Principles of supervision in cognitive behavioural therapy

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Background. Psychotherapy requires clinical supervision. This is systematic guidance of a therapist by a supervisor. Inevitably, there is a question of training new high-quality therapists. This is related to supervision of their basic training. Later, it is important to provide an opportunity for lifelong supervision throughout the entire psychotherapeutic practice.

Method. PUBMED data base was searched for articles using the key words "supervision in CBT", "therapeutic relations", "transference", "countertransference", "schema therapy", "dialectical behavioral therapy". The search was repeated by changing the key word. No language or time constraints were applied. The lists of references of articles detected by this computer data base search were examined manually to find additional articles. We also used the original texts of A. T. Beck, J. Beck, M. Linehan, R. Leahy, J. Young and others. Basically this is a review with conclusions about supervision in cognitive behavioral therapy.

Results. The task of supervision is obvious – to increase the value of the therapeutic process in the client's best interest. At the same time, supervision is an educational process in the truest sense of the word, including an opportunity to select one's own supervisor. This is a very important procedural aspect since the therapist identifies with his/her supervisor, either consciously or unconsciously. Establishing the supervisor-supervisee relationship is based on principles similar to those in the therapeutic relationship. There is an important parallel reflecting the therapist-client relationship. This is because any changes in the supervisory process are analogically transferred onto the therapist-client relationship. Additionally, supervision is oriented towards increasing the therapist's competencies. The CBT therapist's basic skills involve good theoretical knowledge, professional behaviour towards clients, ability to use specific therapeutic strategies for maintaining the therapeutic relationship, sensitivity to parallel processes and accomplishment of changes, and adherence to ethical norms. Given the fact that during supervision, the supervisee may be in any stage of his/her training, supervision must take into consideration where the therapist is in his/her training and development and what he/she has or has not learnt.

Conclusions. Both the literature and our experience underscore the importance of careful supervision of cognitive behavioral therapy. The supervisory relationship is similar to a therapeutic relationship and the supervisee also needs security, acceptance and appreciation for his/her professional growth. However, there is more freedom in the relationship. Supervision may only lead to the supervisee's professional growth if it supports his/her individuality and helps him/her to discover things. Therefore, numerous approaches are used in supervision which are associated with the abilities to self-reflect and to realize transference and countertransference mechanisms.

Key words: supervision, cognitive behavioural therapy, competencies, supervisory relationship, transference, countertransference

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INTRODUCTION

Issues related to the education of high-quality therapists and adequate supervision of their professional growth both in training and later in lifelong education have been repeatedly discussed in international forums[1]. The current practice of a psychotherapy training institute approaching experienced therapists about supervising the trainees is insufficient. A good therapist is not necessarily a good supervisor although in most cases, this is true[2]. This is particularly problematic in cognitive behavioural therapy (CBT), currently characterized by rapid development, global boom and integration with other approaches, previously considered different, strange or unscientific (e.g. Gestalt therapy, person-centred therapy, existential therapy, psychodynamic therapy, mindfulness, etc.). As a result, sometimes, the trainee has less therapeutic experience but more knowledge and specific skills than his/her supervisor trained many years ago and now unable to comprehend what the trainee is presenting. Therefore,

the supervisor may tend to question and mistrust anything new, hindering the trainee who is in touch with the latest developments. Supervisors need systematic training in supervision and further continuing education. Supervision needs its own supervision as well as therapists need supervisors.

Supervision, however, is not therapy and cannot be confused with therapy despite the fact that for a supervisor who is also a therapist, it may be an attractive practice. However, the supervisor's role is not to solve the supervisee's personal or personality problems. His/her primary target is the treated client. The basic differences between supervision and therapy: (a) supervision is an educational process, therapy is a treatment process, (b) in supervision the truth may be told directly as a part of feedback, in therapy the truth is gradually revealed by the client; (c) in supervision we ask whether the supervisee wants to be criticized, in therapy we must be very careful about criticism, preferably avoiding it; (d) in supervision the development of deeper transference is not encouraged (but it may occur), in therapy transference it is anticipated and may be used therapeutically.

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GOALS OF SUPERVISION IN CBT

In CBT, supervision is understood as systematic cooperation between the supervisee and the supervisor, aimed at improving the therapeutic competencies of the therapist when working with particular clients[3]. The primary goal of supervision is to increase the value of the therapeutic process in the client's best interest. This requires agreement between both the supervisor's and the supervisee's behaviour and the therapy model, sensitivity to specific individual peculiarities and focus on the client's interests. The supervised therapist learns to work on changing the client's attitudes, emotions or behaviour in the least stressful, most adaptive and functional way. Therefore, supervision is also focused on improving the supervisee's skills to understand, actively solve and adequately emotionally experience both therapeutic work and oneself in the role of a therapist. To meet this goal, supervision needs to aid in increasing the therapist's competencies, i.e. improve knowledge, abilities and skills, learn to understand his/her own reactions and increase his/her self-confidence. Another task of supervision is to teach the therapist to respect his/her limits and to work with patients in a way that prevents burnout. To provide supervision, the supervisor should be able to[4]:

- Consult and facilitate
- Monitor administrative aspects (keeping records)
- Set up a learning relationship
- Teach, develop and strengthen
- Strengthen the individual ability to discover and choose
- Evaluate the decision process and alternatives
- Monitor professional ethical issues
- Provide expertise

CONTENT OF SUPERVISION

The content of supervision is the problems and relationships of a client, group, organization, therapist-client, therapist-group or therapist-organization relationships, relationships among therapists and supervisor-supervisee relationship[4,5]. CBT supervision is based on the same principles as CBT. In supervision, the basic postulates of learning theory are used such as classical and operant conditioning, cognitive learning and social learning[4,6]. Supervision of the therapeutic process means the supervisor's focus is mainly on the therapist's identifiable behaviour and its dynamics and mediating cognitions, emotions, bodily reactions and deeper attitudes related to the client and the entire context of therapy. The principles used are identical to those in providing therapy. The content of supervision may be as follows[3-9]:

- understanding the case and its conceptualization;
- choice of therapeutic strategies logically resulting from case conceptualization;
- making critical moments conscious, releasing blocks and blind spots in therapy;
- understanding the therapeutic relationship and creating it with a particular patient;
- clarifying the borders of one's competencies and realizing one's own limits;
- understanding the context in which therapy is provided;
- realizing countertransference in thoughts, emotions, bodily reactions, behaviour and attitudes;
- increasing knowledge;
- increasing awareness of ethical issues in therapy;
- development of specific therapeutic skills;
- supporting the therapist's autonomy;
- caring for oneself – preventing burnout.

SUPERVISOR'S TASKS

The supervisor's tasks are to teach the supervisee understand and treat the client 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/her work with the client in the broadest possible context, including attitudes to oneself, others and the world, rela-

tionship to an organization, to teach the supervisee understand attitudes, thoughts, behaviours or emotions related to transference and countertransference. If we accept that the basic principle of supervision is to take care of the therapists' professional development and thus the clients' well-being, we may consider the particular tasks leading to fulfilment of the principle. The supervisor's task is to find a balance between supporting the supervisee's experience and necessary changes in his/her therapeutic understanding so that[8,10]:

- a good supervisory relationship is established in which the therapist feels support, acceptance and appreciation
- a solution to the client's problems is sought
- new skills are naturally learned
- the therapist's professional competencies are increased
- unproductive stereotypes are non-violently adjusted
- the therapist's strengths are supported
- unconscious processes in therapy are named and made conscious
- the ability of self-reflection and realistic self-evaluation is increased
- room is made for recontracting the original order as well as for misunderstanding and disagreement without power effects
- the therapist's own individual style is supported
- the risks in difficult therapeutic situations are named
- attention is paid to ethical dilemmas, borders, power distribution and responsibility
- the risk of harm to both the client and the therapist is reduced
- the risk of burnout is reduced
- the ability to treat one's own injuries is reflected, including self-care and refusal of inadequate expectations and demands.

In many aspects, the supervisor may also be an example to the supervisee of how clients should be treated. Therefore, the supervisor's behaviour should include examples and models required from the therapist, such as respect, security, acceptance, empathy, encouragement and appreciation, congruence, ability to view hidden contracts and offer them metaphorically to the therapist for consideration and other potential solutions, straightforwardness and optimism towards other people[11]. He/she may also become an example in supporting freedom and tolerance for individual differences and styles.

The supervisor's role, however, is not only to reassure the supervisee within the safer setting of the supervisory relationship and to facilitate the experience of acceptance and appreciation (the necessary foundation that further steps are based on) but also to stimulate search, provide a challenge as well as negative feedback in a manner that is stimulating rather than critical. It can give us a chance to step back and reflect, to learn, to search for alternatives and to avoid the easy ways out of blaming others – clients, peers, the organization, society or oneself[12].

ETHICS OF SUPERVISION

The term "supervisor" is easily associated with the idea of some sort of superiority of someone "over" the therapist, someone better, having the power, control, knowledge and competencies that are beyond the therapist's abilities. This results in fear of the supervisor as an authority who mostly looks for faults, points to drawbacks and puts the therapist to shame. Or, on the contrary, of someone who knows everything and can answer any question and solve any problem. If this is what the supervisor suggests, he/she is missing ethical codes that are important for supervision. The supervisor is not "over" the supervisee. They cooperate to find the best way for the client treated by the supervisee. The supervisee should have an opportunity to present his/her mistakes, uncertainties and attitudes without fearing shame. The supervisor's task is to create a helpful and supportive atmosphere. The basic attributes of ethics of supervision are:

Helpfulness and beneficence for the supervisee or client

Supervision should help to make therapy useful and effective for clients. Well-treated clients, rid of their problems, are a credit to the therapist and, to a great extent, such results may be helped by supervision. A non-burnt out therapist, satisfied with his/her work for the benefit of his/her client, is the goal that his/her supervisor may significantly contribute to.

First, do no harm

The client is not a test subject for his/her therapist. Similarly, the therapist is not a test subject for his/her supervisor. Supervision should always be carried out with respect to a potential emotional or health threat to its participants. One of the most frequent sources of damage is unreflected countertransference relationship, especially one containing excessive criticism, labelling, anger refusal, emotional exploitation, border crossing, role blending.

Aptness, accuracy (loyalty to the contract)

At the beginning of supervision, the therapist and the supervisor make a contract that should be relevant, specific, meeting the therapist's, patient's and supervisor's needs. The agenda is determined by the therapist and the supervisor helps him/her to specify and formulate it, or possibly make the hidden part of the order conscious. The order, however, should arise from the therapist's needs. During supervision sessions, the contract may be reformulated and elaborated several times.

Equality of the the therapist and the client (not being abused)

If it is obvious that the client is abused in any way the supervisor points to this fact and provides a critical feedback. The supervisor should help the therapist to clarify the borders of the therapeutic relationship and also help if he/she is abused by the client. Ethical sensitivity involves the development of critical awareness of the impact of the therapist's behaviour on the client, courage to make

ethical decisions and carry them through in spite of resistance, either external (e.g. the organization's greedy interests, family manipulation) or internal (e.g. countertransference, fear of rejection, need to impress). The supervisor himself/herself pays attention to the borders of the supervisory relationship and avoids being manipulated into taking over responsibility for the therapist's decisions. The supervisor must not abuse the power he has over the therapist at the expense of the therapist and for his/her own benefit.

Autonomy and the right to choice

Supervision must not be imposed upon the supervisee who has the right to free choice[11]. The therapist has the right to freely choose his/her supervisor and the supervisor has the right to freely choose whether or not to supervise the participant or therapist.

Interest in oneself, realizing one's own needs, the art of judging what is bearable and what is not

Therapists' stress does not come merely from their clients. It may be related to their attitudes, demands on themselves, organizations they work for and supervision itself. Unrealistically high expectations may prepare the ground for later disillusion and apathy. Supervision should help to protect from burnout. It is essential that the therapist learns to take over responsibility for noticing his/her own overwork and unmet needs and to judge what he/she can or cannot bear.

COMPETENCIES OF CBT THERAPISTS

Supervision is focused on the growth of the therapist's competencies. Recognition of the therapist's competencies in cognitive behavioural therapy assumes good theoretical knowledge, professional behaviour toward the client, ability to use specific therapeutic strategies to maintain therapeutic relationship and to achieve change, and conforming to ethical standards[4,13]. The supervisee should know specific approaches that help to maintain good working alliance with the client and at the same time, use strategies leading to therapeutic change at a standard level[14]. A sensitive balance between security and change is one of the most important skills of good therapists and it cannot be simply learned from a manual. Basic therapeutic skills include the ability to conceptualize the case, establishing and maintaining the therapeutic relationship, defining the borders, listening, supporting the expression of emotions and their cultivation, empowering the client, resistance and endurance, managing complications and conflicts, realizing strategies needed for change[3,13]. Four core competencies in psychotherapy as described by Rodolfa et al.[15] – relationship, case conceptualization, intervention and self-reflection are apparently key for most therapeutic approaches including cognitive behavioural therapy:

Therapeutic relationship is essential for therapy, and without its good establishment, specific therapeutic interventions are not possible. It assumes the ability to sensibly and effectively relate to individuals, groups or families and requires the skills to:

- establish the therapeutic alliance – safe atmosphere (listen, reflect, strengthen, maintain hope etc.)
- titrate the client's anxiety so that it enables cooperation but it is used for change in the sense of the set goals,
- help the client become open, trust and face difficult tasks
- at the same time, the therapist is an example of how to openly, kindly and tolerantly relate to people.

Establishment of the therapeutic relationship necessitates the ability to create a safe atmosphere, listen, reflect, strengthen, maintain hope etc. In their meta-analysis of hundreds of studies of the psychotherapeutic process, Orlinsky et al.[16] concluded that a good psychotherapeutic relationship is a more significant predictor of positive therapy outcomes than any other therapeutic variables or strategies. Interestingly, what clients perceived as important in therapists successful in therapy were experience, positive orientation, good cooperation, vigour, consistency and congruence. The study, however, does not suggest what the therapist should do to achieve these attributes.

Case conceptualization is a skill based on studying theory but development is only possible through practical experience of working with clients, most significantly developed by systematic supervision[10]. Adequate diagnosis and conceptualization of cases means both understanding the current situation for triggers, thoughts, bodily reactions, behaviours and consequences, including maintaining and modifying factors (current cross-section model) and understanding the development of core schemata and conditional beliefs of the client (developmental model) stemming from his/her life story[6]. The schemata lead to development of compensatory or avoidance strategies in the client's behaviour towards oneself and others, including the therapist, and have an impact on symptomatic behaviour, coping with life situations and developing the client's relationships. The case conceptualization competency is manifested in skills such as assessment of phenomena, formulating meaningful hypotheses, ability to integrate materials, ability to ask without suggesting the meaning etc.

Interventions in therapy stem from case conceptualization. Interventions are suggested to alleviate the client's suffering, promote his/her health, modify his/her relationships for the benefit of himself/herself but also of his/her family and those around him/her. The competency of adequate choice of interventions includes assessing the appropriateness of a particular intervention in the given situation, experience with the intervention, assessing its effectiveness, ability to anticipate obstacles and establish procedures to overcome them, etc. Adequate selection of

therapeutic interventions requires continuous growth of the therapist's skills such as becoming acquainted with new knowledge in the field, advances in therapy, ethical and legal norms, recognizing individual and cultural diversity[17,18].

Self-reflection is a complex, highly developed process including the therapist's own cognitions and attitudes, emotions, bodily reactions and behaviour related to the client and therapy. Deep self-reflection interconnects the therapist's current experiencing with his/her personal attitudes, core schemata and conditional assumptions. From the CBT perspective, self-reflection requires[19,20]:

- developed abilities to notice, observe and think about what the therapist himself/herself experiences;
- therapeutic use of one's own thinking, emotional, bodily and imaginative experiences in interaction with the client;
- 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 criticism and learn from it, willingness to be supervised;
- desire for further understanding one's role in the treatment of a particular client.

As far as competencies are concerned, these include **core competencies** that are expected from every therapist,

Table 1. Core and specific competencies in CBT.

	SKILLS	ATTITUDES	KNOWLEDGE
CORE COMPETENCIES	▪ creating safe atmosphere ▪ empathetic listening ▪ validation of the patient's emotional conditions ▪ strengthening of the client ▪ increasing motivation ▪ congruence ▪ self-reflection ▪ strengthening hope ▪ guiding relaxation	▪ good relationships with people ▪ humanity, kindness, tolerance ▪ optimism ▪ tenacity ▪ resistance to stress ▪ curiosity ▪ need for self-development	▪ 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 ▪ the patient's indication for psychotherapy
COMPETENCIES SPECIFIC FOR CBT	▪ working in a CBT model based on case conceptualization and the ability to share it with the client ▪ together with the client, specifying his/her problems and goals in therapy ▪ ability to guide therapeutic sessions in a structured manner (psychoeducation, evaluation, measurement, drawing up plans, feedback, assigning and discussing homework etc. ▪ guiding the client in planning activities and structuring time ▪ identification of automatic thoughts and making them conscious with the client, using the Socratic method, reframing, using recordings of automatic thoughts ▪ performing behavioural experiments with the client ▪ preparing and guiding exposure therapy (education, making graduated steps, client facilitation, flooding, exposure in imagination, interoceptive exposure, exposure with response inhibition ▪ identification and accommodation of cognitive schemata ▪ processing of traumatic emotions ▪ one's own communication skills and guiding the client in training communication skills and assertiveness ▪ solving problems with the client	▪ scientificity and objectivity ▪ Purposefulness and planning ▪ systematic approach	▪ 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, sleep disorders, eating disorders, psychoses, relationship problems, etc.)

independent of the school he/she was trained in, and **specific competencies**, typical for CBT (see Table 1). These competencies are manifested in skills, attitudes and knowledge.

STAGES OF SUPERVISION OF CBT TRAINING PARTICIPANTS

Given the fact that during supervision, the supervisee may be in any stage of his/her training, supervision must take into consideration where the therapist is in his/her training and development and what he/she has or has not learnt. Supervision is a dynamic process – it may be subject to changes and twists and it definitely develops during supervision, from simple to more complex steps.

At the beginning, the supervisee learns basic understanding of the client, analysis of his/her problems in a given time frame, behavioural, cognitive and functional analysis, historical conceptualization of the case and subsequent selection of the most adequate therapeutic strategies. At that time, the supervisor focuses on the therapist's basic skills and helps him/her to create his/her own therapeutic identity. Initially, the therapist should work with simple cases with an outlook for short-term therapy and should not provide psychotherapy to difficult patients due to a lack of experience. The supervision session should be structured, clear, didactic and encouraging. First of all, the therapist should learn to specify his/her supervision order.

During the supervisee's therapeutic maturation, supervision becomes more sophisticated, with frequent role-play, role changes, 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 context and history of the patient, himself/herself and the entire organization, and to process his/her own countertransference reactions[14,21]. The didactic role of supervision becomes less important and it is replaced by guided discovery, role-play, imagination and work with one's own attitudes.

In a similar open-minded atmosphere, trained therapists are supervised. These come for supervision because they feel the need for their own professional growth and not because they want to have enough supervised clients before the training is over. The format of advanced supervision is fully based on all participants' agreement. Although the supervisor may make offers, most important is that the supervisee himself/herself comes with a clearly formulated order.

STRATEGIES FOR CBT SUPERVISION

Supervision should support the supervisee's strengths. Gradually, it should help him/her to realize his/her limits, strengthen competencies needed for managing the client, support his/her personal style and discover his/her blind spots. To achieve this, a number of approaches are used in supervision, related to increasing one's ability for self-reflection and realization of transference and countertransference mechanisms. The most important CBT supervision strategies involve:

Setting up a contract – the supervisee and supervisor set up a supervision contract (order). They need to negotiate the basic issues such as what the supervision will be about, what the therapist's needs and the supervisor's possibilities are. The supervisor usually inquires about the following:

- What problem are you coming with to supervision?
- What do you need from me? How would you formulate your order?

Defining problems and goals – similar to therapy, the supervisor and supervisee define specific problems and goals of supervision. Sometimes, the supervisee has difficulties formulating the problems and goals, especially if he/she is not very experienced or his/her work with the client is complicated, he/she does not know how to understand the case or has difficulties understanding what is happening in the therapy or relationship. The supervisor's role is to help the supervisee formulate the therapeutic problems and specify what to expect from supervision. Typical inductive questions may be as follows:

- What is the importance of the problem to you? What are the impacts on your work with the client or on yourself?
- Could we formulate the order as precisely as possible? What should be the outcome for you?

Clarifying the expectations and responsibilities – Hand in hand with defining problems and goals, the expectations of and responsibilities for both supervision and the work with the client are being clarified. At the very beginning, the supervisor asks about the supervisee's expectations by questions such as: "How can I help you? What do you expect from supervision?" The work with the client is the therapist's responsibility and it cannot be handed over to the supervisor (not even by law) since he/she acts in an advisory capacity only. It is important that the supervisor is not manoeuvred into taking over responsibility for the therapist's decision-making. If therapy under supervision fails, referring the client to another therapist should be considered. It is not advisable that the client is being taking over by the supervisor. The supervisor together with the therapist clarifies the borders of the supervisory relationship.

Active listening – means to understand the context of both the therapeutic and supervisory situations and reflect it, to understand the emotions the supervisee experiences. The supervisor listens more than talks and gives the supervisee enough time to express how he/she understands his/her patient, what is happening in the therapy and what he/she experiences and feels. At the right time, the supervisor begins to ask about other circumstances and uses inductive questions to help the therapist reveal other connections.

Feedback – providing feedback may lead to numerous negative feelings on both sides despite the fact that it is an important part of supervision. Both positive and negative feedback may produce a defensive attitude in both participants: positive from the feelings of "not being too proud" or "not to be conceited", negative feedback may revive the supervisee's experience of criticism in childhood and the supervisor may be concerned about losing a good relationship with the therapist. The basic principle is to give feedback in the first person singular: "I was surprised... I think... I like/don't like... I'm glad that..." etc. It is advisable to balance positive and negative feedback, with positive feedback being clearly prevalent (the ratio is said to be 4:1 but there is no evidence for this rule). Regular open feedback should therefore be discussed as early as in the contract. In positive feedback, regularity is important for encouraging the therapist.. Regularity is also important for negative feedback, to avoid the supervisee's stress from anticipating it as well as the supervisor's criticism overload. Feedback should always be clear and specific so that the receiver may understand it perfectly. General positive evaluation is practically worthless for the supervisee. General negative evaluation may make him/her feel hurt and therefore resistant to or worried about further supervision.

Showing respect – the supervisor should always respect the supervisee and treat him as a partner. Therefore, irony, trivialization, disparagement, reproach, moralizing and superiority should have no place in supervision. Showing respect strengthens the supervisee's self-esteem. As a result, he/she trusts himself/herself and is capable of taking on more responsibility. Another important sign of respect is stressing that the therapist's own decision-making is most important. It is his/her freedom to say, do or change something. Sentences such as "I suggest that you try it. If you decide to do so, do it at your pace and in a way that suits you..." may sometimes boost the therapist's self esteem. It is him/her who will decide on individual steps without being pushed by the supervisor. That is because the therapist is an independent human being deserving esteem and respect. Showing respect is associated with external signs of respect. However, there is also an internal component of respect – experience. If the supervisor does not respect the supervisee as a therapist and a human being he/she should be concerned with his/her own countertransference because the supervisee is very likely to sense his/her internal attitude.

Positive strengthening of the supervisee – the supervisee perceives the supervisor as someone accepting and interested in him/her and his/her therapy. The supervisor manifests his/her interest in the therapist by recalling their conversations and what the therapist said, knowing his/her attitudes and strengths. One of the supervisor's activities is to seek an opportunity for sincere praise. Appreciation and encouragement may encourage more adaptive behaviour and cooperation if the supervisee considers them to be well-deserved. By contrast, if these are perceived as undeserved, they may produce feelings of humiliation. The therapist is able to recognize manipulative praise. He/she sees it is false and this may disturb the supervisory relationship. Insincere praise is worse than saying nothing at all. This supports "games" with unconscious content between the supervisor and the supervisee.

Cognitive restructuring – cognitive restructuring, a common strategy in working with clients, is also used in supervision. However, guiding the therapist using cognitive restructuring may sometimes be tricky. He/she may have a feeling of being treated as a client by the supervisor. But in situations where the therapist has a biased view of the problem, has extreme views of the client's situation or there are apparent cognitive errors, the use of cognitive restructuring is warranted. The Socratic method as the most common form of cognitive restructuring in supervision is based on the presumption that the client will change his/her conviction more faster and in a more competent manner if he/she recognizes the mistakes in his/her thinking by himself/herself. It is much more effective than criticism. Cognitive restructuring may be beneficial especially when the therapist finds himself/herself in a hopeless situation or when he/she is not aware of countertransference. If cognitive restructuring is used in supervision, it is advisable to normalize the process of cognitive restructuring first of all and sometimes, humour might help: "Well, let's try something that you regularly do with your clients – have a look at pros and cons of this view. What do you think? Can we try that?" When training supervisors, the "alter ego" strategy may be used, with a peer trainee transposing his/her own opinion as another possible interpretation of the particular processes in therapy.

Guided discovery – this strategy, often used in the work with clients, is relatively frequent in supervision. Instead of giving the supervisee the facts, the supervisor uses questions to help him/her discover them. As in therapy, inductive questions are used, such as: "Do you think there might be some sort of a connection...?", "If we admit that you are right and at the same time, what you said a while ago is true, it may be concluded that... what do you think?", "I wonder how the patient's wife feels about it. What do you think?", etc.

Working with attitudes – similar to cognitive restructuring, it is only seldom used and it must be the supervisee's order. Working with deeper attitudes (core or conditional schemata) gets us close to personal psychotherapy in which the supervision borders may be easily crossed. However, working with attitudes is warranted if the supervisor sees that the therapist repeatedly makes mistakes in the relationship with the patient or he/she is getting into a similar countertransference situation he/she cannot handle. At such a moment, the supervisor may either recommend work with attitudes in psychotherapy

or offer working on attitudes that are reflected by therapeutic practice.

Playing roles – role-play helps the supervisor to bring a certain moment of therapy to presence and to assess and model therapeutic skills. For the assessment of therapeutic skills, role-play is the most important strategy. Usually, the supervisor or another supervisee (in group supervision) in the role of the patient and the therapist in the role of himself/herself replay an important moment of a psychotherapeutic session. The supervisor or peer supervisee may play the role of the client in various situations. The roles may also be reversed, with the therapist playing the role of his/her client. Sometimes, such a reversal may provide a new level of understanding of what the client experiences in therapy. In a group, role-play may be enriched with other approaches such as the use of a "double" ("alter ego").

Modelling, chaining, observational learning – after replaying a situation in role-play, the therapeutic situation may be gradually modelled, an optimal alternative may be sought and considered as to whether the therapist feels natural in it and how the client will feel. Modelling enables "action learning" and usually gives the therapist more than mere explanation or feedback. More complex situations may be modelled by very short fragments later chained together. The supervisor may also replay the situation and be an example to the therapist. However, this alternative should not be used frequently since the aim of supervision is not to produce the clones of supervisors but to develop the therapists' independence.

Problem-solving – in most cases, supervision is in fact solving problems of various difficulty. Usually, however, not all rules for problem-solving are explicitly used in supervision. Similar to therapy, the supervisor and supervisee may formally approach a difficult case using structured problem-solving. That is, they specifically define problems and goals, then monitor the problem area to get more precise data, brainstorm potential solutions including fantastic and impossible ones, plan ways of assessment, steps and rewards. Subsequently, the plan is applied to therapy and its effectiveness is assessed.

Assignments – supervision commonly involves assignments. These may be related to the **client guidance** itself (e.g. to study one's own recording to notice how often the therapist strengthens the client and how; if this happens rarely, to clarify moments suitable for strengthening), **working on oneself** (e.g. realizing experiences and attitudes leading to countertransference in a particular client; realizing in which other clients this may also occur), and **theoretical study** (the supervisor may recommend the therapist to read a certain scientific text to better understand and work with the client).

Table 2. The most important strategies for CBT supervision.

- setting up a contract and continuous development of the relationship
- defining problems and goals
- clarifying the expectations and responsibilities
- active listening
- feedback
- showing respect
- positive strengthening of the supervisee
- cognitive restructuring
- guided discovery
- working with attitudes
- playing roles
- modelling, chaining, observational learning
- problem-solving
- assignments, related to:
  - client guidance itself
  - working on oneself (what the therapist should learn and train in)
  - theoretical study

TECHNIQUES OF CBT SUPERVISION

There are numerous options for providing CBT supervision and many strategies are used. Most commonly, supervision is provided individually during a contact between the supervisor and the supervisee. However, supervision in a group is also relatively frequent – either as individual supervision in front of a group (the supervisor supervises the trainee in a group circle) or as group supervision, with the entire group of trainees participating from the beginning and the supervisor guiding and summarizing the process of group supervision. Technically, supervision is provided as follows:

Supervision of a case presented by the supervisee to the supervisor or a group – this is the most common approach, with the therapist stating the order and describing problems in the therapy. The supervisor uses inductive questions, feedback, role-play, imagination and other strategies to help the therapist find solutions. The advantages are sufficient time and the possibility to model the situation using role-play. The drawback is that that instead of a real therapeutic situation the therapist's version or stylization is used and therefore, practical skills cannot be assessed in communication with a particular client.

Written supervision of a reported case – communication via e-mail. Between the meetings of the supervisor and supervisee, the therapy may be discussed using e-mail. Practically every session may be analyzed immediately after it is over with the supervisor despite the fact that he/she is in a distant place. The pros are the possibility to express the experiences in sentences and reflect them keeping a distance, potential immediate contact with the

supervisor, the supervision may be continuous throughout the entire therapy. The cons are similar to those in direct supervision. Additionally, there is no chance to replay the situation.

Supervision using role-play – see the detailed description above. The main advantage is the opportunity to see the therapist's practical skills and to develop them using modelling, chaining or imitation.

Supervision of audio recordings – if the supervisee brings or sends session recordings to the supervisor the process of supervision is significantly improved. The supervisor may directly assess the therapist's interaction with his/her client. Sessions may be continuously recorded and most clients do not object to recordings for supervision purposes.

Supervision of video recordings – for the supervisor, this is an ideal opportunity to not only hear but also to see the supervisee in therapy. The recording may be stopped or replayed at important moments. The findings may be used to develop the therapeutic situation by role-play. The disadvantages are the fact that many clients do not consent to being recorded, the need to get the recording equipment and to copy the recordings to storage media.

The Balint group – originally a psychoanalytical approach suitable for supervision of the therapeutic relationship may be used in CBT supervision as its procedures and ideas practically correspond with the strategy for problem-solving. First, a group of up to 16 persons (preferably 8-12 therapists) chooses from several briefly described stories one case to supervise. Then the protagonist spends 15 min talking about his/her problem with the client. In the following 15 min part, the group members ask the protagonist about information to complete his/her presentation. In the next 15 min, the group talks about fantasies they have about the client, therapist and others involved such as the client's and therapist's families, co-workers etc. These fantasies are a sort of "brainstorming" of the group's views, with nobody claiming to be "completely right". In the last 15 min part, the group members say what they would do in the therapist's place. Finally, the therapist tells the others which of their ideas he/she considers important and what occurred to him/her throughout the process.

THE SUPERVISORY RELATIONSHIP

Establishing the supervisor-supervisee relationship (supervisory relationship) is based on principles similar to those in the therapeutic relationship[4,11,19]. In many respects, this relationship reflects the therapist-client relationship. However, more emphasis is put on equality between the two partners and the supervisee's freedom and independence from the very beginning of the supervisory process. This is not therapy. Similar to the client, however, the supervisee should feel secure, understood and accepted. At the same time, he/she should be stimulated to discover further connections in a more differentiated manner. This is guided discovery of one's own therapeutic process[3,6]. The supervisory relationship is based on a clear contract, empathy, positive strengthening and emphasis on relationship characteristics. As in the work with the client, the search process itself is encouraged. Supervision may be effective even without discoveries at any cost. In many cases, well reflected client-therapist relations are sufficient in supervision to bring about the desired changes in therapy. In CBT supervision, the transference relationship between the supervisor and the supervisee is not strengthened. Yet the supervisory process may be expected to develop in a way similar to that in all other relations. There are defence mechanisms, resistance, transference and countertransference, which tend to develop. It is important to reflect on them in the supervisory relationship because this is how the therapist learns to handle them[3,22]. During supervision, the process of its guidance may fall into many "traps". The most important ones are:

1. **I can do it better:** Gradually, the supervisor takes the initiative and uses his own approach through the supervisee. This usually demoralizes the supervisee.
2. **Competing with the supervisee:** The supervisor's competitiveness leads to his/her desire to take the case over. Frequently, these are unconscious dynamic processes associated with compensation of the supervisor's feelings of inadequacy.
3. **A protector:** The supervisee presents his material as a list of mistakes, errors and defeats. The supervisor takes over the therapist's entire responsibility.
4. **A passive optimist:** The supervisor lets things go and just affirms and supports. He/she fears negative feedback and rationalizes his/her behaviour.

CONCLUSION

Supervision is not therapy although many aspects are similar to psychotherapy. The supervisory relationship is similar to therapeutic relationship and the supervisee also needs security, acceptance and appreciation for his professional growth. However, there is more freedom in the relationship. Supervision may only lead to the supervisee's professional growth if it supports his/her individuality and helps him/her to discover things. For this reason a large number of approaches are used in supervision which are associated with the abilities to self-reflect and to recognise transference and countertransference mechanisms.

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