Neuroendocrinology Letters Volume 44 No. 4 2023
ISSN: 0172-780X; ISSN-L: 0172-780X; Electronic/Online ISSN: 2354-4716
Web of Knowledge / Web of Science: Neuroendocrinol Lett
Pub Med / Medline: Neuro Endocrinol Lett

CASE REPORT

Problems in Cognitive-Behavioral Supervision: Theoretical Background and Clinical Application

Jan Prasko[1,2,3,4], Marija Abeltina[5], Ilona Krone[6], Julija Gecaite-Stonciene[7,8], Jakub Vanek[1], Julius Burkauskas[7], Roman Liska[9], Tomas Sollar[3], Alicja Juskiene[7,8], Milos Slepecky[3], Lina Bagdonaviciene[10], Marie Ociskova[1]

1 Department of Psychiatry, Faculty of Medicine and Dentistry, Palacky University in Olomouc, Czech Republic.
2 Jessenia Inc. Rehabilitation Hospital Beroun, Akeso Holding, MINDWELL, s.r.o., Czech Republic.
3 Department of Psychological Sciences, Faculty of Social Sciences and Health Care, Constantine the Philosopher University in Nitra, Slovak Republic.
4 Department of Psychotherapy, Institute for Postgraduate Training in Health Care, Prague, Czech Republic.
5 Latvian Association of CBT, Riga, Latvia.
6 Riga's Stradins University, Department of Health Psychology and Pedagogy, Riga, Latvia.
7 Laboratory of Behavioral Medicine, Neuroscience Institute, Lithuanian University of Health Sciences, Kaunas. Lithuania.
8 Department of Health Psychology, Faculty of Public Health, Lithuanian University of Health Sciences, Palanga, Lithuania.
9 Department of Andragogy and Education Management, Faculty of Education, Charles University in Prague, Czech Republic.
10 MB Psichologija, Panevezys, Lithuania.

Correspondence to: Prof. Dr Jan Prasko, PhD
Department of Psychiatry, Faculty of Medicine and Dentistry, Palacky University Olomouc, I. P. Pavlova 6, 77520 Olomouc, Czech Republic
TEL: +420 603 414 930, E-MAIL: praskojan@seznam.cz

Submitted: 2023-03-15 Accepted: 2023-06-20 Published online: 2023-06-20

Key words: **Supervision; cognitive behavioural therapy; schema therapy; problematic situation; therapeutic relationship; the supervisory relationship**

Neuroendocrinol Lett 2023; **44**(4):234–255 **PMID:** 37466063 NEL440423C02 © 2023 Neuroendocrinology Letters • **www.nel.edu**

Abstract

Cognitive-behavioural therapists and trainees are encouraged to undergo supervision when offering therapy to troubled clients and to process personal attitudes and events likely to affect their therapeutic work. We discuss common problems in cognitive behavioural therapy (CBT) supervision, which may arise at the client, supervisee, or supervisor level. These issues include difficulties with case formulation, therapeutic strategies, and the therapeutic relationship. A supervisor can help their supervisee deal with clients with multifaceted or particularly challenging problems, such as difficulties with compliance, complex psychosocial problems, or chronic mental disorders. We also discuss matters related to the supervision process, the supervisor's role, different supervisory styles, and issues affecting a supervisee's feelings of vulnerability and shame. Furthermore, we analyze distinct supervision styles and potential problems arising from the supervision of experienced CBT therapists.

INTRODUCTION

Systematic supervision is essential to evidence-based training in the early therapists' career (Watkins 2012) and continuous education (Prasko *et al.* 2012a). Cognitive behavioural therapy (CBT) and third-wave CBT therapies (including schema therapy) are considered one of the leading evidence-based psychotherapies for various mental health conditions (David *et al.* 2018) and personality disorders (Bamelis *et al.* 2014). Although distinct, both therapies have a strong basis in the CBT tradition and share many common strategies, including cognitive work and behavioural activation (Young *et al.* 2003).

Rothwell *et al.* (2021) distinguish several forms of supervision: internal managerial, internal reflective, external professional, and external personal. At one end of the continuum, managerial supervision within the organization focuses on the tasks and processes. On the other side is worker-focused personal supervision, which focuses on the narrative that the supervisee brings to the supervision space. All types can be used in CBT supervision.

Apart from shaping the newly developed skills of trainees, the supervision of the psychotherapeutic practice is a crucial part of continuous professional development (Wheeler & Richards 2007). Supervision can effectively support CBT therapists and help students with personal and professional growth. It aims to ensure clients receive good psychotherapy and hone therapist skills throughout their therapeutic career (Greben 1991; Falender & Shafranske 2004).

The primary goal is to offer better psychotherapeutic care for the clients in which the cooperative work between a supervisee and a supervisor strengthens the client's improvement and therapeutic results (Swift *et al.* 2015). A supervisor provides their supervisee ongoing feedback and direction so that the treatment can follow a consistent course and adhere to established evidence-based guidelines. This process can better ensure that clients obtain at least the regulated standard of care (Greben 1991). The secondary aim of psychotherapy supervision is to endorse the development of the supervisee's expertise by affording them hands-on clinical experience combined with supportive and corrective training (Sarnat 2010). Over time, the supervisors take more of a backseat, encouraging the supervisee's autonomy (e.g., in terms of treatment planning and outcome assessment) and leading them toward organizational goals, such as accreditations and independent psychotherapeutic practice (Sarnat 2010).

Supervisions in CBT and Schema therapy create a learning alliance between the supervisee and supervisor, in which the supervisee acquires therapeutic skills while simultaneously evolving their self-awareness (Wilson *et al.* 2016). Accessing supervision during CBT training is vital across various psychological models and disciplines (Wheeler & Richards 2007). The supervisor looks at the psychotherapy process from a broader perspective, uses their knowledge and experience, and anticipates possible pitfalls and problems. Overall, looking at the issues of therapeutic work from different angles during supervision allows noticing the unique aspects that can otherwise be missed in therapeutic work (Wilson *et al.* 2016). Clinical supervision aims to build on and advance the supervisee's knowledge, skills, and attitudes to improve client care and enhance therapists' professional growth and development (Schmidt & Foli-Andersen 2017). It provides specific training on assessment, conceptualization, treatment, and termination.

Helping a supervisee's professional development includes educating them and assessing their foundational and functional competencies in conducting therapy. The Cube Model of psychiatric competency is a theoretical background that consists of these elements (Rodolfa *et al.* 2005). Foundational competencies broadly include the qualities involved in what we call "professionalism," such as being interpersonally effective, valuing self-reflection and self-correction, adhering to ethical standards, being sensitive and responsive to cross-cultural issues, understanding and respecting the scientific underpinnings of human functioning and mental health care, diligently keeping clinical records, and knowing how and when to appropriately consult with other professionals on matters pertinent to client care (Rodolfa *et al.* 2005).

Despite its usefulness and benefits, supervision may bring negative side effects. Specifically, it can trigger distress and self-doubt that may linger over time (Wheeler & Richards 2007; Wilson *et al.* 2016). Diminishing the risk of such outcomes is one of the core tasks of the supervisor. This paper aims to address issues in CBT supervision at the client, therapist, and supervisor levels regarding case conceptualization, therapeutic strategies, and the therapeutic relationship. This article addresses the literature gap regarding difficulties in the CBT supervision process.

DIFFICULTIES IN COGNITIVE BEHAVIOURAL SUPERVISION

CBT supervisors might face a challenge when "difficult" discussions arise. Common examples include ethical issues, conflict with the supervisee, and problems in disrupted supervision relationships. While there are many difficult conversations in psychological or health care between therapists and their clients, other difficult conversations include those that take place among psychotherapists, including supervisors and supervisees, about performance within the therapy, such as when therapists make mistakes or display disrespectful or non-ethical behaviour (Browning *et al.* 2007). Schmidt & Foli-Andersen (2017) compared the quality of CBT supervision in psychiatric training in

Tab. 1. Supervisor's cognitive reconstruction of the therapeutic-client situation

Situation	Automatic thoughts Rate belief 0-100%	Emotions Intensity 1-10	Facts for thought	Fact against thought	More balanced view Rate belief 0-100%	Outcome Emotion intensity 1-10 Action What can I do now and in future
The therapist tells the client that they put little to no effort into therapy because they have a lot of secondary gains from their difficulties.	She is so judgmental. 70 %	Anger 6	She labelled the client. She knows little about the client's history and does not have a proper case formulation. She has struggled with some other clients too.	The client improved with their therapy. She speaks nicely about many clients and found positive aspects of this client. She has worked very well with several clients.	She struggles to understand this client, as with a few other clients. However, she has worked nicely with most clients and improved her work with those she struggled with. She is eager to build her skills and self-reflect and usually does not stigmatise clients. This slip might come from the empty spots in the case conceptualization, and I do not see why she would not be able to become a skilled therapist over time. 80 %	Anger 2 Contempt 1 Annoyance 3 I can help her to understand the case formulation with this client better.
	Why does she want to be a psychotherapist? **She can never be a good therapist with such stigmatising attitude. 75 %**	Contempt 7				
	She is incompetent in proper supervision. 70 %	Annoyance 6				

Denmark with theoretical recommendations for good CBT supervision (Padesky 1996; Milne & James 2000; Milne & James 2002; Bennett-Levy 2006; Milne 2009; Bennett-Levy *et al.* 2009).

In the evaluation of the generic supervision skills, 86 % of supervisees rated their supervisor as supportive, encouraging, empathic, warm, and genuine, and 92 % rated their supervisors favourably for "active listening." Most found that instructions given during supervision were generally clear (92 %) and that supervision was collaborative (89 %). Although the general supervisory skills evaluation was largely favourable, the supervisees' perception of the specific skills showed room for improvement. Fourteen items were investigated for CBT-specific supervision skills and methods. Thirty-six per cent of respondents reported that their supervisor did not create a collaborative plan, 31 % reported a lack of organization and management in the supervision session, and 22 % found that their supervisor did not summarise all parts of the session. Thirty-three per cent found that the supervisor provided too little constructive feedback (oral or written), be it positive or negative. When asked whether the supervisor asked for and received feedback on what the supervisee had gained from the supervision session and which aspects they would like to change, 55 % found this area lacking. Two-thirds of the supervisees said they rarely or never received homework assignments (to be done before the next supervision session), and 47 % reported that the supervisor failed to follow up on homework when it was given. When asked if the supervisor tested their theoretical knowledge of CBT (e.g., "What kind of homework assignment would you give in this situation to a client with anxiety?"), 64 % stated that they were tested too little in this area. Approximately a third of the sample (31 %) perceived that they were insufficiently challenged to rethink or justify their views. Sixty-one per cent found that the supervisor did not "guide learning" often enough in their sessions (i.e., did not enable the supervisee to actively learn or develop skills during the session, by model teaching or by demonstrating the correct execution of interventions). Sixty-one per cent reported that role-play was not used in their supervision, and another 14 % said it was rarely used. The Socratic dialogue was lacking in the supervision of 29 % of respondents. Half of the participants felt that their supervisor provided too little "traditional teaching of CBT theory." Furthermore, 72 % reported that video or audio material was never used in their supervision, and 18 % stated it was rarely used. In the 14 CBT-specific supervision items, 61 % of respondents reported five or more things as lacking, and 47 % reported half or more of the items as lacking.

The categorization of these findings highlights common issues in the following areas:

- Understanding of conceptualization
- General specific skills
- Relationship processes (including transference, countertransference)
- Problems with third parties, organizations etc.

An assumed function of supervision is to improve outcomes for clients. Two studies have considered the perspective of clients. Milne *et al.* (2003) assessed the effectiveness of CBT supervision in terms of its observed impact on a supervisee and their clients. The authors showed that the supervision could be effective, as measured by changes in sessions following supervision. A considerable proportion of the supervision content transfers to psychotherapy. However, as Milne *et al.* (2003; p. 200) pointed out, this does "not support the notion that a complete 1:1 transfer of actions from supervision to therapy necessarily make for good therapy." In a qualitative study, Vallance (2004) explored counsellors' observations of the effect of supervision on work with clients. She found that emotional support from supervision benefits supervisees and directly affects client work, ensures that supervisees are not distracted by their emotions, and prevents contamination of the client's processes (Table 1).

1. OBSTACLES IN CASE FORMULATION

Case formulation (conceptualization) is a powerful therapeutic and supervision tool that can be highly beneficial to therapists, supervisors, and clients, leading to an increased understanding of clients' or supervisees' difficulties, feeling understood and accepted, and a sense of relief (Redhead *et al.* 2015). Case formulation helps understand a client's problems. Shared case conceptualization leads to feeling understood and accepted by the client, reinforces an emotional shift, and enables the therapist to move forward. Problems with case formulation can result from many issues in the therapeutic setting, such as demands for quick results, financial requirements, time pressure, and avoiding difficult themes from the supervisee. Common examples are suicidality, jealousy, the death of a child, rape or other painful trauma. Difficulties with case formulation can be connected to problems evaluating the client, the lack of the supervisee's experiences or their desire to speed up the therapeutic work by directly offering a problem-solving strategy for their clients. Case formulation is sometimes misused when a supervisee hurries and does not prepare properly for supervised sessions. A firm contract between the supervisor and the supervisee regarding how to prepare for supervision can prevent these difficulties.

1a) Obstacles in conceptualization connected with the client

Assessment is a fundamental step in producing case formulation and change during therapy. Case formulation is a dynamic process continually developed with new evolving materials (Prasko *et al.* 2019). Nevertheless, doing a proper assessment can be challenging. Some clients can consciously or subconsciously conceal important information regarding the presenting problems and suppress or deny their key emotions (e.g., anger in case of depression, shame in narcissism etc.). Some clients might also not recognize what triggers their stress reactions, thoughts, or emotions during stressful situations. A different native language, cognitive deficits, or problems with hearing or speech expression could also limit the collection of relevant information (Prasko *et al.* 2019). These complications can lead to an incomplete case formulation that lacks the underpinning required for a sufficient understanding of the subjects. Sometimes the early phase of the treatment concentrates on increasing the client's motivation to undergo therapy, and the case formulation could be unsatisfactory. In such cases, a supervisor can emphasize balancing the case formulation and discussing ways to test suggestions (Prasko *et al.* 2011) (Box 1).

1b) Obstacles in conceptualization connected with the supervisee

Conducting effective psychotherapy brings several challenging aspects that make supervision itself. First, basic therapeutic skills are crucial, and therapists need to demonstrate good empathy, care, respect and understanding (Prasko *et al.* 2021a). However, what is appropriate and beneficial for one client may not be for another because clients (especially those with personality disorders) differ in their need to be close to their therapist and their preferred interpersonal styles. Second, therapists need to learn cognitive conceptualization for each disorder separately and how to use this theoretical knowledge to create general treatment plans because key knowledge and approaches to modifying plans vary from disorder to disorder (Prasko *et al.* 2011). For example, in depressed clients, effective treatment focuses - among other things - on negative thoughts about themselves, the world, and the future.

In contrast, in those with obsessive-compulsive disorder, the key cognitions are intrusive thoughts, which require a different approach regarding the conceptualization and effective cognitive strategies (Salkovskis *et al.* 1998). Still, the knowledge of the common topics of the specific mental disorders should not overshadow the client's life story, and it should not be used to pressure the client into agreeing with parts that do not fit (Box 2).

The formulation process can also result in distress. Clinical implications indicate that a formulation should be undertaken sensitively and collaboratively to maximize its benefits and minimizes any possible negative effects (Prasko *et al.* 2019).

The most common problems when supervising the formulation of a client's problem tend to be:

A) The therapist has an insufficient understanding of the client's conceptualization
   a. Beginning trainee
   b. Undertook insufficient examination of the client
   c. Did not adopt the conceptualization of the new information they acquired during the therapy

Box 1. Case vignette – Client with complaints about not being appreciated

The following dialogue between the supervisor and the supervisee shows the training process regarding reflection and conceptualisation in CBT terminology. The therapist first said that the client's behaviour "does not make sense", after which the supervisor requested the therapist to develop hypotheses that could help explain the client's responses during the session and allow them to respond empathically.

Supervisee: My client often suffers in sessions with regretful complaints about not being appreciated at home or work. He gives many examples of his friends not taking him of what he does for them and not doing anything for himself. He often tells me that no one values him for what he does at work and that his efforts are not appreciated. However, let's say that I appreciate him in the session. In one case, I enjoyed his sense of humour and diligence at work, and he couldn't accept it and immediately diverted the conversation to another topic. He seems to crave recognition at work and home, but when I express it to him in session, he ignores it. He can't accept it. I think it can be similar at work and with his wife.

Supervisor: Yes, it is strange. He says he wants a reward, but when he gets it, he immediately distracts the whole conversation and changes the topic. There may be some logic to this in his life. When you consider his life story, can you think of a way to explain this paradox? Can you think of any connections? I'm not saying you have to know for sure. Let's try to put it as a hypothesis. Then you can find out whether there are enough facts for this hypothesis or ask for further clarification for such a formulation. Can you think of a hypothesis?

Supervisee: Maybe he selectively filters it somehow when I praise him. Alternatively, he directly disqualifies it without telling me. I realise that when he was a child, his mother praised him excessively and then criticized him. She often praised him manipulatively because she wanted something back from him after the praise. His father underestimated him and mocked him. He told me once that we, therapists, have to flatter people. Maybe that's why he thinks it can't be taken seriously when someone praises him. It might be the same with his wife and work as me. They may praise him sometimes, but he distracts them. Maybe that's why they gradually stopped praising him when they saw that he didn't react positively to it himself. I don't know if that's the case, but it's possible.

Supervisor: It occurs to me that you are talking about a cognitive error based on the client's core belief. What could it be about?

Supervisee: I think it could be related to "unlovability" or "incompetence" beliefs. However, it's hard to identify them directly because he got stuck when we did the downward arrow technique. When I tried to generalise some automatic thoughts with him, for example, "Nobody compliments me", I couldn't come up with a core belief about oneself with the questions "And what does that mean about you" or "What's the worst part". He always focuses on other people, and they don't like him. We didn't uncover his core belief about himself because he always diverted attention to complaints about other people. I tried it repeatedly with him. Similarly, when I empathetically confronted him about the fact that when I praise him, he changes the subject and does not respond to the praise, he said that I only flatter him. Others do not praise him at all or sometimes flatter him manipulatively. Again, I tried to help him with the downward arrow technique to find out what it was about him, and again he was distracted, so nothing came out of it.

Supervisor: You describe it very nicely. It seems like his repeating pattern. This can be understood from the first hypothesis you made. He cannot accept praise because, after excessive praise, his mother manipulated or immediately criticised him, and his father mostly criticised him. Now, therefore, he avoids compliments because he does not believe them.

Supervisee: It's true. He probably doesn't trust the compliments. He tells himself that it's all insincere and people's way of manipulating him. Other than remarking to me as a therapist just flattering him for professional reasons, he said no such thing about others. I'll try to look it up. This could be a core belief about others, for example, "Others cannot be trusted", but also "Others will hurt me" because both could be related to what he experienced in childhood. He may be afraid to trust people at work and home. He told me he could not confide with his wife because she would take advantage of it. I didn't ask further; maybe I should have because I would have learned more about how it is with closeness and trust her. Therefore, his relationship with his wife may not be close enough for him. I can look into that further.

Supervisor: I like how you conceptualise what is going on with him and connect his childhood with possible current behaviour patterns. You are right that we are at the level of a hypothesis that still needs to be verified. Nevertheless, so far, it all makes sense to me. You are looking for a way to observe him more, and when you meet him, you will see if the hypotheses are true. I am also glad that you realise that it is a hypothesis, not a truth and that it needs to be verified, not carried away by it. What can you think of as the best way to test this hypothesis?

Supervisee: I can go back to what I wrote down when investigating him and review his session notes and assignments. Furthermore, look at it all in terms of this hypothesis. Also, what I think is more important, I can go back with him to what happened in his childhood and try to find out if some similar feelings, as he had with his mother or father, do not also appear in him with his wife, with some co-workers and with me. I can also work with him on schemas about other people first, focusing on schemas about himself. He repeatedly shifts the topic from himself to other people. If we could connect it to his childhood experiences, he might understand better why he doesn't appreciate praise.

Supervisor: Absolutely. That seems like a good procedure, and I like that. You could search through what you have already recorded from the point of view of the hypothesis you have created. Then, you might connect the experience from childhood to the current one in relationships, including your relationship, and try to find meaning in it.

Box 2. Case vignette – Unclear core beliefs and conditional rules

When interviewing a supervisee, a supervisor may find that the supervisee is offering the client's core beliefs and conditional rules that are consistent with the model of the disorder but for which they have no basis in the client's story. The client does not identify with the schemas offered. According to the therapist, the client does not want to "let him win" and avoids discussing experiences that might match the therapist's hypothetical beliefs.

The supervisor asks the supervisee what emotions they experience in this situation with the client and what they would need from the client. The therapist gets to the point where they would need the client to recognise the schemas they have provided. A supervisor then offers their supervisee to try a chair technique during supervision. First, they play the client and let the therapist themselves. Then, when they realise that the supervisee is pressuring the client, they offer a role reversal where the supervisee becomes the client, and the supervisor becomes the therapist. The supervisor then replays what the supervisee did.. They ask what is happening to the supervisee in the client's position. The supervised person feels under pressure, powerless, and pushed into a corner. While in the client role, the supervisor asks them what they need most. The supervisee realises they would need more security and freedom without the therapists pressuring them about their schemas.

B) Problems conceptualizing a client who is difficult to obtain data from
   a. The client has problems remembering important information
   b. The client has a severe disorder that prevents them from providing valid data
   c. The client seems untrustworthy and reserved
   d. The client pushes the therapist for quick results instead of sharing more about the problem first
C) The therapist has a good conceptualization, but the content prevents work with the client
   a. They think this is such a serious issue that they would not know how to deal with it

Box 3. Case vignette – "Not motivated" adolescent depressive client

Supervisee: I have worked with a 16-year-old client Jane for eight sessions. I have already talked about her several times. I tried what we discussed in supervision, but it didn't work very well. The main problem is that she is not motivated to work in therapy. Thus, I don't know what to do if she doesn't want to.

Supervisor: You told me the last time that she experienced depression. Is that right?

Supervisee: Yes, she is depressed. A psychiatrist recommended me to her, and she came with her parents.

Supervisor: Last supervision, you told me that you were supplementing the conceptualisation, exploring it nicely, and connecting it with recent experiences. Moreover, you also said to me that you have an amicable relationship, and she trusts you. She also started with activity planning and did cognitive reconstruction, and I had a very good feeling about it. Today, though, you look disappointed when you talk about her, and it's different from the last time when I felt you were happy working with her.

Supervisee: Yes, I am disappointed. She didn't bring her homework and got worse. It is not surprising when she does nothing.

Supervisor: If I understand correctly, you are disappointed because Jane, who is depressed, didn't do her homework, and she feels worse in one session.

Supervisee: Oh yeah. It could be her fault, but it could also be mine. I guess I didn't discuss it enough because she told me she didn't understand well and didn't know what to do.

Supervisor: That's possible. What do you think about what you have accomplished before?

Supervisee: It wasn't good enough because it's worse now?

Supervisor: Do you mean the worsening depression the client complained about last time?

Supervisee: Yes, if it worked, she would have improved.

Supervisor: Do I understand correctly that you feel disappointed that you could not help Jane overcome her depression in eight sessions?

Supervisee: You are right. I want a lot. I guess I'm already under the influence of her mother, who keeps calling and saying that Jane has to take exams, that she's not improving, she should study and be normal... Her mother is in a hurry. I understand that, but I'm probably subject to it unnecessarily.

Supervisor: The mother seems to be putting much pressure on Jane to get well and is quite impatient…

Supervisee: You're right. Her pressure is being transferred to me, and I don't care if she calls again and says that Jane is not getting better... However, the most important thing for me is that Jane feels good. With a mother like that, she's under constant pressure at home, and I don't want to make it similarly difficult for her.

Supervisor: With this new insight, what do you think about your work and Jane's motivation?

Supervisee: Jane is trying. The fact that she didn't bring an assignment once when she didn't understand it is an exception. She always made it before. Maybe she also felt worse about not understanding the assignment. I should probably talk to her mother more, so she doesn't put so much pressure on her. Moreover, I will adapt to Jane's pace so I won't put pressure on her. She does what she can.

Supervisor: That sounds good. I'm glad you realised that Jane is trying and that you need to talk to her mother. If you want, we can role-play it together, I'll be the mother, and you tell me what you need.

Box 4. Case vignette – Client with anorexia loses weight again

A male supervisee approached his supervisor with an assignment when his female client with anorexia began to lose weight again, even though the therapy process had been successful before. According to the supervisee's description, the client's mood deteriorated, and she started to doubt whether she could live without the disorder. She said she had never achieved anything and that the same was true of the therapy.

The supervisor asked the supervisee to role-play, using role reversal, where the therapist would play the role of the client and the supervisor would play the therapist's part. In the role of the client, the therapist experienced helplessness and found herself in a " Compliant Surrenderer" mode, which reflected the "failure schema". In this role, the therapist became aware of emotions such as resignation and sadness and realised how difficult it is to cope with the current situation. The supervisor expressed understanding of the emotions and asked about what the client needed (acceptance). The changes achieved so far (long-term maintenance of a good weight, reduction of vomiting), which he then appreciated. He then asked what the client would like to do after finishing school (study, work). In the role of therapist, the supervisor asked the supervisee in the client role to imagine these situations. The therapist felt significantly strengthened and was eager to implement these ideas.

After the role-play, the supervisor and the supervisee discussed the modes using puppets. They also introduced the Detached Protector and Healthy Adult modes.

At the end of the supervision session, the supervisee reported that he understood his client better and had now experienced tools he could use with her.

b. They stigmatize the client after learning about them during the conceptualization process
c. They are so strongly under the influence of colleagues' opinions that it is impossible to work with the client
d. The therapist believes that other types of psychotherapy would be more suitable, although there are various ways to help with presenting problems within the therapist's school of psychotherapy

In contrast, the therapist sometimes oversimplifies the case conceptualization, especially when the specific diagnosis is present. For example, the therapists may only focus on the catastrophic misinterpretations of physical or mental feelings in clients with panic disorder. Understanding the general formulation and treatment of the disorder is often insufficient because clients often have comorbid conditions or the context of the issues is missing. In these circumstances, idiosyncratic rather than nomothetic case formulation might be more useful for the therapeutic process. Therapists also need to learn to conceptualize quickly during a session and use that conceptualization to develop a strategy for helping the client feel better and motivated for the next session. This requires sophisticated use of cognitive principles and the ability to promptly apply them "here and now" during a psychotherapeutic session (Prasko *et al.* 2012a). Increasing motivation for therapeutic work usually relies on careful case conceptualization (Box 3).

A supervisee's lack of experience can create difficulties in case conceptualization. Novice therapists frequently struggle with case formulation at the beginning of the training. They need to absorb the elementary client's understanding, the analysis of their problems, behavioural, cognitive, and functional analyses, and the historical case formulation. The supervisor should also consider the supervisee's developmental stage to create appropriate case formulation. A lack of experience with certain clientele can trigger feelings of anxiety and helplessness in a therapist. These emotions and related cognition may prevent learning enough information to plan therapy or overcome an obstacle (Box 4).

Novice therapists

The strict application of manualized treatment without adequate evaluation and appropriate in-deep first intake frequently misses many important aspects, including the unique needs of a specific client. Clients with similar diagnoses usually have different childhood experiences, relationship formation, current contexts and thus, case formulation. Trainees can experience difficulties connecting diverse material levels to a functional model. In such cases, the supervisor's role is to help the trainee build an effective case conceptualization using interviews, playing roles, or discovering provocative questions to acquire appropriate material. The supervisor may also need to lead the supervisee in building an effective idiosyncratic case formulation that would help build effective working hypotheses and treatment plans.

Novice therapists occasionally confuse case formulation and clinical diagnosis, and a supervisor needs to support the understanding that these are not the same. The diagnosis can only shed light on the part of the case formulation connected to the client's symptoms and cannot explain the broader framework of their development and maintenance. While training institutes teach trainees case formulation, and trainees ought to acquire the required knowledge, supervisors repeatedly need to help the supervisees to apply the knowledge in specific cases or to broaden their understanding of the case conceptualization. It is valuable to recommend that trainees study the book chapters about case formulation (Beck 1995; Davidson 2008; Kuyken *et al.* 2009).

The therapist might also use diagnosis-driven case conceptualization to explain the clients' problems. However, the appropriate assessment instruments and

Box 5. Case vignette – Uncollaborative client with obsessive-compulsive disorder with poor insight

The supervisee brought the case for supervision about the male client (age 34) with obsessive-compulsive disorder (OCD). The client came to therapy at the instigation of his wife. She found it difficult to keep up with his cleaning standards, which were the cause of their daily arguments. The patient suffered from anxiety-provoking intrusive thoughts that he or his kids would be contaminated with germs. As a result, he engaged in various activities related to cleaning at home and work and demanded the same from the family members. The supervisee brought the classical Salkovskis's model for OCD as a major part of case conceptualization to the supervision. However, at this point, the supervisee found it difficult to proceed further. According to him, the patient was completely unmotivated to have traditional CBT for OCD combined with psychopharmacological treatment. He was also unwilling to talk about his intrusions and compulsions further. Most of the time, he complained about his relationship with his wife and how she did not understand the danger for their kids if she refused to keep the house clean and disinfect all surfaces daily. The supervisee felt hopeless with his patient and was afraid even to suggest such methods as exposure and response prevention. As a result, she tried to pressure him to understand that he had OCD and that he, not his wife, needed help. Usually, he was not looking forward to the sessions and felt like a failure afterwards. The supervisor listened carefully to the supervisee and encouraged her to take more time to build a broader case conceptualization, including the possible personality traits that might have affected the client's denial and therapeutic process. Also, the supervisor encouraged them to strengthen their therapeutic relationship before addressing the OCD and asking about his general and therapy needs. Furthermore, the supervisor suggests considering motivational interviewing first to help strengthen his cognitive dissonance, to emphasize change talk, realize the advantages and disadvantages of the patient's compulsions and how they affect the relationship with his family and the chances of meeting the client's personal needs.

clinical evaluation do not indicate the presence of the disorder. Appropriately using psychological scales or forms can be difficult for beginners who are unsure whether they can ask certain questions. They might depend more on an official diagnosis or results from psychological assessments than on the practical consequences of a cautiously managed investigative dialogue with the client, which lead them to a valid clinical judgment and insight. An in-depth case formulation helps better understand the mental issue and the person. The client's goals, needs and schemas; cognitive, behavioural, and functional analysis are central to accomplishing effective therapy, not only changing one or two problems. Otherwise, the therapist may run into a much bigger problem of the "Procrustean bed" effect, which is trying to tailor *the person for the therapy* rather than tailoring *the therapy for the person*. As a result, this may lead to a worsened therapeutic relationship and negative consequences for the client overall.

Therapy with the uncollaborative client

Some clients have difficult or acute problems, experience severe psychotic symptoms, feel helpless and hopeless, have deep depression or withdrawal symptoms, or take high doses of benzodiazepines, among other issues. They might struggle to cooperate. Occasionally, beginners want to help non-adherent clients and start therapy without reaching an agreement or case formulation (Box 5).

Box 6. Case vignette –"Please give me more strategies": A client with a first-time major depressive episode

The supervisee came to the supervision with a clear request for more techniques to work with the female client (age 25) with a major depressive episode. In the case conceptualization, he presented the short history of the client's personal life and the course of the disorder. They had 16 sessions, during which the supervisee did various behavioural activation techniques. He also provided extended psychoeducation on a depressive episode, cognitive restructuring, cognitive continuum explained cognitive errors, and trained the patient in problem-solving skills. Nevertheless, the patient still reports moderate depressive symptoms. The supervisee complains that the patient does only half of her homework and sometimes does not attend her sessions. As a result, the supervisee thinks that he needs more strategies to tackle the patient's depressive symptoms and doubts himself whether he can and should do imagery rescripting, chair work, or other techniques from Schema therapy, which he has learned a bit from the books. When the supervisor asked about the patient's childhood, the supervisee said that he knew very little, as the patient said, "All was okay in my childhood; I had good parents, studied well and had enough friends. There is no need to talk about it." The supervisee is not sure about the origins of the patient's depression, what triggered her episode, and how did her best functioning without depression looked like. The supervisee also feels irritated with his patient. During the supervision, the supervisor supported the supervisee's efforts to help the client yet encouraged him to explore the patient's needs more. The supervisor also suggested exploring the possible function of depression in the patient's life and the belief about being helpless, which may affect her belief in herself as a patient in therapy. Finally, he also recommended conceptualizing the patient's core beliefs and conditional rules, which could help to target the therapeutic plan.

Premature use of problem-solving strategies

Many novice trainees undertake supervision asking for strategies. Most of them want to help relieve their clients from troubling symptoms immediately, may feel under pressure to reach results from their employer, or due to lack of experience (Box 6).

Understandably, these psychotherapists try to help their clients in the shortest possible time. It is also understandable that they easily lose confidence if they do not immediately see clear results. The supervisor's job is to support the supervisee in remaining calm, being kind and reflecting on their own and their client's experience. A supervisor uses guided discovery to create the conditions under which the supervisee can realize that therapy will be a system of trial and error unless they understand the client's problems well. Trust on both sides helps when making a case formulation and individually fitting parts of a client's story into the overall picture: on the part of the therapist so that they understand the client better and on the part of the client, whom the therapist questions systematically and for whom they place pieces into a mosaic so that the client understands themselves better, and may in turn, therefore, trust the therapist more. Clients have not usually experienced such a systematic interest in their symptoms, problems and story, and no one has previously helped them place it into a meaningful framework.

1c) Obstacles in conceptualization connected with the supervisor

To resolve these during supervision, one must be aware of a supervisee's possible adverse reactions to a case formulation. The formulation should be addressed carefully, sensitively, and collaboratively to maximize its benefits and minimize negative effects.

Another factor which makes cognitive therapy supervision challenging is the importance of two-level conceptualization and planning. Supervisors need not only conceptualize the client's difficulties and determine how to alleviate them but also conceptualize the therapist's difficulties and how to approach and teach them. The supervisor first identifies the client's most important issues, cognitions, and behaviours to address. They then identify the skills (conceptual and technical) that the therapist could use for effective treatment. Finally, they conceptualize the therapist's struggles and develop a plan to help them in these areas.

For the supervisor to fulfil these tasks, they continually assess the therapist's competencies and create a supervision plan. This plan considers how best to instruct the therapist - taking into account their level of expertise and experience, their attitude towards supervision, and personality of the supervisor, their clients, preferences, personality styles and previous (or current) experience with supervision.

2. OBSTACLES IN STRATEGIES

Supervisors help students improve their initial examination, case conceptualization, therapeutic plan, and competencies for implementation. Usually, these competencies are taught according to the supervisor's orientation - students learn to think about problems and how to treat them according to a specific training scheme (e.g., CBT).

2a) Obstacles in strategies connected with the client

Supervisors play an important role in helping supervisees deal with common obstacles in implementing techniques, such as assigning homework, asking for feedback, ending sessions on time, balancing a directive approach with guided discovery, and responding when clients habitually say, "yes, but...". As an illustration, the following dialogue shows a supervisor recommending how their supervisee can enhance a client's use of thought records (Box 7).

Box 7. Case vignette – Automatic thoughts of the client are in the form of questions

Supervisor: I am glad you brought copies of your client's homework. We can review them together. As I see it, most of the Automatic Negative Thoughts column entries are written as questions. He writes here: What if the anxiety never ends? What if we don't have enough money? What if my marriage fails? It looks like concerns in the form of questions.

Supervisee: You're right. It likely is. I don't know how to respond because the question is hard to test.

Supervisor: Yeah, that's hard. Can you think of how to work with concerns in the form of questions?

Supervisee: I remember now that we converted questions to predictions in training. Maybe it would work.

Supervisor: That's a good idea. You can ask the client what they are most worried about instead of answering. For example, he asks: What if we don't have enough money? Ask him about the worst thing that can happen. Alternatively, you can ask him what it would mean about him if it turned out that way.

Supervisee: It occurs to me that he will come out with hopeless or self-deprecating thoughts and feel sicker. Maybe he will tell himself that he is incapable and will never be well, which will be worse for him than if he only asks questions.

Supervisor: You're right, and he might feel stronger emotions for a moment than when he only asks questions. Nevertheless, you can test together whether he is really "incompetent" "using his record of automatic thoughts. Do you think you will not find evidence against the belief" "I am incompetent"?

Supervisee: We'll probably find that, or we'll discover it. It will be associated with stronger emotions for a while. We can better determine the cognitive error, and I can see that there is a better chance of working with a record of automatic negative thoughts. Thank you for guiding me to this.

Box 8. Case vignette – Client without homework and role-playing

Supervisor: Perhaps we could role-play a homework situation with your client. What do you think?
Supervisee: We can. It might help me.
Supervisor: Okay. I will act as your client. You described her very well, and I will try to put myself in her role. You tried asking me about the homework based on how we discussed it. Maybe first summarise how you're going to do it.
Supervisor: Okay. I won't give up after she says she didn't do her homework. I feel this is important for her further progress.
Supervisor: Very good. So, we can try role-playing, and I will sit in her chair. (The supervisor moves to another chair.)
Supervisor / Client: Hello.
Supervisee: Hello. How have you been since the last meeting?
Supervisor/Client: Pretty good. I had much work at school and on projects, and it went by quickly. However, I'm sorry I didn't have time for homework. I'm really busy and don't have time...
Supervisee: I see you are proud of your work at school and on projects. That sounds great to me. However, you also said you don't have time for homework.
Supervisor/Client: Yes, I tried to work with those thoughts in my mind as much as possible, but I didn't have time to write them down.
Supervisee: I'm happy that you tried to work with automatic thoughts in your mind. Nevertheless, there were obstacles to their writing down. It may be important to explore these obstacles more if it could help you. Some people find that writing homework is not easy, and analysing the difficulties can help us understand this. Could we try to explore it together?
Supervisor/Client: We can. (She sits back in her supervisor's chair.)
Supervisor: How do you feel now?
Supervisee: (smiling): It wasn't that difficult. I think I did it quite well.
Supervisor: (smiles): I liked it too, and I'm looking forward to hearing how it went next time!

2b) Obstacles in strategies connected with the supervisee

At times, the anxiety experienced by the supervisees within a highly charged supervision can signal critical opportunities for their professional development (Wilson *et al.* 2016). At these junctures, the supervisor's understanding and interventions are not always sharply distinguished from the skills of the psychotherapist (Rubin 1989). The didactic portion of being a CBT supervisor involves educating supervisees about implementing the methods of CBT but also giving wide-ranging directives that will help supervisees stay on task and be effective therapists in general (Whitman & Jacobs 1998; Padesky 1996). An example of the typical use of role-playing is below (Box 8).

2c) Obstacles in strategies connected with the supervisor

A supervisor may also sometimes experience difficulties responding to a supervisee, especially when the supervisee seems overconfident or otherwise very vulnerable. The supervisor is concerned that the interaction would lead to tension, conflict, or emotional injury (Box 9). The supervisor may therefore avoid some important topics in supervision.

3. OBSTACLES IN THERAPEUTIC RELATION

The supervisor and their relationship with the supervisee influence the supervisee and their understanding of the psychotherapeutic process with clients (Guest & Beutler 1988; Hansen *et al.* 1982; Lambert & Ogles 1997; Milne & James 2000; Kilminster & Jolly 2000; Freitas 2002). A common difficulty in the supervisory process appears to be the management of the therapist's feelings in their relationship with the client and the supervisor (Gauthier 1984, Prasko *et al.* 2021a).

Strozier *et al.* (1993) examined the cognitive aspects of supervision. They found that an environment that provides support and a manageable challenge facilitates the supervisee's development and a supervisee's experience of being supported due to the supervisor's focus on their relationship. Furthermore, Milne *et al.* (2003) found that there was appropriate thematic transference from the supervision to the therapeutic sessions and that observation of the thematic transfer improved the supervisee's awareness of how various CBT methodologies can promote change.

Box 9. Case vignette – The monologue of the supervisee about how well he works

During supervision, the supervisee kept talking in a long monologue in which he tried to show how well he performed the therapy and did not leave the supervisor's room for the questions the supervisor wished to ask. The supervisor realised that he was concerned that if he entered into the supervisee's monologues, it could lead to tension, or the supervisee would become offended. He, therefore, considered how to confront him with the situation empathically to avoid conflict. During the next supervisory session, he said, "I'm glad you know a lot about the client and have formed several hypotheses about why the client is struggling in relationships. To understand your client better, I need to ask more about some things. Therefore, I would like to enter your narrative with questions. Could we arrange for me to ask you curious questions now?"

Although each supervisory situation requires a different approach, the basic rule is to keep communication between the supervisor and the supervisees open (Gauthier 1984). Therapists in supervision may not disclose unhelpful events in therapy or adverse effects from supervision because they fear a negative evaluation (Prasko *et al.* 2021b). It is undeniable that seeking support from colleagues is helpful, and it helps the therapist to feel less isolated, provides support, and can help solve complex problems. Nevertheless, it cannot subsidize an interview with the supervisor and the joint work on the issues. Supervisors' assessment should be helped and supported to keep good practice.

3a) Obstacles in therapeutic relations connected with the client

There is a concern that supervision ought not to become therapy; indeed, there is a good link between helping a supervisee understand the client, developing CBT skills, and understanding their personal issues with treatment (Prasko *et al.* 2010). While supervision is not psychotherapy, a subset of listening and intervention skills are common to both (Box 10). Schames (2006) suggests that clinical supervision should be planned to achieve educational and therapeutic goals. Avoiding difficult discussions in supervision, however, can have negative therapeutic consequences.

Unlike most on-the-job supervision, clinical supervision is a two-way process in which the supervisee is responsible for their education and guides the supervision process to achieve the required skills and knowledge (Prasko *et al.* 2021a). The supervisor and supervisee should build regular evaluations to assess progress, and the supervisee should evaluate their growth and the supervisor's assistance in their development and change.

The supervisory process can be distorted in several ways (Dewane 2007):

- The supervisor uses the supervisee as a confidante.
- The supervisor degrades the supervisee through personal remarks.
- The supervisor could have the therapist or student carry much of the supervisor's assignment.
- The supervisee reports personal problems to the supervisor, and the supervisor helps psychotherapeutically with the issues.
- The incapacity to sustain a collegial relationship once the supervisory alliance starts.

The supervisor or the supervisee needs to recognize the issue, if they arise, and bring them up during the supervision for discussion and resolution.

The supervisor wants to control the entire therapy of the supervisee

The greatest skill of supervision is to balance a student's leadership and to leave them free space to take responsibility for caring for their clients. Some supervisors struggle to find this balance and provide them with too much guidance (Gauthier 1984). This is difficult for novice therapists, as this may become an addition which may make them feel inadequate. Furthermore, if the supervisees disregard the supervisor's advice and go their way in the session, they might regret it. This situation should be managed according to the supervisor and supervisee's experience level. Following the supervisor's advice is usually recommended if the supervisee is new to the therapy. However, the supervisor should raise this issue later, especially if they accuse the supervisee of not following their recommendations. Instead of criticizing the supervisor's behaviour, the supervisee could tell the supervisor how it affects them. For example, they might say that taking control of the therapy makes the supervisee think their ability to make therapeutic decisions is not developing. On the other side, supervisees benefit from being open to constructive criticism.

The supervisor and supervisee have different theoretical orientations

Sometimes supervisees work with supervisors who do not share the same theoretical orientation. This might happen when students are supervised before they can choose for themselves. Trainees may be confused about whether they can recognize the direction of their supervisor (Gauthier 1984). If they do, they usually have to go against their beliefs about understanding and treating

Box 10. Case vignette – Automatic thoughts of the supervisee

Supervisor: I understand that you often work with similar clients. In what ways do you think this case is different?
Supervisee: I feel messy with him. Like I'm confused about how to understand him and what to do...
Supervisor: I'm glad you're talking about these feelings. What goes through your head when you feel confused? Can you remember the last time you felt confused?
Supervisee: Let me think...
Supervisor: Okay, take it easy, remember…
Supervisee: Last time he spoke about his job and family, he kept changing the subject. That's interesting. I have a series of automatic negative thoughts at times like this... I tell myself I'm a bad therapist. That good therapists know what to do, and I've already been doing four sessions of just taking the anamnesis. I cannot connect the dots. A good therapist knows how to help clients and is not confused. I say to myself that I must prepare more the next time. I look in the textbook about how to work with such rambling and long-winded clients.
Supervisor: You captured your automatic negative thoughts nicely. Perhaps they would be worth cognitive restructuring. What do you think?
Supervisee: Well, that might help me.

mental health problems best. In addition, if students follow their orientation and are supervised by someone from a different school, they risk being inadequately supervised. An open and respectable discussion usually helps resolve this issue. Most supervisors want supervisees who have the same theoretical orientation. However, this does not necessarily mean supervisees are not allowed to seek a supervisor with a different theoretical approach or that it would necessarily harm the supervisee. Learning various types of therapy can eventually make a novel therapist a better therapist. The experience gained from other supervisors will affect their work, regardless of the orientation they end up with. Acquiring a variety of supervisory experiences can also positively change supervisees' careers.

Therapists sometimes look for supervisors according to their orientation and then realize that the supervisor does not place the expected emphasis on it. For example, a trainee may seek a CBT supervisor but note that feedback and advice are often more psychodynamic. The trainee might feel disappointed that they are not receiving the supervision they want. Some supervisors understand this, and although they may work more eclectically, they may focus more on one direction in the supervisory relationship (e.g., cognitive-behavioural approach). Other supervisors are less receptive and require students to follow their advice, even if this does not match the student's understanding of what a CBT therapist should do.

When the ideas concerning cooperation are major and irresolvable, it is usually possible to change the supervisor. Still, such change may be difficult, especially for trainees in the middle of the course. If the change is impossible, the best strategy is to discover what can be learned from this experience. Even a negative experience can bring positive results – a therapist might deepen their understanding of their preferences regarding their work, or they will learn to set clear contracts with future supervisors. It is highly recommended to prepare questions for the first meeting with the supervisor and interview them before making a contract, without relying on the formal record of their resume or the stories of others.

Supervisee's fears of supervisor's negative assessment

The supervisor's assessment may be the biggest concern for novice therapists in a supervisory relationship. This concern is not unfounded, as supervision usually includes an evaluator aspect. Supervisors might become so focused on providing hints leading to improvements that they may forget to praise and otherwise reinforce the strong elements of the supervisee's work. This tendency enhances the natural inclination to bring problematic parts of therapeutic sessions into supervision. Trainees that lack positive reinforcement often leave a supervision session feeling discouraged and thinking their work is poor. This can negatively affect therapy, as novice therapists try to focus more on doing "everything right" for fear of reprimands during supervision. One possible way to deal with the fear of negative evaluation is to restructure the perception of the supervision. Once novice therapists find that the feedback encourages and helps them, they relax and become more open to constructive criticism. The safe place of supervision also helps to practice the therapist's assertive communication in which they might ask for positive reinforcement if they want more of it.

Another reason for concerns about a supervisor's evaluation is that the basis for assessment is elusive and unclear. What happens if a supervisor misinterprets their supervisee's idea? Moreover, what about the treatment of a client who is not improving? What happens if the client interrupts the therapy? Do these events lead to a worse assessment or other negative conclusions? The best way to clarify this is to determine the supervisor's evaluation criteria at the beginning of the supervision. Supervisees would benefit from knowing that developing therapeutic skills is gradual and that the evaluation is not black and white. Supervisors look at the "broader context" when evaluating – the general tendency to grow in the primary assessment areas.

Lack of time for supervision

In contrast to overly careful supervisors, some supervisors do not have time for their supervisees. They may skip supervisory meetings or reject them, and they cannot be reached outside the set time for supervision, even in very difficult situations. When such supervisors eventually meet with their supervisees, the meetings are very quick and are often interrupted by phone calls or other people. Regardless of the exact nature of the problem, students do not receive sufficient supervision. This is problematic for many reasons. First, the consequence of such management is a poorer quality of client care. As mentioned, no supervisor expects supervisees to start training and have the skills to do quality work. However, supervision meetings need to be conducted with higher quality standards from the supervisor's side.

Along with a poor quality of client care, inadequate supervision also results in a poor experience for the participants. Supervisees then feel they have not acquired any new skills or knowledge (Gauthier 1984). They also do not have the opportunity for someone to advise them. They will also be unable to learn how supervision is done - what they will learn best through their supervisory experience.

When dealing with this issue, supervisees are encouraged to be open to their concerns – to tell the supervisor they feel they are in a vacuum and need more frequent and regular supervision. While finding time for supervisees is definitely up to the supervisor, the supervisees can also come up with some suggestions. Maybe it would be better if the meetings took place at different times, if the case studies were occasionally discussed by phone, or if, for example, they found a suitable

replacement for the supervisor. Some supervisors will be open to requests for improved supervision and will do their best to be aware of the effect of their behaviour on both the supervisees and their clients.

When open communication and problem-solving do not improve the availability of supervision, supervisees may express concerns over the possible consequences of insufficient supervision. If this does not effectively change the situation, the supervisee will benefit from looking for another supervisor. Supervision is a complex task requiring teaching and clinical skills, as well as an awareness of the numerous responsibilities of the position (Whitman & Jacobs 1998). Supervisors are responsible for ensuring that clients receive satisfactory treatment. Evaluating supervisees within an educational framework is the primary responsibility of the training program and profession. Finally, a supervisor's responsibilities include self-examination during supervision. Engaging in self-reflection might help the overburdened supervisor find a cause and solution to their busy schedule.

Disagreement on moral/ethical issues

Clients sometimes share sensitive information that may be a cause for concern for their therapists. For example, a client may occasionally talk about suicidal feelings, have sexual fantasies about their therapist, offer gifts, report that they engage in illegal activities, or know about the ill-treatment of children. In any such situation, consultation with the supervisor is, of course, necessary. The supervisee and the supervisor may have different views on resolving these issues. For example, a supervisee may think that a client's suicidal ideation is false, while a supervisor may think otherwise. In such situations, it is especially important to talk about these differences.

The trainees need to know that their supervisor has ethical, moral, legal, and professional responsibility for clients. The supervisor's decision should be respected if it aligns with good practice and the country's legal norms. If the disagreement cannot be resolved, the trainee might ask for an opinion from another expert.

A supervisor is trying to be a therapist for the supervisee

Therapists should not use the supervisory relationship for personal therapy; the supervision's goal is to help their clients. Still, it is sometimes difficult to set this limit because it is justifiable for the supervisor to comment on or ask about the supervisee's behaviour (Gold 2004). This creates a dual relationship, however, in which the supervisor acts as both a supervisor and a therapist. Knowing about a supervisee's personal life can affect the supervisory evaluation of their work, and this assessment sets out the boundaries that need to be met. The supervisee's responsibility is often to avoid personal questions in the supervisory relationship. Sometimes, however, the supervisor initiates the therapeutic approach while the supervisee tries to distract themselves during the supervision meeting; an open conversation with the supervisor best resolves these problems.

"My supervisor is my boss."

Supervision by superiors can be perceived as an obstacle to quality supervision, as mutual relations of superiority and subordination can negatively affect the supervision process. If the supervisor has managerial competence towards the supervisee and has a direct say in their position, rewards or salary, it can trigger anxiety and concern in the supervisee. This is even more true if the supervisor applies a critical approach to the supervisee's progress and asks questions to which the supervisee does not know the answer. This approach may create a need for the supervisee to report the results of the therapy overly positively. Supervision by a superior should, therefore, only be applied in exceptional cases and only under the condition that the relationship between the supervisee and the supervisor is based on mutual respect.

Supervisor inappropriate behaviour

One of the most difficult situations that novice therapists encounter is inappropriate supervisor behaviour. There is old evidence of a high incidence of sexual harassment by supervisors (Fitzgerald *et al.* 1988), with recent statistics being unknown. Supervisors can flatter their supervisees too much, ask them personal questions (such as about their relationship or supervisee relationships), and even make sexual suggestions. Such behaviour is very uncomfortable for supervisees and leaves them uncertain how to resolve the situation. There are many reasons why this type of situation is so difficult to deal with. First, there is a power imbalance in the supervisory relationship. The supervisor has a certain power over a trainee's career and, in a sense, their future. Supervisors will provide recommendations when applying for further education or work and sign the documents required to obtain a license. Novice therapists may fear problems if they do not comply with a supervisor's demands. Many beginning therapists who face this difficult situation also feel insecure because they do not know whom to turn to.

In professional circles, colleagues seem to be friendly with each other, and students or young specialists might worry about whether there is anyone who will respect their confidentiality requirements. Another common worry is whether complaints will be taken seriously. The main problem with this inappropriate behaviour is often a lack of evidence that something has happened. Many supervisees fear they will not be believed if they complain about inappropriate behaviour. In light of these concerns, deciding to deal with this ethical issue is often just the start of the process. Authors recommend that the best way to approach this is to be assertive and direct - to say what the issue is, why it is problematic, and how the problem could be resolved. It

Box 11. Case vignette – The client smelled of heavy perfume

A supervisee talked about his work with a client who suffered from agoraphobia. The client worked hard and achieved partial progress in exposure therapy. During the therapy, however, she fell in love with the supervisee. She was trying to demonstrate how well she handled the individual exposures and was progressing too quickly. Travelling outside the city was too difficult for her, and she stopped the exposure altogether. She was ashamed to reveal this in therapy, so she lied that she was successfully continuing her exposures. The supervisee was delighted with her good work. However, he noticed that the client was much more attentive to him than usual. She would bring small gifts such as nuts or bananas to the session. She also smelled prominently of heavy perfume. The therapist ignored these signals because he did not see them as important when the treatment was progressing so well. He was surprised and exasperated by the client´s husband, who called the therapist for advice on how to help his wife take a holiday across the country when she has not yet been able to go outside their city. She recently had to take high doses of sedatives to leave town with her husband. The husband, therefore, asked whether it would not be better for the client to receive sedatives before the trip.

The supervisee concluded that he would have to confront the client about the situation, and suggest to her that she had not been telling him the truth and also point out the transference situation that her relationship with him was developing outside the therapeutic boundaries (according to him, she was in love with him). He was uncomfortable doing this because he imagined how hurtful it would be for the client.

The supervisor suggested that he would play the role of the client, and the supervisee would try to find a way to say it. The supervisee was embarrassed at first but then said it quite matter-of-factly. They then switched roles so the supervisee would note how he perceived himself when the supervisor replayed the therapeutic intervention.

is difficult to determine whether this would be effective due to the inappropriate behaviour of some supervisors. Although supervisees want to stop unacceptable behaviour, they do not want to risk their situation worsening.

In some cases, supervisees may feel that the supervisor is open to feedback and is worth talking to. However, this is not always possible, and it will be necessary to transfer the matter to a superior - the head of the course, the department, or the professional ethics committee. Supervisees need to consider whether or not to address this situation during the training experience. Trainees need to be encouraged to deal with situations in which supervisors behave inappropriately. It is likely that the supervisor has treated others similarly and will continue to do so. This has several important consequences. A complaint about inappropriate behaviour may not be the first; it could confirm other complaints and clarify the case of an unethical supervisor. Secondly, a complaint could protect future supervisees in a similar situation.

Another basic recommendation is to document everything. Although it would be unethical to secretly record a supervision meeting, taking notes after each supervision meeting can be very useful. These comments can be used to complain. If supervisees raise their complaints after the training, some people (especially the accused supervisor) might question the accuracy of their complaints. The complaint will therefore be much more convincing if the events are documented.

A supervisor helps their supervisee use guided discovery to recognize the wider framework of what is happening in the therapeutic alliance, especially when focusing on transference and countertransference (Box 11). Without the proper formation of a therapeutic

Box 12. Case vignette – The client wanted advice from the therapist

The supervisee reported their work with a client with a depressive disorder. This client greatly admired the supervised therapist and wanted her advice and recommendations about what to do. This became frustrating for the supervisee because she felt overwhelmed by the client's needs and felt she was failing as a therapist and providing supportive therapy instead of CBT. Therefore, she confronted the client with the situation and uncompromisingly informed him that he must figure everything out by himself and that it was impossible to give him advice all the time because he would thus continue to rely on others. The client fell into despair and attempted suicide. The supervisee did not know how to behave towards him in the therapy session on his return from the hospital.

The supervisor asked the supervisee what she needed as a therapist and what she thought her client needed. She needed to tell him that she was sorry for what happened. On the other hand, she wanted him to learn to make decisions for himself and support him in this gradually. In her opinion, the client would need acceptance, especially after trying to kill himself, and for the therapist to show that he can learn to make his own decisions but that they could do it gradually, step by step. The supervisor appreciated how the supervisee had thought about the needs of both parties and offered to role-play the client so that she could tell him that. When supervised in role-playing, she was sensitive and firm at the same time. She was satisfied when the supervisor replayed her reaction when changing roles. The subsequent session went well, and the client started to improve.

Box 13. Case vignette - Supervisee admires the client

The supervisee admires her client during her supervision. She does not notice that the client makes unreasonable decisions in life in marriage and work. On the contrary, she thinks that he makes competent decisions. The client often stays at work after hours with a female colleague who is attracted to him and rarely presents at home, where his wife becomes jealous of him. Similarly, the husband of this colleague becomes jealous. The supervisee still talks enthusiastically about the uniqueness of this client, who has the right to be free. The wife is said to be cold, and the client needs kind contact with co-workers. She has a friendly relationship with the client, and she thinks the client deserves a good connection with her colleague at work.

The supervisor expresses understanding of the supervisee's enthusiasm for the client and communicates that it is obvious that the supervisee wants to help the client very much. Then she invites the supervised therapist to think together about the therapeutic relationship and whether it is possible to create more distance in it. She asks if the relationship with the supervisee reminds her of other relationships in her life. If she has someone she likes very much, she wishes him freedom and a warm relationship? The supervisee thoughtfully says it is similar to the son who has a cold girlfriend whom she does not like very much. However, she does not allow her son to speak about the relationship because she fears rejection. The supervisor appreciates the honesty of the supervisee. Something from her relationship with her son may carry over to her relationship with the client. It's a hypothesis she could explore further. Then she offers that they can together create, with the help of stuffed animals, a probable dialogue with a client who is very successful at work but whose marriage is failing. They could use mods to create a situation with a wife and colleague. She puts small stuffed animals on the table. She asks the supervisee to use them to model what can hypothetically happen with individual modes in a married relationship and what is in a relationship with a colleague at work.

relationship, specific therapeutic strategies cannot be used (Gold 2004; Prasko *et al.* 2022).

Complications in creating a therapeutic alliance may mirror a client's trouble with relationships in their life and their transference into therapy. Therapists frequently do not have adequate distance and are not objective in evaluating the relationship with the client (Vyskocilova & Prasko 2013). This is not because they do not want to develop the relationship appropriately but because the client's adversities in childhood and stories about conflicts may emotionally overwhelm them. The task of a supervisor is to help the supervisee recognize the circumstances and map countertransference to the clients (Box 12).

Supervision supports understanding. Mere knowledge is unsatisfactory because, lacking continuous supervision, the initial faults can be reinforced by repetition. A therapeutic alliance needs the therapist to form a safe atmosphere, listen, reflect, understand, appreciate, strengthen, and maintain hope (Bennett-Levy *et al.* 2009). Reduced therapeutic alliance may produce client resistance (Leahy 2003). The therapeutic relationship is thus central to supervision (Praško *et al.* 2011). A supervisor can help recognize what is happening in the relationship between the supervisee and the client, both from the therapist's report about the client and through guided discovery, role-playing, and imagination.

3b) Problems with therapeutic relations connected with the supervisee

The supervisee's relationship with the client is influenced by transference and countertransference. In the case of therapist-to-client transference, the distortion is caused by past experiences with people the client resembles in certain characteristics or manifestations. In the case of countertransference, the therapist reacts to the client's transference behaviour (Andersen & Przybylinski 2012). It is essential that the supervisor can help the supervisee to realize and manage these processes for the benefit of the client and themselves (Yourman & Farber 1996). The influence of transference and countertransference on the formulation of the case can disrupt the objectivity of selecting client data and the way it is processed (Box 13).

A sensitively built therapeutic relationship, monitoring and re-evaluating the therapy process and self-reflection are the main antidotes to distorting ideas (Prasko *et al.* 2021c). The function of supervision is irreplaceable in this case (Reichelt & Skjerve 2002). The supervisor's task is to identify unconscious processes, help the supervisee become aware of them, and use them for therapy (Prasko *et al.* 2022) (Box 14).

The supervisor helps the supervisee to reflect on cognitions and emotional reactions to the client and determine whether they are based on facts or unfounded interpretations or whether they are a reaction to the client's attitudes or experiences with similar clients (Box 15).

There are similar processes, mechanisms, and phenomena in supervision as in client therapy. A supervisor should recognize difficult therapist emotions, for example, hostility, helplessness, tension or loss of boundaries, and make it clear in supervision (Prasko *et al.* 2010; Prasko *et al.* 2022) (Box 16).

Supervision is especially important when treating difficult clients, such as those with eating disorders, health anxiety disorders, or personality disorders, or when a conflictual or powerless situation arises in therapy. Supervision helps to understand what the therapist could not recognize when they were overwhelmed by their countertransference.

Box 14. Case vignette – What makes this client so special to you

Supervisee: I would like to discuss the 17-year-old client Alena in today's supervision. I'm worried about her.
Supervisor: Okay. I can see that it bothers you. How do you feel now that you have to talk about her?
Supervisee: I'm nervous and afraid that it will turn out that I don't understand her or that I'm doing something wrong!
Supervisor: Good that you talk about it. It must be important because, as I know you, you are usually calm during supervision. How is this client different from other clients?
Supervisee: Honestly, I don't know at all. I was surprised by my reactions. I have worked in psychotherapy with adolescents and young people for many years and enjoy the work. However, my emotional responses to Alena are very strong. I don't know why that is, and I would like to understand it more.
Supervisor: Do you mind asking me what you think about Alena when you are experiencing tension and fear that you will not understand something or do it wrong?
Supervisee: I think I should help her immediately if possible. I should also offer her more sessions. She is young and has already experienced so many traumatic things! It's not fair! I'm afraid she's so affected that anything could happen between sessions. She has no support in the family. Her relatives do not believe she is so sick that she cannot care for herself. I get mad at her sometimes too!
Supervisor: Thank you for describing your experience. Do you think about this client outside of the session?
Supervisee: Quite often! I'm tired of always thinking about how to help her more. Each time he brings different pressing issues to the session, we don't get to work on a problem systematically. Maybe you could help me with that?
Supervisor: The question about appropriate strategies is good, and I see you're thinking a lot about this young lady. You told me it was unusual for you in some way. What makes this client so special to you?
Supervisee: I feel sorry for her. I empathise with her complicated story. No one helped her, not even her own family. I want to be different. I wish her a good life!
Supervisor: Thank you for this answer. What do you think about this reaction of yours?
Supervisee: When I hear myself, it sounds exaggerated.
Supervisor: It's interesting how you look at it yourself after you said it. This may be valuable to you. Do you think it might be related to the client's story and the formulation of her story?
Supervisee: I didn't think of that. I didn't think about it from this perspective. However, it could be related to her story ... (pause). Well, I can think of something. Six months ago, her sister, on whom Alena depended, went to work abroad. The nurse had to discuss every decision with her beforehand. The client wants something like this from me now. Every time she comes, she wants me to help her decide. If I don't discuss it in detail with her, you can see the tension and anxiety on her face.
Supervisor: That is a good point and an interesting hypothesis about what happens in the therapeutic process. How do you feel now?
Supervisee: I'm quite relieved. Like I feel more congruent, more myself.

Transference and countertransference reactions are part of the normal therapeutic relationship and, if reflected upon, can benefit the therapy process. It is important to find the connection between the formulation of the client's case, the therapeutic process and the problems in the therapeutic relationship (Prasko *et al.* 2022). It is then possible to reformulate the case and find a different treatment plan.

3c) Obstacles in therapeutic relations connected with the supervisor

Countertransference connection to the supervisor's schemas

The attention paid to the emotional and cognitive reactions of the client, therapist, and supervisor is a basic component of cognitive behavioural therapy and its supervision, especially when supervising work with difficult issues (Lombardo *et al.* 2009). Despite step-by-step

Box 15. Case vignette – Supervisee criticises the client

During supervision, the supervisee charged her client. She disliked him, slandering him as a self-centred and selfish person who makes secondary gains from his depression. She doubts that the client is depressed because he can even laugh. When asked about the relationship, she said she felt comfortable with the client during contact and liked him.
The supervisor asked the supervisee to draw two columns on paper. In the first, she should write the client's negatives and the second, the positives. The supervisor repeated to the supervisee what she had said about the client. He then asked how she understood the self-centredness and selfishness she wrote in the negatives from the client's story. Why did the client treat some people this way? Were there also people the client didn't treat like this? How did he treat her? The supervisor then asked the therapist to sit in the Prosecutor's chair, from which she conducted the client's prosecution. Then she transferred her to the Advocate's chair. In the end, the supervisor asked the supervisee to sit in the Judge's chair, who would consider the speech of the Prosecutor and the Advocate and give the verdict as she understood the client. The supervisee, as a judge, spoke kindly of her client.
The supervisor noted that it was interesting that she previously saw the client in what she said about him alternately in a detached, negative light and then in a positive light. In the role of judge, he saw him somewhere in between. He asked the supervisor what she understood from her story.

Box 16. Case vignette – Supervisee labelled the client

During supervision, the supervisee spoke critically of his client as a stupid, limited person. The client did not improve in therapy, and they repeatedly planned steps in the treatment together, and the client did not take them. According to the supervisee, he did not cooperate and did not want to get rid of the symptoms he suffered from. The supervisee criticised the client and sought approval from the supervisor of his opinion that the client was unmotivated for treatment and was stupid. He also thought that we, as therapists, are the smart ones.

The supervisor understood the therapist's frustration when the client did not improve. He went back to the last session with the client and asked the therapist to describe the situation when he felt most frustrated. It was a situation where the client said he could not write his homework. The supervisor asked how the supervisee felt about it. The supervisee felt helpless and betrayed. He told the client that if he did not do the assignments, he could not improve. The supervisor asked about modes that were popping up in the therapist. The Vulnerable Child appeared first, then the Critic. What did the supervisee need most at that moment? The supervisee realised that he most needed the appreciation that would come if the client did his homework well.

The supervisor then asked the supervisee to empathize with the client's needs when he came to the session and could not complete the homework. According to the supervisee, the client was in Compliant surrender mode. What client schema was based on? Probably from the Failure scheme. As a child, he was often criticised by his father for being incompetent and then failed in school because he did not believe in himself. So, what did the client need at that moment? According to the supervisee, the client required acceptance.

The supervisor offered to play the client, and the supervisee tried to respond in a way that might meet both needs. In role-playing, the supervisee said to the role-playing client: I understand the homework could not be completed. This happens sometimes; it is possible that we need to go through it together again and prepare for it. Last time we rushed the input, I did not ask if you understood it well. We will try to fix it now.

treatments and an emphasis on techniques, countertransference is ubiquitous and part of all therapeutic and supervisory relationships (Gold 2004). To guide a client or supervisee well in uncovering their thoughts and emotional responses, the therapist and the supervisor need to recognize, label, understand, and express their emotions (Lombardo *et al.* 2009). Understanding one's limitations and resistance to change is essential for understanding the client, therapist, supervisor, and oneself (Leahy 2003). When the supervisors recognize the emotional responses a supervised individual evokes, they can consider how they are likely to respond, at least partly, to their client. Sometimes the supervisors talk about the so-called parallel process - the client's reactions to the therapist, such as those evoked by the therapist in the supervisor (Box 17). However, this view must be taken with caution because it has never been scientifically proven with certainty.

We mainly capture the countertransference reaction in our behaviour, thoughts, emotional experiences and physical symptoms. CBT includes the full expression of emotions during therapy because the therapist is, among other things, a model for the client to behave naturally while cultivating and mature. The same is true for supervision. The supervisor becomes a role model for the therapist, especially if the supervised individual is in training and is just beginning to develop their therapeutic style. Just as a therapist encourages the client to pay attention to their bodily reactions, it is important to pay attention to their own, as they may be alerted to unconscious processes in the therapeutic relationship. The supervisor needs to do the same. Physical reactions often reveal emotional motives that we are unaware of or automatically divert attention from because they are difficult for us to tolerate. Every change in the therapist's physical and emotional experience or behaviour

Box 17. Case vignette – Supervisee wants diagnosis from supervisor

During supervision, the supervisee communicated the client's symptoms, talked about the differential diagnosis, and repeatedly asked the supervisor's opinion on the most likely diagnosis of the client. It was clear that the supervisee wanted to confirm their diagnosis. The supervisor initially felt pressured and anxious about not being able to respond to the supervisee, and both were tense. The supervisor then described her feelings and emphasized that the supervisee was treating a complicated client and, understandably, that one can feel powerless in the role of therapist.

The normalisation of the supervisee's response (with so many symptoms, anyone can feel lost) allowed a search for the transference between the supervisee and the supervisor (the supervisee treated the supervisor as omniscient). The supervisor named his own emotions and mode (anxiety, confusion, Vulnerable Child mode) and described that he felt similarly when tested by the teacher at the gymnasium (possibly transferred to the therapist).

Then she looked for a response, looked for the right answer in his imagination and applied it to the supervisee as a "Healthy adult" (giving responsibility for the client to the supervisee). She shared, "I can see he's a difficult client, and I feel chaos. You have done much work because you have so much information about him." The supervisor asked for a diagnosis: "Which diagnosis best fits your description and would be the most likely?"

Tab. 2. Countertransference as an activation of therapist or supervisor´s schemas

Excessive requirements	Supervisors or therapists with anankastic traits often see clients or supervisees as irresponsible, spoiled, or lazy. They believe expressing emotions or insecurity can be threatening or devastating. They have difficulty expressing warmth and empathy for the client or supervisee and place excessive emphasis on "logic" and "rationality". Supervisees may feel that supervision is an opportunity for them supervisor to show that they are smarter than their clients. A perfectionist supervisor may attempt to compensate for his lack of competence by demanding perfect performance from themselves or a supervisee.
Abandonment	A supervisor with an insufficiently processed abandonment schema may be concerned that if they confront the supervisee with something negative, the supervised individual will change supervisors. The premature termination of supervision is understood as a personal refusal of the supervisor. A supervisor under the influence of an abandonment scheme may behave in various ways that reflect that pattern: for example, they may take extreme care of the supervisee on the one hand, but on the other hand, they may avoid entering into a meaningful contract. Extreme care can protect the supervisee from difficulties, offering advice, procrastination with negative feedback, or a preferential solution to the supervisee's problems that they have in common with the supervisor. A supervisor who avoids establishing a relationship often focuses on conceptualisation and techniques rather than meaningful discussions about building a relationship. Such a supervisor avoids more difficult topics and anxious provocative interventions. They usually take the supervisee's different views, missed sessions or lack of interest in supervision badly. The supervisee's resistance is often perceived as a personal rejection.
Excessive need for acceptance	A "likeable" supervisor can be very proficient in showing empathy for a supervisee. They believe the supervisee should feel good no matter what happens. Many supervisees appreciate a supervisor's warmth and empathy because they never express negative emotions or confront shortcomings. This type of supervisor usually avoids questions about a supervisee's negative emotions, as these topics seem to upset them and are unacceptable. A supervised individual may miss meetings, be late, or not do homework. A supervisor with an excessive need for acceptance does not want to "provoke a conflict" and so tolerates it all. If the therapist fails the client, the supervisor tends to blame themselves for their incompetence. Their attitude tells them, "if a therapist fails, it is my failure."
The need for exceptionality	A supervisor with narcissistic personality traits sees supervision as an opportunity to show off their exceptional talent. Supervision of a complex case can begin with glorious hopes and the supervisor's statement that the supervisee has finally found a "true supervisor" to help them solve everything. They like to advise and know everything best. The supervisor's investment in the image of being the best, a "special" supervisor can denigrate all therapists who have "failed" in treating a difficult client. On the other hand, supervisees might need to cooperate with and admire the supervisor. This can encourage the supervisor to show off, make surprise interventions, or break boundaries themselves. If the therapy does not work, the supervisor will become bored, angry, or criticise the supervisee. Rather than empathising with the supervised individual's understandable frustration Changing the narcissistic perspective is difficult because it always tends to see mistakes in others. To change a selfish perspective, we must be able to ask ourselves: How would I feel in the position of this supervisee?"

toward the client and the supervisor toward the supervisor indicates automatic thoughts. Changing the tone of voice, feelings of insecurity, urgency, command, reluctance to supervise, or lengthening or shortening meetings, are typical manifestations of countertransference reactions.

Countertransference is often affected by the therapist's or supervisor's core beliefs and conditional rules. Different clients or supervisees can activate various schemes. In this context, Leahy (2003) described several schemes (Table 3).

4. SUPERVISOR DRIFT

CBT supervision is a highly structured, agenda-driven method that provides a significant challenge. The term "supervisory drift" describes instances in which core supervision components, such as outcomes monitoring, direct observation, and mutual feedback, are omitted, avoided, or deprioritized (Townend *et al.* 2002). Despite promoting action-based methods in leading supervisory texts, many reviews indicate that action-based procedures are used relatively infrequently in CBT supervision. Townend *et al.* (2002) have identified symptoms of supervisor drift, such as the lack of structure in supervision sessions, the absence of a supervision contract that outlines express learning objectives, insufficient clarity in the learning agenda within sessions, and an inclination towards the excessive utilization of case conceptualization, case discussion, and symbolic methods. Additionally, supervisors tend to rely too heavily on teaching and directing, while active, experiential learning is minimal, and homework usage is restrictive. Audio or videotaping is also limited. The session lacked enactive learning methods such as role-playing, rehearsals, and feedback. There was a shortage of routine clinical outcome monitoring or limited utilization. Objective evaluation methods, such as adherence competence rating instruments, were either absent or employed to a limited degree. Furthermore, various ways to ensure accurate and constructive feedback were not implemented. Lastly, culture and issues of difference in the supervisory relationship were not addressed explicitly.

Pugh & Margetts (2020) suggested that several aspects could potentially lead to supervisory drift, such as a lack of knowledge regarding supervision approaches, pessimistic beliefs about these approaches, apprehension and humiliation during their enactment, the desire to protect the supervisory relationship instead of risking it with difficult conversations and the lack of time to incorporate certain methods in a supervision session. Possible factors are it potentially dived:

Experiential level - previous experience in supervision impacts the supervisee, and the supervisor comes to the supervisory relationship with their expectations of what should happen during the sessions and their views on the overall goal (Roscoe 2021).

Cognitive level

- *Supervisor cognitions* - Supervisors bring their own beliefs about themselves and understanding of therapy to the supervisory relationship. These personal and therapeutic beliefs shape the supervisor's "supervisor self" based on supervision experiences, including supervisor training. Supervisors can find it difficult to take on the normative aspects of supervision due to their schemas, such as needing approval. It is not yet known which supervisor cognitions are specifically associated with supervisory drift, but there will likely be similarities to those associated with therapy.
- *Supervisee cognitions* - The drift can be supervisee-led, as they may have certain beliefs and assumptions that influence how they behave in supervision. These could be personal self-beliefs, therapist self-rules and assumptions, or situation-specific negative automatic thoughts. Views such as *"The supervisor is always right"* can prevent a supervisee from suggesting changes to how supervision is structured, such as being reluctant to suggest the supervisor include more modelling in sessions.

Emotional level

- *Supervisor emotions* - Supervisors, especially newly appointed supervisors, may feel anxious about being seen as knowledgeable enough for the role or embarrassed about their clinical work if the supervisee is likely to criticize them.
- *Supervisee emotions* - Supervision involves supervisees letting others see and evaluate their clinical work, which may trigger a range of emotions such as anxiety, fear, shame, embarrassment, or sadness. Failing to normalize or name these emotions within supervision could lead to supervisees engaging in safety-seeking behaviours to protect themselves.

To summarise, Supervisor and supervisee cognitions and emotions can lead to supervisor and supervisee behaviours that perpetuate drift in supervision. Drift may go unnoticed or unchallenged in routine practice.

Potential solutions

- *Staying on track:* Avoiding drift at the outset is preferable, but all supervisors and supervisees are human, so errors are unavoidable and to be expected. The key is spotting errors and responding appropriately. It is essential to become familiar with best practice guidance and regularly use it in supervision. With these principles in mind, supervisors and supervisees can jointly reflect on whether supervision sessions have included these facets regularly. For supervisors, reviewing the supervisory dynamic could be seen as cyclists 'pulling over' to rest, examining where they have been and are going.
- *Anticipating problems before they arise:* To normalize interpersonal and intrapersonal reflection within supervision, gathering a basic overview of the supervisee's personal and therapist self-history can be helpful. The supervisor can ask the supervisee questions about managing the supervisory relationship, such as "What background information do you think it is important for me to know about you?" or "How might we address differences of opinion?" The responses can then be used to anticipate instances in supervision where these might be relevant.
- *Adapting supervision to the supervisee's needs:* Effective supervisors will consider the supervisee's emotional, learning and context needs. Supervisors should consider the supervisee's learning style preferences and the context in which the supervision takes place to move between normative, formative, and restorative tasks. Trainees may need a greater focus on the supervision's normative or formative aspects, while inexperienced therapists may need a greater emphasis on the formative elements.
- *Using active supervision methods to understand drift better:* Supervisors can help supervisees understand the concept of self-multiplicity and how to use role-plays to explore the different selves of the supervisee. The 'different selves , 'can help the supervisee gain meta-cognitive awareness of their motivations. For example, the supervisor might ask the supervisee to interview their 'resistant self. " Supervisors can use chair work to help supervisees handle criticism, including managing personal sensitivity to criticism and negative feedback, by interviewing the supervisee's "personal self" and "therapist self." The supervisor can also add a playful aspect to supervision by asking the supervisee to shift between chairs. The supervisor can start by interviewing the supervisee's self to find out why they are sensitive to criticism, and then the therapist self, who can give reasons for incorporating video into supervision. The supervisor can end by asking the supervisee to talk to the personnel and therapist to find a balance.
- *Supervision of Supervision (SoS):* SoS involves a process of reflection to help the supervisor consider how their various selves contribute to their

Tab 3. Examples of ethical problems described by supervisees

- My supervisor humiliates me and makes negative personal comments about me, sometimes in front of other supervisees.
- I used to be friends with a person who supervised me. Do we have to cut our friendship? I don't understand why, as long as it is after work hours.
- My supervisor openly discusses another worker's inadequacies with me, yet he never speaks with the worker about it.
- My colleague plays computer games the whole day and does not spend much time working with clients. My supervisor was unwilling to address it and said, 'Mind your own business. He gets his work done, and that's all that's important.'
- A good friend of mine approached me with a request to take on her six-year-old daughter, who struggles with anxiety as a client. Even before that, I had been pointing out that I didn't like how she raised her daughter and how anxious she was towards her. If I decide to take on the daughter, won't that ruin our relationship?
- My 15-year-old client tried to commit suicide and is now in a psychiatric hospital. I'm blaming myself for whether I made any mistake in the therapy, but the client wants to see me in the hospital anyway. Should I come to her during visits and arrange further cooperation? Won't the psychiatrists blame me for the mistake?
- A fellow therapist asked me whether I would take an acquaintance of his into therapy. However, the client has a problem that I do not specialize in. If I don't take him on, he might think I'm inconsiderate, but if I do, what if I'm not competent enough to deal with the client's problem?

supervisory practice. Supervisors may struggle to be objective about their supervisory competence or blind spots, so engaging in SoS is essential for developing and improving the capacity to de-centre from supervision. A fresh set of eyes allows an impartial observation of the dynamics that are in operation between the supervisor and supervisee. The meta-supervisor can also use frameworks to provide feedback on the supervisor-evaluee's skillset.

- *Alliance measures:* Supervisory alliance is important for effective supervision. However, there is limited evidence on how widely these measures are used in CBT supervision. Supervisory alliance is important for effective supervision, but there is limited evidence on how widely these measures are used. A validated alliance measure could facilitate the disclosure of helpful negative feedback and allow for a mutual exchange of feedback about each party's experience of supervision. Supervisors need to keep themselves in balance by recognizing when a supervisee or their clinical practice has changed. They should use appropriate strategies to negotiate an ongoing change in supervision, such as group supervision. Supervisors' personal and professional beliefs can impact the consistency or inconsistency of behaviours that result in supervisor drift.

Supervisors who hold strong, healthy beliefs or are more aware of their triggers are less likely to give up on evidence-based practice. Even though supervisors can bring their own beliefs to the relationship, they can still become "drifted" by indulging in certain aspects of supervision, which can negatively affect the supervisee's progress and outcome.

To summarize, the supervisor and supervisee can use existing CBT principles such as self-practice and self-reflection to make sense of supervisory drift and why it occurs. A bespoke formulation of supervisory drift helps the supervisor and supervisee have a shared language for discussing the phenomenon. The supervisor can draw upon existing best practice resources, such as the EBCS framework and the range of resources, to help them evaluate and improve their supervision skills and self-reflection. These resources can also be introduced to the supervisee to promote more effective use of supervision time.

ETHICAL ISSUES

Ethics involves the embodiment of values into rules for action (Strom-Gottfried 2007). Supervisors have to support their supervisees in recognizing the four fundamentals that should be explored:
(1) The reality of a therapeutic relationship;
(2) Recognizable threat;
(3) Recognize a specific victim;
(4) Evaluation of the significance of the risk (Bolton *et al.* 2015).

The same ethical problems that could occur in a therapeutic relationship could be paralleled in a supervisory relationship (Dewane 2005; 2007; Schames 2006). From therapeutic relationship assessments to dual relationships, the supervisory relationship can be troubled by the likelihood of inappropriate, painful, and potentially controversial situations (Walker & Clark 1999). Ethical concerns are an essential part of the therapeutic or supervisory relationship and facilitate the therapeutic process in a therapeutic relationship (Table 2).

There is an ethical alarm when there is doubt or conflict about values. Values are ideals, principles, and standards that inform decision-making or activities. Largely, values tell us more about what we believe; ethics tell us more about how we act. In the spirit of a parallel process, ethical dilemmas can facilitate the supervisory process and be a good opportunity for personal insight and professional development.

One critical role of a supervisor is to help the therapist in supervision learn how to conduct ethical practice through ethical practice activities. Ethical actions result from the supervisee's values in the affiliation between the client and therapist (Schames 2006).

Some supervisors can abuse this relationship by applying unnecessary power or sneeringly playing "Father (Mother) Knows Best" (Kadushin 1992) with students. One of the most painful violations is when supervisors try to "therapy" a supervisee (Jacobs 1991). A study by Rosenblatt & Mayer (1975) found that second-year training students identified four objectionable styles of supervision: constrictive (too close), aloof (disinterested), amorphous (too loose), and therapeutic (personal), which was by far the most objectionable.

Conversely, newly promoted supervisors may feel lonely when they find former colleagues strangely distant. Kadushin, in his description of the supervisory relationship as "Games Supervisors Play" (1992), précises this reality as "they cannot party with the old gang anymore." There will always be a power differential, making a dual relationship impossible. Kadushin also talks about how supervisors avoid exerting administrative power by pretending that all relationships are egalitarian with the game "I Am Just Like You."

Supervision can be parallel to therapy in that there is a start and a finish that must be identified effectively by the supervisor. Sometimes, supervision must be changed because either the supervisor or supervisee is moving or changing jobs, or the supervisor feels the supervisee is not progressing in their approaches and knowledge of the clinical practice. These unexpected terminations should be discussed, and a referral to another supervisor should be made when possible.

CONCLUSION

Generally, supervision has positive impacts on the supervisee, whereby supervisees grow and develop through supervision. Supervision affects the therapist's self-awareness, skills, self-efficacy, theoretical orientation, support and outcomes for the client. The supervisor has to handle the process with a great deal of knowledge and empathy of what the supervisee needs to learn. The supervisor and supervisee need to maintain a trusting relationship that increases the supervisee's capability to improve and expand clinical skills to bring good care to clients. With the help of an experienced supervisor, the supervision process can be challenging for the supervisee and rewarding. When the therapist and supervisor bring certain attributes to the supervisory situation, all the more can be accomplished in their work together. Considering both its pleasures and its pains, psychotherapy supervision is a creative and fulfilling undertaking for supervisees and their supervisors. Self-practice/self-reflection is a valuable training strategy in CBT, which has a range of beneficial outcomes. It can also be used to continue personal and professional development.

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.

Acknowledgement

This paper was supported by COOPERATIO (a program of Charles University, 2022-2026, GEED).

REFERENCES

1 Andersen SM & Przybylinski E (2012). Experiments on transference in interpersonal relations: Implications for treatment. Psychotherapy (Chic). **49**(3): 370–383.
2 Bamelis LL, Evers SM, Spinhoven P, Arntz A (2014). Results of a multicenter randomized controlled trial of the clinical effectiveness of schema therapy for personality disorders. Am J Psychiatry. **171**(3): 305–322.
3 Beck JS (1995). Cognitive Therapy: Basics and Beyond. New York, The Guilford Press.
4 Bennett-Levy J, McManus F, Westling BE, Fennell M (2009). Acquiring and refining CBT skills and competencies: which training methods are perceived to be most effective? Behav Cogn Psychother. **37**: 571–583.
5 Bennett-Levy J (2006). Therapist skills: a cognitive model of their acquisition and refinement. Behav Cogn Psychother. **34**(5): 57–78.
6 Bolton JM, Gunnell D, Turecki G (2015). Suicide risk assessment and intervention in people with mental illness. BMJ. **351**: h4978.
7 Browning DM, Meyer EC, Truog R, Solomon MZ (2007). Difficult conversations in health care: cultivating relational learning to address the hidden curriculum. Acad Med. **82**: 905–913.
8 David D, Cristea I, Hofmann SG (2018). Why Cognitive Behavioral Therapy Is the Current Gold Standard of Psychotherapy. Front Psychiatry. **9**: 4.
9 Davidson K (2008). Cognitive Therapy for Personality Disorders. A Guide for Clinicians. 2nd ed., New York, Routledge.
10 Dewane CJ (2007). Supervisor, beware: ethical dangers in supervision. Social Work Today. **7**(4): 34.
11 Dewane CJ (2005). Use of self: A primer revisited. Clinical Social Work Journal. **34**(4): 543–558.
12 Falender CA, Cornish JA, Goodyear R, Hatcher R, Kaslow NJ, Leventhal G, Shafranske E, Sigmon ST, Stoltenberg C, Grus C (2004). Defining competencies in psychology supervision: a consensus statement. J Clin Psychol. **60**(7): 771–785.
13 Fitzgerald LF, Hesson-McInnis M (1989). The dimensions of sexual harassment: A structural analysis. Journal of Vocational Behavior. 35 (3): 309-326.
14 Freitas GJ (2002). The impact of psychotherapy supervision on client outcome: a critical examination of two decades of research. Psychotherapy: Theory, Research, Practice, Training. **39**: 354–367.
15 Gauthier M (1984). Countertransference and supervision: a discussion of some dynamics from the point of view of the supervisee. Can J Psychiatry. **29**(6): 513–519.
16 Gold JH (2004). Reflections on psychodynamic psychotherapy supervision for psychiatrists in clinical practice. J Psychiatr Pract. **10**(3): 162–169.
17 Greben SE (1991). Interpersonal aspects of the supervision of individual psychotherapy. Am J Psychother. **45**(3): 306–316.
18 Guest PD, Beutler LE (1988). Impact of psychotherapy supervision on therapist orientation and values. Journal of Consulting & Clinical Psychology. **56**(5): 653–658.
19 Hansen JC, Robins TH, Grimes J (1982). Review of research on practicum supervision. Counselor Education and Supervision. **22**(1): 15–23.
20 Jacobs C (1991). Violations of the supervisory relationship: an ethical and educational blind spot. Social Work. **36**(2): 130–135.
21 Kadushin A (1992). Supervision in Social Work, 3rd ed., New York: Columbia University Press.

22 Kilminster SM, Jolly BC (2000). Effective supervision in clinical practice settings: a literature review. Medical Education. **34**(10): 827–840.
23 Kuyken W, Padesky CA, Dudley R (2009). Collaborative Case Conceptualization: Working Effectively with Clients in Cognitive-Behavioral Therapy. New York, NY: Guilford Press.
24 Lambert MJ, Ogles BM (1997). The effectiveness of psychotherapy supervision. In C. Watkins (Ed.), Handbook of psychotherapy supervision (pp. 421–446). New York: John Wiley & Sons Inc.
25 Leahy RL (2003). Overcoming Resistance in Cognitive Therapy. The Guilford Press, New York.
26 Lombardo C, Milne D, Procter R (2009). Getting to the heart of clinical supervision: a theoretical review of the role of emotions in professional development. Behav Cogn Psychother. **37**(2): 207–219.
27 Milne D, James I (2000). A systematic review of effective cognitive-behavioural supervision. British Journal of Clinical Psychology. **39**(Pt 2): 111–127.
28 Milne D (2009). Evidence-based clinical supervision: principles and practice. Oxford, UK: Blackwell Publishing Ltd.
29 Milne DL, James IA (2000). Systematic review of effective cognitive-behavioural supervision. Br J Clin Psychol. **39**(2): 111–127.
30 Milne DL, James IA (2002). The observed impact of training on competence in clinical supervision. Br J Clin Psychol. **41**(1): 55–72.
31 Milne DL, Pilkington J, Gracie J, James I. (2003). Transferring skills from supervision to therapy: A qualitative and quantitative N /1 analysis. Behavioural and Cognitive Psychotherapy. **31**: 193–202.
32 Nadler RP (1976). Utilizing reflected countertransference Applying the reflection process as a teaching tool in supervision. Can Psychiatr Assoc J. **21**(3): 145–150.
33 Padesky CA (1996). Developing cognitive therapist competency: teaching and supervision models. In: Salkovskis PM, editor. Frontiers of Cognitive Therapy. London: Guilford Press; 266–292.
34 Prasko J & Vyskocilova J (2010). Countertransference during supervision in cognitive behavioral therapy. Act Nerv Super Rediviva. **52**(4): 251–260.
35 Prasko J, Abeltina M, Vanek J, Dicevicius D, Ociskova M, Krone I, Kantor K, Burkauskas J, Juskiene A, Slepecky M, Bagdonaviciene L (2021c). How to use self-reflection in cognitive behavioral supervision. Act Nerv Super Rediviva. **63**(2): 68–83.
36 Prasko J, Dicevicius D, Abeltina M, Krone I, Slepecky M, Ociskova M, Bagdonaviciene L, Grambal A (2019). How to work with conceptualization in cognitive behavioral supervision. Act Nerv Super Rediviva. **61**(3–4): 126–138.
37 Prasko J, Dicevicius D, Ociskova M, Vanek J, Slepecky M, Krone I, Abeltina M, Bagdonaviciene L (2021a). Therapeutic and supervision relationship in cognitive behavioral supervision. Act Nerv Super Rediviva. **63**(1): 22–35.
38 Prasko J, Diveky T, Grambal A, Kamaradova D, Mozny P, Sigmundova Z, Slepecky M, Vyskocilova J (2010). Transference and countertransference in cognitive behavioral therapy. Biomed Pap Med Fac Univ Palacky Olomouc Czech Repub. **154**(3): 189–198.
39 Prasko J, Mozny P, Novotny M, Slepecky M, Vyskocilova J (2012b). Self-reflection in cognitive behavioural therapy and supervision. Biomed Pap Med Fac Univ Palacky Olomouc Czech Repub. **156**(4): 377–384.
40 Prasko J, Ociskova M, Vanek J, Burkauskas J, Slepecky M, Bite I, Krone I, Sollar T, Juskiene A (2022). Managing transference and countertransference in cognitive behavioral supervision: theoretical framework and clinical application. Psychol Res Behav Manag. **15**: 2129–2155.
41 Prasko J, Vyskocilova J, Mozny P, Novotny M, Slepecky M (2011). Therapist and supervisor competencies in cognitive behavioural therapy. Neuroendocrinology Letters. **32**(6): 101–109.
42 Prasko J, Vyskocilova J, Slepecky M, Novotny M (2012c). Principles of supervision in cognitive behavioural therapy. Biomed Pap Med Fac Univ Palacky Olomouc Czech Repub. **156**(1): 70–79.
43 Pugh M, Margetts A (2020). Are you sitting (un) comfortably? Action-based supervision and supervisory drift. The Cognitive Behaviour Therapist. **13**: e17.
44 Redhead S, Johnstone L, Nightingale J (2015). Clients' experiences of formulation in cognitive behaviour therapy. Psychol Psychother. **88**(4): 453–467.
45 Reichelt S & Skjerve J (2002). Correspondence between supervisors and trainees in their perception of supervision events. J Clin Psychol. **58**: 759–772.
46 Rodolfa E, Bent R, Eisman E, Nelson P, Rehm L, Ritchie P (2005). A cube model for competency development: implications for psychology educators and regulators. Professional Psychology: Research and Practice. **36**(4): 347–354.
47 Roscoe J (2021). Maximizing trainee cognitive behavioural therapists' use of clinical supervision: can a bespoke workshop help to broaden their horizons? Journal of Applied Psychology and Social Science. **6**: 58–89.
48 Rosenblatt A & Mayer J (1975). Objectionable supervisory styles: Students' views. Social Work. **20**(3): 184–188.
49 Rothwell C, Kehoe A, Farook SF, Illing J (2021). Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review. BMJ Open. **11**(9): e052929.
50 Rubin SS (1989). At the border of supervision: critical moments in psychotherapists' development. Am J Psychother. **43**(3): 387–397.
51 Salkovskis PM, Forrester E, Richards C (1998). Cognitive-behavioural approach to understanding obsessional thinking. Br J Psychiatry Suppl. (35): 53–63.
52 Sarnat J (2010). Key competencies of the psychodynamic psychotherapist and how to teach them in supervision. Psychotherapy (Chic). **47**(1): 20–27.
53 Schames G (2006). Transference enactments in clinical supervision. Clinical Social Work Journal. **34**(4): 407–425.
54 Schmidt LM, Foli-Andersen NJ (2017). Psychotherapy and cognitive behavioral therapy supervision in Danish psychiatry: training the next generation of psychiatrists. Acad Psychiatry. **41**(1): 4–9.
55 Strom-Gottfried KJ (2007). Straight talk about professional ethics. Chicago: Lyceum.
56 Strozier AL, Kivlighan DM, Thoreson RW (1993). Supervisor intentions, supervisee reactions and helpfulness: A case study of the process of supervision. Professional Psychology: Research and Practice. **24**(1): 13–19.
57 Swift JK, Callahan JL, Rousmaniere TG, Whipple JL, Dexter K, Wrape ER (2015). Using client outcome monitoring as a tool for supervision. Psychotherapy (Chic). **52**(2): 180–184.
58 Taibbi R (2013). Clinical social work supervision: practice and process (2nd ed). Pearson.
59 Townend M, Iannetta L, Freeston MH (2002). Clinical supervision in practice: a survey of UK cognitive behavioural psychotherapists accredited by the BABCP. Behavioural and Cognitive Psychotherapy. **30**: 485
60 Vallance K (2004). Exploring counsellor perceptions of the impact of counselling supervision on clients. British Journal of Guidance and Counselling. **32**(4): 559–574.
61 Vyskocilová J, Prasko J (2013). Ethical reflection and psychotherapy. Neuro Endocrinol Lett. **34**(7): 590-600.
62 Walker R & Clark J (1999). Heading off boundary problems: Clinical supervision as risk management. Psychiatric Services. **50**(11): 1435–1439.
63 Watkins CE Jr (2012). Development of the psychotherapy supervisor: Review and reflections on 30 years of theory and research. Am J Psychother. **66**(1): 45–83.
64 Wheeler S, Richards K (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. Counselling and Psychotherapy Research. **7**(1): 54–65.
65 Whitman SM, Jacobs EG (1998). Responsibilities of the psychotherapy supervisor. Am J Psychother. **52**(2): 166–175.
66 Wilson HM, Davies JS, Weatherhead S (2016). Trainee therapists' experiences of supervision during training: a meta-synthesis. Clin Psychol Psychother. **23**(4): 340–351.
67 Young JE, Klosko JS, Weishaar ME (2003). Schema therapy. New York: Guilford.
68 Yourman DB & Farber BA (1996). Nondisclosure and distortion in psychotherapy supervision. Prof Psychol Res Pract. **33**: 567–575.