular proof. I tell myself that I am stupid, proving I am silly... This is not a concrete fact demonstrating that you are stupid. Furthermore, what is the evidence against the fact that you are foolish and not up to it?
Supervisor as a client: I had a good session with you. I also graduated with pretty good grades, got into college, and finished it. I was promoted to the head of a department at work. People ask my opinion and take it as essential.
Supervisee as a therapist: That´s great. That is much evidence against that negative thought. What could you say as a more balanced thought?
Supervisor as a client: I criticise myself for being stupid and not good at it, and then I feel anxious, which blocks me, but in reality, I did well in the session and turned out to be smart enough.
Supervisee as a therapist: Write this nice sentence. How much do you believe in it?
Supervisor as a client: Quite a lot. At around 80 %.
Supervisee as a therapist: And what does it do with the anxiety? You said it was an 8 out of 10 at the start.
Supervisor as a client: It has dropped to 4.
Supervisee as a therapist: What could you do the next time the same thought occurs when you have homework or in another similar situation?
Supervisor as a client: I tell myself I won't hinder myself and start writing it down. I might do some belly breathing beforehand to reduce anxiety.
Supervisor: What do you think about our role-play?
Supervisee: It was great. I understood my client more and tried a different approach in responding. You were an impeccable client. He feels anxious, but I already understand and know how to deal with it. Thank you.
Supervisor: Nice job. I felt very comfortable in the role of a client. You supported me a lot and understood and guided me in a clear and structured way.

Box 2. Case vignette – using imagination for overcoming problems with comorbid client

Supervisee: I have a new patient with whom I have trouble getting started. He has several problems, including depression, severe social anxiety, and excessive worry and distress. Even though I've identified these issues and set goals in each area, I can't seem to focus on them. Instead, we're still dealing with what he'll bring to the session and what happened in the week between our meetings. I can't direct him to systematic work, and I feel like I'm failing therapeutically in working with him.
Supervisor: I understand it takes much work to focus on systematic problem-solving with him because he always brings up something that happened during the week. He brings new ideas every week and wants to talk about them, and you do not lead to solving some of the issues systematically. You tell yourself that you are a failing therapist.
Supervisor: Yes. It is so.
Supervisor: Can we try using your imagination to work on this obstacle?
Supervisee: I can try...
Supervisor: Can you imagine for a moment that you have superpowers? Imagine that you are someone like superman and still in the role of a therapist, i.e. a super-therapist.
Supervisee: I can imagine it, but it's a bit weird...
Supervisor: Great, hold on. So, you can imagine you are the best psychotherapist in the world. You are an excellent expert who knows everything about clients with comorbid problems, and he can work with them on practically anything. He automatically knows which problem to start working with and how to keep the client on topic. Can you imagine that?
Supervisee: Yes, I can.
Supervisor: And how are you feeling?
Supervisee: I feel very good. I am calm, balanced, and purposeful. It's a good feeling that I know how to do it. I feel like doing something, and I have a strong drive.
Supervisor: Absolutely. Just go on. You are a super-therapist, and you know your student. What will you do in the next session with this patient who keeps bringing up new topics?
Supervisee: I will return with him to the initial goals we set. I will ask him which is the most important so we can start working on it. Then which is second and which is next? We could make a hierarchy of goals together. I compliment him and ask if we can start working on the first one now. Furthermore, we will continue on it in the following sessions until we reach the goal. I will tell him I trust that we can do it because, although it is not easy, I sense that he wants it a lot.
Supervisor: That sounds like an excellent plan. How about we try this while role-playing? You will play yourself, and I will be your client. Can we try it?
Supervisee: Why not.
Supervisee as a therapist: I enjoyed writing down your main problems and goals in our second session after you confided in me about your life. I had a great time working with you on this. You were constructive and to the point. Let's look at this list again. Could we rate individual problems from 1 (minor issue) to 10 (severe problem)? Which of the issues is the most important to you?
Supervisor as a client: …. The worst is that I don't get enough done at work and home due to being in a lousy mood and unfocused.
Supervisee as a therapist: Thank you, you put it nicely. You rate depression and the resulting decline in activity as your most important problem.
Supervisor as a client: Yes, it is.
Supervisee as a therapist: I suggest we concentrate on this and the subsequent few sessions on this problem and leave the others for later. Do you agree? I will explain how we will work together on this step by step.
Supervisor as a client: Yes, that sounds good to me. However, I wonder if I can do it.
Supervisee as a therapist: We will do it at your pace, step by step, from the easiest step gradually. We will agree on the size of each step so that it is achievable for you and, at the same time, helps you. Is it okay for you?
Supervisor as a client: Okay, I will try...
Supervisor: Thank you for role-playing. How do you feel? What was important to you in this exercise where I started with the idea of a super therapist and continued with role-playing?
Supervisee: The imagery, as weird as it sounds, helped me feel more confident. Moreover, I focused on what I wanted and kept the same direction. It was exciting to think like a super-therapist.

more than a cognitive assessment because it includes emotions, feelings, motivational elements, and bodily experiences. The experience carries a story, and one learns better than logical thinking. When talking about clinical work, the supervisor draws the supervisee into complex, multi-layered interactions that have been emotionally or physically lived, with meaning and imagination as important as the spoken word (Prasko *et al.* 2020). Images are used in surveillance in many ways (Skolnick Weisberg 2014). Sometimes the supervisee says, "I don't know where to start with this client. They have many problems." In this (and many other) situations, the supervisor can offer a little exercise in imagination (Prasko *et al.* 2019). This can help the supervisor recognise what is going on in the relationship between the supervisee and the client, how the case conceptualisation is supplemented, or how they manage treatment strategies with the client.

Imagery training is part of basic training approaches in cognitive behavioural therapy (Prasko & Vyskocilova 2015; Prasko *et al.* 2020). Three steps are recommended for using imagination training in supervision:

(1) The supervisor and the supervisee discuss the problematic situation with the client and, in the discussion, create a scenario for an appropriate course of action;
(2) In the next phase, the supervisee imagines themselves in the situation with the client, how they

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proceed, and how they complete the respective step. At the same time, they are an observer – as if they were watching themselves in a movie while completing a task. When they complete the task, the supervisee should praise themselves. This notion of self-success undermines habitual thought patterns focused on anticipating failure.
(3) At the end of the imagination training, the therapist imagines possible problems that may arise during the task and ways to cope with them. The therapist must end the training with a pleasant feeling that they have completed the task.

ROLE-PLAYING AND PSYCHODRAMA TECHNIQUES

The replaying methods originally came from Moreno's psychodrama and Gestalt therapy. Typical examples of experiential techniques in CBT are the psychodramatic replay of childhood memory situations, an empty chair, role reversal, and strategies using two or more chairs (Beck 1995). These approaches allow for increased self-understanding in therapy. However, they can also help the therapist in supervision understand how they create a therapeutic relationship when working with a specific patient. Specific techniques where the supervisee is asked to play themselves or their client can also help to model what is happening in the interaction between the supervisee and the client and to find more effective interaction strategies (Prasko *et al.* 2022).

a) Monologue

The monologue allows the supervisee to increase their self-reflection, affecting their communication with the client. The supervisee sits on a chair and talks about the client, the therapeutic steps, what they say about it, how they feel about the therapeutic relationship, the strategies used, conceptualisation and the like. This monologue helps the supervisee to express their hidden thoughts, attitudes, and beliefs about the patient, process, problems, and relations (Prasko *et al.* 2023). The supervisee does not directly address the supervisor but clarifies the therapy and the therapeutic relationship. The automatic thoughts, deeper-rooted attitudes, and beliefs associated with the supervisee´s ideas can then be processed by usual cognitive methods. Subsequently, this enriched understanding can be used to practice interacting with the patient, which the supervisor can use role-play.

b) An empty chair

The empty chair can be fictitiously occupied by a client to whom the therapist may speak. The therapist could be a personal message or state what their parents, partner, co-worker, or significant other might tell the client. Then they can follow a role-play where the supervisor directly plays the client. Unlike direct role-playing, which focuses on practising specific skills, the empty

Box 2. Case vignette – Empty chair in supervision work with anger outbursts

Supervisor: How about I fictitiously sit Maria in this empty chair? You can tell her anything you want and that things aren't working out for her in therapy.
Supervisee: Maria, your tantrums annoy me. Even if you later usually apologise. You take advantage of the fact that I am kind to you and forgive you for everything. However, I may not overlook it on the inside, and I can't bring myself to tell you about that. You're taking advantage of that. Still, I like you, but I don't think it means anything more. I would never want to have a closer relationship with you. You are very impulsive and explosive; you don't want to accept that you should change something. Either you feel you are better than others or that others are right, and you are the worst.
Moreover, your mood is constantly changing. I often don't know what position you are in. However, I enjoy the sessions with you. You are honest and direct; you say what comes to mind and hide nothing. You also think a lot about others and their needs; I like that about you. You are sensitive, gentle, and intelligent if you are not overwhelmed by emotions. Sometimes I see you as my daughter. However, you're not my daughter. You are Maria, who has her family and good and bad qualities. I'm sorry that our therapy isn't going the way I'd like, and you often tell me that nothing is getting better and that you're still sick. We will work towards making you feel more satisfied at home and work. However, it will take us some time. We'll even have to work on the relationship with your father that you don't want to talk about. I also have a little trouble discussing this point with you because I have a similar situation with my father. I couldn't be angry at him, even if I wanted to be. That's why I also have problems with conflicts with men. I want them as much as I wanted my dad as a child, and they won't give them to me. Like you, I am sometimes helpless with them. However, I want to learn not to be powerless. I would like it if you weren't helpless with men too. It is not easy to guide you to this when I am not very good at it.
Supervisor: You said it quite openly. Thank you for your trust.
Supervisee: That wasn't all. However, I realised a few things I couldn't tell her and many things I could tell her.
Supervisor: So tell me what you could and couldn't say to her...
Supervisee: I could tell her that I would like to find some rules for those outbursts of anger because then I would be angry with her, and I don't want that. I can also admit that bitterness makes me vulnerable. I understand how hard it is to be angry with my father, I've struggled with it myself, and I still can't quite handle it. But it is essential. I can also tell her that I like her, how honest she is and that she doesn't hide anything, but sometimes I would be more careful not to hurt others. I could also appreciate that he thinks of others and helps them.
Supervisor: That sounds good. It seems like that was all you said to an empty chair. Is there anything you can't say?

Supervisee: Probably not. I would have to choose a different form to avoid hurting her. Also, it's perhaps redundant and tactless to tell her that she's impulsive and explosive and that she can't relate to the fact that she should change. It's the kind of criticism as if I were her mother. I don't even have to tell her I like her. That is perhaps unnecessary. It would distract her from the main issues. Not even that I see her a bit like my daughter, and I sometimes pass it on to her. That's my problem, not hers.
Supervisor: Good thinking. Confirming your countertransference could be misleading and confusing for her, and that's mainly your problem. Self-disclosure only makes sense if it helps the client.
Supervisee: Well, maybe it would help if I told her I have trouble responding to her anger. Because I can't contain her rage nor allow it to be calmly vented or cultivated.
Supervisor: Hmm, that sounds interesting. Can we try it out in a role-play?
Supervisee: We certainly can.
Supervisor as Maria: Doctor, we have been working together for six months, and I still feel the same. I'm still sick.
Supervisee in her role: I'm sorry that you don't experience any change... At the same time, you worked hard on yourself; you did much good work at home... I have to appreciate that... You're also less angry with yourself... and you manage more at work... I'm proud of you for that... They also understand that you come to me regularly and usually on time, even though you are far away and it is not easy for you at all...I appreciate it... However, it must be unpleasant to say that you are not improving.
Supervisor as Maria: I'm probably exaggerating a bit... I manage a lot more at work and home... Even though those feelings of anger are less frequent, I'm still tense and exhausted from it, you know, I'm still angry with myself...
Supervisee in her role: I also feel you are more in control. I like how open and honest you are, and I would be careful not to hurt others unnecessarily. You are right, though; tantrums still occur, and I can't respond to them because I feel helpless at that moment. Maybe I should learn to react more directly and forcefully at times like this. If I empathise with your outburst, it doesn't change much. Next time you will behave like that again. Neither your husband nor I can stop it. However, you managed to get it under control at work, where there was a threat of trouble. I'm glad. I would be thrilled if you got it under control with me, my daughter, and my husband. You are very important to my husband and daughter. Moreover, I like you too.
Supervisor as Maria: Sometimes I choke with anger at work. Then sometimes, I take it out on my husband, daughter or even you. That's the price for that control at work. Even if you don't deserve it, I know that, but I can't control myself now. However, I don't want to be so impulsive and angry anymore.
Supervisee in her role: We have discussed this repeatedly and often come back to your father, who behaved this way. It is difficult to reject his fierce criticism because you would feel ungrateful. You say to yourself that he is my father and has done much for me. However, you seem angry with him! Although he did much good for you, he hurt you too…
Supervisor as Maria: I can feel how he hurts me a lot, but the anger... I don't feel it for him yet... Even though I already know I should probably feel it, this emotion doesn't appear... If that's what she felt, I'd be afraid to tell him and lose him forever... and I don't want that.
Supervisee in her role: I think it would be a good idea to first deal with the emotional wounds you suffered in your life from your father. I empathised with you repeatedly when you described your childhood memories of an explosive father who was oblivious to your needs and attacked your mother and you as children...
Supervisor as Maria: Maybe it's hard for me to treat my husband and my daughter the same way...
Supervisee in her role: I understand that, but you want to change it, which seems essential to me... You think not only about yourself but also about your husband and daughter and how they will come to this, and that makes me happy...
Supervisor as Maria: You're right, I would like to change it... For my daughter and my husband, but also for myself because I hate myself for it.
Supervisor: So, how do you see it? How would you prefer to do it?
Supervisee: I had already discussed some of what we played out with her before, but only some things. However, I moved the conversation about her father further in our scene this time. It would be nice if it worked out how I wanted to and how we played it out now.
Supervisor: I agree. I feel good about our role-play. What do you think would be the best for you to do as homework?
Supervisee: The most important thing is to learn about her relationship with her father and help her understand that it is crucial not to avoid it in the way she has been doing so far.
Supervisor: It takes work. However, you said she said it herself that she is theoretically aware of it, and she doesn't manage to experience it emotionally.
Supervisee: The last time we switched roles, it helped me empathise with her better. I was wondering if I could try it at the next session when I have it mapped out from both sides.

chair is about realising what the supervisee perceives as emotionally important concerning the client. Only then do they create an appropriate response.

c) Role change

Changing or reversing roles is one of the most common strategies in supervision. The supervisor or member of the supervision group plays the supervisee, and the supervisee plays their client. The goal is for the supervisee to understand better how the client feels, his needs, what he experiences in the therapeutic situation and how the behaviour of the supervised therapist affects them (Prasko *et al.* 2023). The supervised therapist can then think about what they would like or

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Box 3. Case vignette – Change the role during the supervision session

Therapist: I would probably need to try how she experiences it from her position. Like last time, I would try to play Lucia, and you, please, play the therapist.
Supervisor: Okay, here we go.
Therapist as Lucia: I know my mom criticises me and puts me down, and I feel sick almost every time I see her or talk to her on the phone. I freeze and become paralysed. I feel no anger towards her; I only feel helplessness, regret, sadness, and anger towards myself.
Supervisor as a therapist: I feel sorry for you whenever you talk about it. It's unfair what you're going through. Because you helped her so much and she doesn't appreciate it, she criticises you...
Therapist as Lucia: You're right, I'm trying, and she keeps criticising me. It's not fair.
Supervisor as a therapist: Do you remember some situation before, especially from childhood, when you felt similarly helpless, full of self-pity, sadness, and anger?
Therapist in the role of Lucia: I have experienced countless situations like this with my mother...
Supervisor as a therapist: Try to think of one situation that comes to mind first….
Therapist in the role of Lucia: ... I already got one. I was about twelve, and it was the holidays. Mom was sick then, so I went shopping with my dad and brother. Then I prepared the holiday lunch. Mom was sitting there still checking on me, and she wasn't happy with how I did it. I felt helpless.
Moreover, I was sorry and wanted us to enjoy a nice meal together, especially with my brother and dad. I did my best, but at the same time, I was crying because my mother kept criticising me.
Supervisor as a therapist: It must have been difficult for a 12-year-old girl. Shopping, cooking, taking care of everything, trying hard, and still hearing the criticism... What did you need the most in that situation, Lucia?
Therapist in the role of Lucia: For someone to stand up for me. So that we don't allow it, we either silenced her or sent her away...
Supervisor as a therapist: Who could help you with this? Who could stop mom and protect you?
Therapist in the role of Lucia: That's hard; everyone was afraid of her... I don't know. Only the grandmother, her mother. She always liked me, and my mom respected her. Grandma was the same to her as mom was to me. At the same time, my grandmother loved me.
Supervisor as a therapist: Okay, you cook, and mom starts getting angry. Grandma is coming. What should she do to help you?... Here we will sit your mom (moves the chair, puts a coffee cup on it) and here will be your grandmother (puts another coffee cup on the table). What should your grandmother tell your mother to help you?
The therapist in the role of grandmother: Stop it, Elizabeth, don't be so nasty and ungrateful. You can't treat Lucia like that. She cleaned everything, did the shopping, and now she's cooking lunch. That was your job, and she did it all for you. Moreover, you're attacking her. Go to the living room and watch TV. Let Lucia finish it.
Supervisor as a therapist: Don't worry, Lucia, you are safe. We won't let mom criticise you anymore. You cleaned everything, shopped well, and even cooked. Grandma is proud of you, your dad and your brother too… How do you feel now, Lucia?
Therapist in the role of Lucia: I feel relieved that someone stood up for me. However, I'm still upset about it all.
Supervisor as a therapist: What else would you need?
Therapist in the role of Lucia: Someone should appreciate what I have done and hug me…
Supervisor as a therapist: Grandma or someone else?
Therapist in the role of Lucia: Grandma, brother, and dad... That would be fine for me.
Supervisor as a therapist: We put them on the table next to your grandmother (he put two cups there). What exactly are they saying?
Therapist in the role of Lucia: Dad says that I am a clever and good girl and that I could fully replace my mother. Lunch looks excellent, and he is proud to have such a daughter. My brother says he has a fantastic sister, the best in the world. Grandma says I'm big now, I can cook like an adult, and she admires me for how much I can do.
Supervisor as a therapist: How do you feel now?
Therapist as Lucia: Very good; it's okay; everyone is on my side. My dad and brother hug me again, and I feel they love me.
Supervisor as a therapist: I'll play it for you to enjoy. Here's your daddy (grabs the bigger cup and modulates his voice): "You're a good girl, Lucia, and you've done a good job. I'm proud to have a daughter who thinks of others and runs the household when needed." Here's brother (adding a smaller cup): "I have the most wonderful sister in the world, and I want you to know it."
Plus, there's grandma (taking a coffee cup): "You're a grown lady, Lucia. I admire you for how many things you can handle well. Mom is critical, but she likes you too, but she can't show gratitude. That's why she had to leave."
Supervisor: So, how did you experience it as Lucia?
Therapist: It was enjoyable; I would like to try it with her.
Supervisor: What do you think will work in therapy?
Therapist: I think she realised how important it is to work with the relationship with the mother. Plus, it's up to me to make her feel safe and accepted to stand up to her mother's wrath. Rewriting where someone would care for her can help her dare to feel it. I also have to tell her that if she gets mad at her mother, it doesn't mean she rejects her mother…
Supervisor: Perfect. I will be happy to hear what happens next time.

could change about their behaviour. The supervisee can also observe the alternative work of the supervisor or one of the members of the supervision group with the problem they are currently dealing with.

d) Multi-chair role-playing

In the multi-chair method, each chair can represent any person in therapy, including the supervised therapist and the supervisor. When the supervisee moves to other chairs (roles), it gives them a more profound insight into the client's and their own needs, and they can react more clearly to fulfil them.

a) Role-playing

Role play helps the supervisee present a moment of therapy and assess and further model therapeutic

Box 4. Case vignette – Multi-chair role-playing during the supervision session with Therapist Anna and difficulties in setting boundaries in the therapy

In the following case, the therapist brings the situation with her client, in which she feels helpless. She finds it difficult to set boundaries with the client regarding time, payment, homework and other conditions in which a client, Linda, constantly crosses her boundaries. Linda also has a complicated history of emotional and physical abuse from her father. Therefore, it is difficult for the client to set the boundaries, as the Guilt-inducing parent mode of the supervisee, Ana, is activated. Both supervisor and Ana agreed to zoom in on this situation when the client has not paid for the last three months (even though there is no particular financial reason) and her behavioural response of becoming submissive and letting go of the boundaries. For this, both agreed to use multi-chair role-playing, where Chair 1 was dedicated to Ana's Guilt-inducing Parent mode, Chair 2 – to Ana's Vulnerable Child mode, and Chair 3 – to Ana's Healthy Adult mode.

Ana: OK, I am ready; a bit nervous, however.

Supervisor: Ana, this is great that you agreed to try this method to understand better what is happening within you when you are confronted with this client, which leads to not setting healthy boundaries for Linda and affecting her mood and, thus, therapeutic work. Could you first shortly describe the last situation with Linda?

Ana: Well, she came to me on Monday. I usually discuss organisational matters initially, so I asked about the payments. She said, "Yes, sorry, will do next time". Yet I hear this answer most of the time. Later, she started complaining about her spouse, saying he is too passive, that he does not earn enough, that nobody gets her, that nobody understands her, and that everyone tries to use her. After validating her feelings, I tried to change our focus and explore what it meant to her and her behavioural response. She got even angrier. Most of the time, she feels that she does not listen or value my efforts and therapy as such, and nothing I could say would make a difference. On the other hand, I know how many difficulties she faced and currently faces from her parents, so I felt lost and guilty that I could not help her enough, and she can feel abused by me as well.

Supervisor: This sounds tough, I could imagine. Ana, could we try this: could you sit on this chair and be your Guilt-inducing parent. The one that believes that you must help everyone no matter what the cause is, can you try this? Can you say something to this vulnerable side of you that feels hurt?

Ana, in a Guilt-inducing parent mode: [changes the chair] Ana, I know you are a good girl, but you can always be better; you should try much harder to help this client; you are responsible that she is not getting better, you should come up with something; maybe this is the reason why she is not paying you; perhaps you should put your needs aside now and think about Linda's; she is the one who suffers, and she needs you.

Supervisor: OK, we could stop here for a moment. That sounds like harsh words are coming from a calm, soft voice, which makes it even more difficult. Ana, can you sit on another chair [Chair 2] and reflect on how you feel?

Ana in a Vulnerable child mode: I feel guilty and shameful… I feel defective, that something is wrong with me, and that my needs are unimportant. After years of education, I am still not capable of helping people, and this is devastating.

Supervisor: Ana, that must be hard. Especially with these thoughts to still trying to help the client. Ana, is there something that you need at this moment? Just imagine if the session was paused; what words would you need to hear?

Ana is in a Vulnerable child mode: I am not sure, I want to feel appreciated, I want to feel good enough, and I wish not to feel so much responsibility.

Supervisor: These are essential, universal needs that you are telling yourself and me now. Could you sit on the third chair and be your Healthy Adult side? What would you say to your vulnerable side?

Ana in a Healthy Adult Mode: Ok, I will try [change the chair]. Ana [looks at the empty chair where the vulnerable side was sitting], I hear it is hard for you. You try hard; you wish your client the best. I also know that you did much thorough work with this client, yet you feel that there needs to be more collaboration between you. I also know so many people that you have already helped. However, the responsibility is indeed shared between you and your client. You are not alone in bearing this heavy weight. And for this, you are worth being paid. This is your work, and you work very hard.

Supervisor: Well said, Ana. I agree with you. How do you feel now?

Therapist: I feel better and am empowered to set boundaries next time and be more assertive. I know it is also essential for the client, not only me. Yet, before planning it on a behavioural level, I would like to try and understand my client better in this situation as well.

Supervisor: It is good that you suggested this first, and I was going to say it. Maybe we could try to identify Linda's modes that are activated in this situation to understand her and her possible reactions better, especially when knowing her history.

Ana: Yes, let's try…

skills (Prasko & Vyskocilova 2015). Role-playing strategies are the most important factor in evaluating therapeutic skills. Role-play refers to acting a part, usually in a training or supervision context, where we practice clinical skills from the role of therapist or client (Prasko *et al.* 2013). Role-playing helps the supervisor present a specific therapy moment and assess and further model therapeutic skills. As a rule, the supervisor or other supervisee (in group supervision work) plays the client, the therapist role-plays themselves, and they play an important moment in the psychotherapeutic session. The supervisor or a fellow supervisee can play the client in different situations. It is also possible to reverse the roles where the therapist plays the client. Role reversal sometimes offers a new understanding of what is happening with the client in therapy (Prasko & Vyskocilova 2015). In a group, it is possible to enrich the role-playing with other approaches, such as "doppelganger". The most significant advantage of role-playing in supervision is the possibility of seeing the therapist's practical skills and further developing them through modelling, chaining or imitation. Role-playing is usually underused in supervision and should be emphasised more (Milne 2008).

Role-playing should be used explicitly and systematically, and the lessons learned from the role-play need to be tested in an actual situation with the client. In addition to the cognitive aspects of understanding, role-playing should be emotionally similar to the clinical case. If role-plays are too technical and emotionless, dissimilar to actual interactions between the CBT therapist and the client, they risk becoming abstract intellectual activities rather than real experiential learning (Friedberg *et al.* 2009).

Optimising therapeutic interventions during supervision sometimes requires testing and practising interventions by role-playing (Praško & Vyskočilová 2015). The supervisor helps the therapist to reflect and plan an approach to a specific situation with the client (Kuyken *et al.* 2009, Prasko *et al.* 2011, Prasko *et al.* 2020). Typical steps may look like this:

(1) *Analysis of communication:* The supervisor asks the supervisee to describe the situation and express what went well and what they would like to change. The goal is to find the communication exchange between therapist and client that hinders progress during therapy. The situation can also be presented using video if the supervisee has a recording.
(2) *Demonstrating the situation:* It is often necessary to role-play the case to illustrate what is happening in therapy. The supervisor or group member plays the client, and the supervisee plays themselves.
(3) *Evaluation:* The supervisor, therapist, and group (if present) discuss what went well in the role-play situation, what parts should be improved, or what alternative approach would be helpful.
(4) *Building an alternative course* of action: The supervisor (or group) helps the supervisee think through and plan an alternative action pattern.
(5) *Playing an alternative pattern:* The supervisor usually plays the role of the client. It is also possible for the supervisor to play the desired behaviour first and the supervisee to play the client to see how to handle the intervention and to experience how the client might experience it. It is only then to switch roles, and the supervisee plays the therapist. The supervisee can replay the entire or the individual parts of the scene as needed so that the intervention can be fine-tuned and the supervisee feels natural about it.
(6) *Feedback:* The supervisor finds out how satisfied they are with the replayed version of the intervention and how they feel about it (Prasko *et al.* 2010; Prasko *et al.* 2020). They give feedback on what they liked and then focus on what could be improved or done differently.
(7) *Next Steps:* Sometimes, changing roles may be appropriate. Subsequently, the supervisor asks about feelings about the role of the patient.

Box 5. Case vignette – Supervision work with cognitive restructuring during role-playing

Supervisee: She is failing to do cognitive restructuring. Especially when she has to do it for homework; if I lead her enough in the session, she always manages to do well. When she tries to do it at home, it's often a little off. Instead of writing an alternative, more balanced response than the original automatic thought, she writes a positive slogan such as, "I will never think negatively again" or, "I will try harder next time to show that I can do it." She says that these slogans make her feel better, but in the same breath, she complains that nothing is getting better.
Supervisor: I understand. From what you're saying, it sounds better during your session. What is the difference between that and homework?
Supervisee: The last time she was doing her homework, the described situation was that she was angry with her 9-year-old son, who brought back a snack from school that she had given him to school. At the same time, she had thoughts like: "If he doesn't eat, he'll be sick! I can't force him to follow any order. I'm a bad mother, and he'll end up as stupid as me!" When she said that, she became helpless. And then there was the second fragment when she screamed at her son. Then came other automatic thoughts like, "I'm not in control. I can't control myself! I will destroy his confidence! I am an incompetent mother! He will be neurotic." After a series of thoughts, she first felt anxiety and helplessness, then anger at her son, which led to an explosion. After an outburst of anger, she became angry with herself and felt helpless... As an alternative view, she wrote to herself: "I will never explode at my son again". She did not think over the thoughts that led to the outburst of anger at her son. I tried to work it out with her….

During the session, she was angry with herself because she repeatedly thought, "I'm stupid". This interested her the most, and she wanted me to assure her of the opposite. When I didn't want to do that, she countered by saying that I didn't want to tell her so as not to offend her...
Supervisor: Okay, I will play Lucia, who has done the homework, and you try to cooperate with me.
Supervisee in his role: Lucia, we will look at the homework together. If I remember correctly, you should record your automatic thoughts and emotions when you find yourself uncomfortable, ask for evidence for and against those thoughts and find an alternative point of view. How did you do that?
Supervisor as a client: It was okay, look. I made one entry each day. Here is the situation with my son. I found out he didn't eat the snack I made for him this morning at school. I thought, "He's going to be ill!" I believed in it at 80 %, making my anxiety a 9 out of 10. "Why can't he listen to me? " I believed it at 70 %; it made my anger an 8 out of 10. "He'll be the same cripple as me! He will be neurotic." I believed this thought at 90 % and freaked out 9 out of 10. "I'm an incompetent mother!" I also believed it was 90 % and 9 out of 10, which made me angry at myself. Then I yelled at my son.
Supervisee as a therapist: What thoughts and emotions led you to yell at your son?
Supervisor as a client: Um, I don't know... Probably the idea that he will be neurotic... and it will be my mistake.
Supervisee as a therapist: Were there any thoughts that might have triggered the anger? Let's try to get back to the situation...
Supervisor as a client: Yeah, he's doing it on purpose... That he doesn't eat snacks... Moreover, I'll blame myself for the fact that I raised a neurotic boy...
Supervisee as a therapist: Do you think this might have triggered anger at your son that led you to yell at him?
Supervisor as a client: Yes. I'm a selfish idiot! I only think of myself! I should be ashamed, and my son is neurotic!
Supervisee as a therapist: There could be other thoughts... Let's stick with what you wrote about home exercise.
Supervisor as a client: (irritably) I wrote that I would never yell at him again. I believed in it at 90 %. I was relieved, and all my emotions dropped to 4.
Supervisee as a therapist: I don't see how this could have eased the thought of "He's going to be ill" or "He's going to be a neurotic like me."
Supervisor as a client: (reluctantly) I was relieved and felt good. What else do you want from me? I did the best I could…
Supervisee as a therapist: What's going on, Lucia? It seems that you were feeling a little desperate…
Supervisor as a client: It doesn't matter. You don't understand me at all...
Supervisee: Yeah, so we got into that situation. I don't know how it got there. We haven't finished working on the ideas. I feel like a porcelain elephant trying to make her not get mad at me or the therapy I give her…
Supervisor: So, we can go back to it, evaluate what happened, what could have been different, and then look for an alternative approach. Let's play the situation again. What do you think?
Supervisee: I'll be happy to do that. Maybe it was a good thing I asked about the thoughts that led to her getting angry at her son and yelling at him, which was missing from her report.
Supervisor: I liked that too. That was a crucial hidden part that Lucia did not discover at home, and it immediately led to self-blaming and probably painful emotions in the session…. How did you react?
Supervisee: I underestimated that this is a different situation, and I didn't realise it could hurt her and start blocking her therapeutic work. However, I wanted to continue with her homework, so we don't just jump from one thing to another…
Supervisor: Got it. It was a hard thing to decide… Do you think you could attend to both things?
Supervisee: I don't know… Maybe I could…. I could empathise with what she was experiencing at the time and write down those thoughts. Ask her if she thinks this more often… Say that we'll do that once we've done the homework because it is essential, and then go back to the original record…
Supervisor: That makes sense to me… Do you still think about how we acted it out or the initial situation with Lucia?
Supervisor: Okay, I'm going to play Lucia, who doesn't do her homework well, and you try to work with me as a therapist.
Supervisee as a therapist: Can we go over the homework together? If I remember correctly, we discussed that you would record your automatic thoughts and emotions when you are not feeling well. Then choose one automatic thought and find evidence for it and against it. From this evidence, you would have developed an alternative view of the situation that would be more useful and truthful to you. How did you do it?
Supervisor as a client: It was good; watch. I made one entry every day. Here is the situation with my second-grade son. I discovered he didn't eat the morning snack I had made for school. I thought, "If he doesn't eat properly, he'll be sick!" I believed it was 70 %, and the anxiety intensity was 9 out of 10. "He'll be as neurotic as I am! I believed this idea 90 % and freaked out at 9 out of 10. "I'm an incompetent mother!" I also believed it at 90 %, and the emotions were 9 out of 10, making me angry with myself. At first, I was anxious, and then I was screaming at my son at home.
Supervisee as a therapist: What thoughts and emotions led you to yell at your son?
Supervisor as a client: I don't even know... Probably the idea that he will be neurotic... that he will be the same cripple as me...
Supervisee as a therapist: I see. Did you also have thoughts that caused anger? Let's try to go back to that situation...
Supervisor as a client: Yeah, I thought the boy was doing it on purpose... That he doesn't eat the snacks... To show that I'm incompetent and that he should be with his father instead. In addition, I blamed myself for raising a neurotic boy...
Supervisee as a therapist: Do you think this may have triggered anger at your son that led you to yell at him?
Supervisor as a client: Yes. I'm a selfish idiot! I only think of myself! I should be ashamed! My son is neurotic, and it is my fault.
Supervisee as a therapist: Can there be other ideas...? Let's stick with what you wrote about home exercises.

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Supervisor as a client: (irritably) I wrote that I never want to yell at him again. I believe that at 90 %. I was relieved, and all my emotions dropped to 4.
Supervisee as a therapist: I don't see how this could facilitate the idea of "He's going to be sick" or "He's going to be neurotic like me."
Supervisor as a client: (reluctantly) I was relieved and felt good anyway. What else do you want from me? I did the best I could…
Supervisee as a therapist: What's going on, Lucia? It seems you were feeling a bit desperate…
Supervisor as a client: It doesn't matter. You don't understand me at all...
Supervisee: Yeah, that's how we got into that situation. I don't know how it got there. We still need to finish working on the ideas. I feel like a porcelain elephant trying not to resent me or the therapy I give her…
Supervisor: So, we can go back to it, evaluate what happened, what could have been different, and then look for an alternative approach. Let's play the situation again. What do you think?
Supervisee: I will be happy if we do that. Maybe it was a good thing I asked about the thoughts that led her to get mad at her son and yell at him, which was missing from her report.
Supervisor: I liked that too. That was the crucial hidden part that Lucia hadn't discovered at home. This immediately led to self-blame and probably painful emotions in the session…. How did you react?
Supervisee: I underestimated that... I thought it was a different situation, and we would treat it sometime next time. I didn't realise it could hurt her and start blocking her work. However, I wanted to continue with her homework so we wouldn't jump from one thing to another…
Supervisor: I see. It was a challenging decision... Could you do both?
Supervisee: I don't know… Maybe so…. I could empathise with what she was going through and write those thoughts down. We ask her if she seems to have these thoughts more often...
Supervisor: That makes sense to me... Are you still thinking about how we played it or the default situation with Lucia?
Supervisee: There was another part. As a more balanced response, she wrote to herself that she would never yell at her son again. I clarified that it was a command, not a more balanced thought. She said it helps but does not allow her because she cannot obey such self-command. This is a situation that happens to us quite often.
Supervisor: Yes, I understand... How do you know what is happening in that situation? You said the thought couldn't make me feel better, and I said that I felt better anyway and then asked what else you wanted from me. I did the best I could...
Supervisee: You reacted like her; it was similar in the session... She had to defend herself... But why? I just wanted to help her find other, more balanced thoughts instead of commands she can't keep.
Supervisor: She found one idea and felt relieved, even though it was more of a liability than a constructive idea…
Supervisee: I didn't appreciate her efforts; on the contrary, I devalued them... That's probably why she started to feel frustrated... Moreover, she already denied herself and fought for herself... It's so hard...
Supervisor: I'm glad how quickly you find essential things. Even though they are so delicate...
Supervisee: Well, if I could figure it out directly in the session with the client... it's easier that way; I don't have to react right away... I can think about it...
Supervisor: Still, I'm glad you're progressing so fast... You're making great progress... You're thinking in the right direction.
Supervisee: I wonder what to do next time in a similar situation. Maybe the best thing to do would be to credit her for her idea and then ask how it affects those original automatic thoughts. I can also tell her that I understand that if she commits to it, she will be relieved because she wants to believe it. And then, I can ask which of those commitments worked in the past when she found herself in a similar situation again and which didn't. It would be nice if she realised that these unrealistic expectations would calm her in the short term but will not help in the long time. However, I can't tell her; she must figure it out herself.
Supervisor: That sounds good. Can we try to role-play it? I will play Lucia again.
Supervisee as a therapist: Lucia, remember which thought preceded when you started yelling at your son.
Supervisor as a client: I thought she was doing it on purpose. And then that if he were neurotic, everyone would blame it on me. They would look at me as a failure as a mother... I thought selfishly of myself...
Supervisee as a therapist: Lucia, now it's self-accusing thoughts... It's painful to blame yourself like that... Does it happen often? I'll write down the thoughts you just described, and we'll look at them once we finish this homework. What do you say?
Supervisor as a client: I tend to blame myself often. I will be glad if you can advise me on this. Self-reproach always blocks me, as I am not able to think much. I go on and on about how bad I am.
Supervisee as a therapist: It will be essential to address this. Can we finish our homework first?
Supervisor as a client: Yes. I wrote one constructive idea there: never yell at my son again. I was relieved when I made such a commitment to myself.
Supervisee as a therapist: I understand that making such a good commission will be a relief, and I wish you to fulfil it. Have you ever made such a commitment in the past?
Supervisor as a client: Yes, I did, for example, with a colleague at work who calls me repeatedly. I managed not to say anything to her for two months, even when I was angry with her...
Supervisee as a therapist: Good, it seems to be working for you with her. What helps you in this?
Supervisor as a client: I guess fear helps me. My boss told me that if I yelled at this colleague and cursed at her, she would fire me. Losing my job is a big fear of mine. How would I explain it to my parents and friends? That's why I'm holding on.

Supervisee as a therapist: I understand you. There are several reasons why this works. However, the important thing is that it works for you. Have you ever made a similar commitment to your son?
Supervisor as a client: That too... but it didn't work... Like with my boyfriend. I keep vowing not to yell at them, but I can't. I always stop the screaming for a while but then start again. I guess I'm not afraid of being "fired". Although the friend already said that he had had enough. But he won't leave. I hope so. He always forgave everything.
Supervisee as a therapist: Lucia, I like how honest you are now. Can we go back to your negative automatic thoughts in this situation?
Supervisor as a client: Sure. I want to keep my resolve, but it seems unrealistic. I've already taken it repeatedly, and it didn't keep me going.
Supervisee as a therapist: You have these thoughts recorded in the chart: "He's going to be neurotic! He's going to be like me! It's going to be my fault! I failed as a mother!" Plus, we had other thoughts that led to you yelling at your son. They are: "He's doing it on purpose. I will be blamed that I raised a neurotic boy." Which of these thoughts is the most important to you right now?
Supervisor as a client: I'll make him neurotic, and I'm afraid of that, and then when I get angry, it's not him. However, it probably wouldn't have started without the fear of what would happen to him.
Supervisee as a therapist: This seems to be more understandable. As I see it, the idea of "I'm going to make him neurotic" makes you feel fear and anxiety. Can we consider whether you have any evidence that your son will become neurotic?
Supervisor as a client: Sometimes, he is worried about a test at school. Then he studies excessively and can't get his head around it, so he says it will turn out badly. Then I yell at him, and he cries. Sometimes he runs away from the TV when there is a scary scene.
Supervisee as a therapist: Yes, we have some evidence you think might support that. For me, they are not that convincing because many children his age behave similarly. Do you think you could also find any evidence against him becoming neurotic?
Supervisor as a client: He is pretty bold. He bravely skis and even swims alone at the dam. He can easily cook for himself and is very independent. Even though he is only in the second grade, he can travel all around Prague and not get lost. He is also often carefree and enjoys fairy tales. He has many friends in

(8) *Assignment of homework:* The supervisor and supervisee discuss what the therapist could implement based on the rehearsed situation by the next meeting.

e) Modelling

Modelling is a valuable method for both declarative and procedural systems and can provide a bridge between the two. Experiential methods – role-playing and experiential work – and modelling and reflective practice are seen as embedding new learning into a process system. After replaying the situation during role-playing, it is possible to gradually model the therapeutic situation, look for an optimal alternative and always consider how naturally the therapist feels in it and how the client will feel. Modelling enables "learning in action" and usually brings much more to the therapist than explanation or feedback alone. More complex situations can be modelled in concise sections and then chained together. The supervisor can also act out the situation and be a role model for the therapist. However, this option may mean producing "clones" of supervisors and not developing the independence of therapists and their uniqueness in the therapist's role. Of course, it is very tempting for supervisors to present themselves as a role-model and be admired by younger and inexperienced colleagues. It is also difficult to show mistakes or incompetence on the side of the supervisee. Sometimes there are other motivations and factors hidden behind this behaviour on both sides.

There are still some doubts about whether modelling as a strategy was given enough attention in the training and supervision. Technological advances offer new opportunities in this regard. In particular, Bennett-Levy & Perry (2009) argued that online CBT training could provide a specific advantage for modelling performance, as videos can be repeatedly viewed from different perspectives, compared to one-off demonstrations in training sessions, workshops or supervision. Not surprisingly, role-playing emerges as a valuable strategy for embedding procedural skills.

f) Role-playing with toys

Stuffed animals, puppets, or dolls can represent the supervisee and the client. Toys increase perspective and encourage creativity. The supervisor asks the supervisee to re-enact the situation from the therapy session with toys. The supervisor can choose individual characters, mainly the supervisee and the client, but can also ask for the roles of particular modes of the client or the supervisee or the roles of other people, e.g., the client's family members, supervisor, and co-workers. Afterwards, the supervisor and the supervisee discuss it and seek optimal interaction(as described in the Role-play section). Then they can act out the scenario with toys or indirect interaction, where the supervisor plays the client, and the supervisor plays the therapist.

g) Mindfulness-Based Role-Play supervision

Mindfulness-Based Role-Play in supervision focuses on the therapist's empathic understanding of the client (Andersson *et al.* 2010). This method is similar to the empty chair and integrates role-playing with a mindful dialogue approach that allows the supervisee to access subtle information about the client. It helps to retrieve

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class. He adores his friend, and they do boy things together. He is very much like him, and the friend is completely impassive.
Supervisee as a therapist: You smile brightly when discussing your son. I will now read you your evidence for and against future neurosis... (reads evidence aloud). What could you say to yourself when you hear this evidence to make it more balanced when your son doesn't eat a snack and approves of it in front of you?
Supervisor as a client: He wasn't hungry or forgot because he was fooling around with his friends during the break. He does not behave neurotically, and it is normal if he is sometimes afraid of a spelling test. He has an easygoing nature.
Supervisee as a therapist: How much do you believe in this new, more balanced view?
Supervisor as a client: Now I believe it is 90 %.
Supervisor: So, how do you feel about it now that we've role-played it?
Supervisee: It was pretty good. I'm happy with it. I don't know how you felt in the role of Lucia, but I experienced the whole scene as good teamwork. You looked pretty happy in the part of Lucia.
Supervisor: If you want, we can switch roles, you will be Lucia, and I will play you to see it from the opposite side.
They play the whole scene in opposite roles.
Supervisor: How did you feel in the role of Lucia?
Supervisee: It was lovely. I felt that you took me seriously and appreciated me, and it was good to name why my son is probably not at such a risk of being neurotic. I was pleased to see evidence that he was doing well.
Supervisor: I'm happy you also experienced it from the role of Lucia. We are nearing the end of the session. What do you think about homework? I would like it to be based on what we discussed today. Do you have any idea what would help you?
Supervisee: I might like to return to the cognitive restructuring with Lucia that we didn't finish last time because she was scared. I ask her what happened then and how she felt about it, and then I tell her I appreciate her homework and I'll do it the way we did it together. The important thing is that I understand her more now.
Supervisor: I believe you can do it. I loved how you did therapy with me and played Lucia today, and I felt that you understood her and could empathise with her.

information that is not readily available to the supervisee's consciousness (Andersson *et al.* 2010). Andersson and colleagues (2010) described three phases of this supervisory work:

(1) **Familiarisation phase**, where the supervisee plays the role of self and the role of the client, what it looks like when they are having a therapeutic conversation;
(2) **Thematic phase**, where the role play focuses on a theme, i.e., an area of difficulty in the therapy (for the supervised therapist or client);
(3) **The sharing phase**, where the interaction between the supervised therapist and the client, leads to an imaginary sharing of how each of them felt in the therapeutic situation and how they perceived the needs of the other (Andersson *et al.* 2010).

The supervisor slows down the process, helps focus on details, emotions and bodily sensations, and invites repetition of the client's position. Focusing on such information increases the supervisee's awareness of both roles (the client's and the therapist's). According to the outcomes of a pilot study, such an approach in supervision helps to increase therapists' empathy and improve therapeutic effects (Andersson *et al.* 2010).

OBSERVATIONAL AND EVALUATION TECHNIQUES

Audio and videotaped sessions are effective and recommended but underutilised modalities (Gonsalvez *et al.* 2016; Friedberg 2018). For CBT, a specific emphasis is on consistent training of individual interventions using role-playing and their management in supervision with audio – or video – feedback (Prasko *et al.* 2011a).

Supervision with video recordings is the optimal way to hear and see the supervisee directly working with clients. The supervisor regularly listens to the recorded sessions of the supervisee and provides precise feedback to develop further the supervisee's skills (Beck *et al.* 2008; Newman & Beck 2008). The recording can be stopped at important moments, and it is possible to return to essential sections repeatedly. After discussing what is happening with the supervisee and the client at the given moment, it is possible to plan and replay a more effective reaction of the supervisee. With increasing data protection requirements and considering the potential tendency to show only successful sessions, there is currently discussion about the interchangeability of recorded practice with standardised role plays (Linnes *et al.* 2019).

Nevertheless, if it is possible to ensure confidentiality and secure data storage conditions, for example, by using secure e-supervision applications (Deane *et al.* 2015), audio and video-taped sessions could be added to the previously discussed techniques as a highly valued tool for self-reflection and precise feedback. Video-taped sessions are a good solution for the supervisee's cognitive and memory biases (forgetting mistakes, not recognising ethical issues, not conceptualising a problem, countertransference situations, cognitive avoidance, etc.).

The *Give-me-5* and the *I-spy* techniques could be used (Gonsalvez *et al.* 2016). The main idea of the first

technique is to find only five critical moments in the session. The supervisor and supervisee compare their observations and discuss if it is appropriate to use other skill-developing techniques, such as role-play. It could be beneficial for inexperienced therapists not to be overwhelmed by the feedback. The *I-spy* technique is about "zooming in" on the session to analyse just one or few specific aspects, for example, how the supervisee is doing a Socratic dialogue (Gonsalvez *et al.* 2016).

In addition to videotaped sessions with the client, recording the supervision can be greatly valued. Videotaping can be used in the supervision of skills, where the supervisee and the supervisor play back what has happened in the therapy session and then work together to look for alternatives through role-playing and role changes. If they record individual scenes, they can then elaborate on them as needed. Recording imagery practice, for example, could be repeatedly used by the supervisee for rehearsal purposes, and it could be a part of homework. This approach could help supervisees accelerate skill acquisition by utilising this material outside supervision sessions.

During the supervision process, it is essential to minimise supervisory drift or reduce the risk of disregarding core elements of supervision (Pugh & Margetts 2020). Supervisors' and supervisees' avoidance and safety behaviour management are crucial points for successful supervision (Roscoe *et al.* 2022). Formal and informal supervision evaluation techniques could be a solution.

In a therapist-client setting, high-intensive client feedback about outcomes and sessions significantly reduced dropout and therapy duration (Janse *et al.* 2016). By analogy, the supervisee's feedback could improve supervision efficacy.

Supervision Adherence and Guidance Evaluation (SAGE) original tool (Milne *et al.* 2011; Reiser & Milne 2014) or its shortened version (Reiser *et al.* 2018) could be used for meta-supervision, where the supervisor takes consultancy sessions with a more experienced colleague, or it could be adopted as discussion material with a supervisee or for supervisor's self-evaluation.

The supervisor could perform an informal evaluation by asking for feedback at the end of the supervision session. Likewise, the therapist does it in the CBT session with the client: "What was important to you? How do you feel about our contact and supervision process today?"

For supervisees to evaluate supervision qualitatively and quantitatively, it is possible to use the Cognitive Therapy Scale (CTS, Young & Beck 1980) or its updated versions (e.g. CTS-Revised (Blackburn *et al.* 2001), which covers all essential elements that a CBT session should cover – general (creating agenda setting adherence, giving feedback, collaboration, pacing and efficient use of time and interpersonal effectiveness) and cognitive therapy specific elements (eliciting appropriate emotional expression, eliciting key cognitions, eliciting behaviours, guided discovery, conceptual integration item, application of change methods, homework setting); and rates them on a scale of 0-6. Regular use of this questionnaire can show the quality of the session, which is then related to the clinical outcome (Trepka *et al.* 2004).

CONCLUSION

One of the supervisor's main tasks is to help the supervisee to hone their skills to ensure the best possible therapeutic outcomes. The skill-building also aims to support the development of the therapist's style along with their self-confidence, self-reflection, and reflection on the therapeutic process. Different training and supervision strategies may help train other knowledge/skills. Supervisors need to have a flexible variety of skills and know which learning methods might be most effective concerning the supervisee's abilities and needs with a particular client.

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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