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## **Working with maladaptive therapist modes: An action-experiential approach to supervision.**

### **Introduction**

Clinical supervision refers to the provision of relationship-based education and training that supports, develops, and evaluates the work of colleagues (Milne, 2018). Consensus indicates that good quality supervision, like good quality ST, should involve the ‘head’ (case discussion), ‘heart’ (experiential processes), and ‘hands’ (doing). Action-experiential supervisory methods refer to a collection of active procedures involving simulated interactions with other individuals (e.g. one’s clients), parts of the self (e.g. one’s modes), or both (Pugh, 2019; Pugh & Margetts, in review). These include *role-plays* ([re-]enactments of past, present, and future interactions); *empty-chairwork* (imaginal dialogues with an ‘other’ held, symbolically, in an empty chair); *multi-chairwork* (speaking from multiple chairs representing different perspectives or self-parts); and *imagery-based* methods. Active methods such as role-play are centralised in ST supervision and play an important role in assessing competence, fine-tuning skills, and ‘working through’ problematic therapy processes (e.g. complimentary or symmetrical therapist-client schemas) (Nadort, van Genderen, & Behary, 2012).

### **Supervisory Drift**

Despite a growing evidence-base, action-experiential procedures are often omitted from supervisory interactions (e.g. Townend, Iannetta, & Freeston, 2002). Why do ST supervisors ‘drift’ from these methods? Various factors are likely to contribute, including inexperience (lack of training in enactive supervisory methods), emotional discomfort (fears about getting experiential techniques ‘wrong’), and contextual factors (time limitations) (Pugh & Margetts,

in review). Preliminary research supports some of these hypotheses: clinicians generally dislike role-plays despite finding them useful (Fertleman, Gibbs, & Eisen, 2005) and supervisors often doubt their ability to use experiential procedures effectively (Owen-Pugh & Symons, 2013). This drift comes with considerable costs, however, potentially limiting supervisee's opportunities for technical, professional, and personal development, as well as the overall quality of supervision.

### **Therapist modes**

Given the complexity of their work, ST therapists must be sensitive observers of their own schema processes (Greenwald & Young, 1998; Nadort et al., 2012). Research indicates that maladaptive therapist modes (MTMs) can be pronounced amongst ST therapists and contribute to impoverished self-care, burn-out, and work dissatisfaction (e.g. Simpson et al., 2019). Left unchecked, MTM are also likely to impact upon therapeutic processes including alliance formation, countertransference, and the implementation of core interventions (e.g. empathic confrontation). Accordingly, assessing and regulating one's MTM (and, by extension, one's schemas), in conjunction to developing of healthier ways of coping, are crucial tasks for ST supervision.

### **Action-experiential approaches to working with MTMs**

#### **Assessment**

Therapists are sometimes unaware of how maladaptive modes impact their clinical work. *Awareness-orientated role-plays* clarify how MTM influence the provision of ST through the recreation of supervisee-client interactions. Witnessing these reconstructions also informs the supervisor's understanding of how supervisee-client modes interact. This procedure involves the supervisee enacting the 'therapist' and the 'client' (in separate chairs) at key therapeutic junctures. Role-play is paused intermittently to allow the supervisee to focus inwards and clarify which modes are triggered. In doing so, supervisees practice moving from

a position of ‘reflection-on-action’ (attending to one’s modes *after* interactions with the client) and towards ‘reflection-in-action’ (mode awareness *during* interactions). Chairs representing key MTMs are then introduced into the supervisory space.

Once identified, supervisees are invited to re-organise MTM chairs to symbolise their alignments, constellations, or sequential activations (*‘chair-based representations’*). For example, anxiety (i.e. vulnerable child mode) may ‘sit behind’ a supervisee’s disinterest in a client (i.e. detached protector mode), while demanding parent and overcontroller modes might ‘couple together’ to ensure that schema therapy is delivered ‘perfectly’. Using chairs to represent MTMs (as opposed to objects or diagrams) is the preferred method as this enables supervisees to move into dialogues with greater ease.

Finally, *intrapersonal role-plays* (also known as ‘voice dialogue’ or ‘mode interviews’) help supervisees to better understand how and why MTMs become activated with particular clients. This involves the supervisee switching seats and ‘speaking as’ the mode in question. Here, the role of the supervisor is to ‘get to know’ this aspect of the supervisee’s internal experience (Supervisor: “*Change seats and speak as the part of you that feels bored with this client.* [Supervisee changes seats]. *Nice to meet you, ‘Bored Side’. Tell me about yourself. How do you feel about working with this client?’*”). Possible questions for intrapersonal role-plays are provided in Table 1. Having voiced their mode, the supervisee returns to their original chair and reflects on the dialogue from a position of decentred self-awareness (Supervisor: “*Thanks for speaking with me, ‘Bored Side’. Now, come back to your original chair and, as you do that, allow ‘Bored Side’ to remain in the empty seat.* [Supervisee switches seats]. *Notice how you can now experience ‘Bored Side’ from a greater distance.* [Gestures to the empty chair]”). Supervisee-led confrontation might then follow, ideally from the embodied perspective of their ‘healthy internal supervisor’.

### **Managing MTMs: The ‘healthy internal supervisor’**

ST supervision guidelines emphasise self-reflection, personal therapy, and the application of schema-focused techniques to regulate MTMs (Nadort et al., 2012). Empirical support for these approaches is limited, however. Cultivating a ‘healthy internal supervisor’ (HIS) provides supervisees with an additional resource for managing MTMs *in-situ* (Bell, Dixon, & Kolts, 2017). An excellent guide to constructing a compassionate internal supervisor has been provided by Bell (2015) (see also Appendix 1). As we shall see, dialogues with the HIS serves additional functions, such as resolving negative counter-transference, enhancing self-reflection, and supporting self-care through self-(re)parenting.

### **Counter-transference**

*Countertransference* refers to therapists’ cognitive-affective reactions to the client or therapeutic situation. Negative reactions to clients are common in ST and usually arise from supervisees’ maladaptive appraisals of therapy events or supervisee-client schema complementarities. Unmanaged, these responses can be detrimental to the delivery of therapy (Westra et al., 2012). Experiential approaches to resolving countertransference are advantageous for several reasons, including concretising MTM processes, overcoming supervisee coping modes (e.g. avoidance and intellectualisation), and maximising compassion for ‘difficult’ clients.

Role-reversal is a well-known method for working through countertransference (Chesner, 1999, Kellogg, 2015). This procedure begins with the supervisee (chair one) disclosing their experience of therapy directly to the client, represented by an empty seat (chair two) (Supervisor: “*Tell this client* [gesturing to the empty chair] *how you feel about working with them*”). Next, the supervisee adopts the client’s point-of-view (switching to chair two) and describes their experience of therapeutic process (Supervisor: “*Change seats*. [Supervisee moves to chair two]. *Speaking as your client - tell me about yourself. What brought you to therapy? How are you finding treatment so far?*”). Kellogg (2015) recommends that ‘self-

doubling' is used throughout role-reversal to ensure each individual's disclosures are forthright (Supervisor: [Speaking to the 'therapist-as-client']. "*Stand behind your chair.* [Supervisee stands up]. *From this position, share your true experience of therapy. What is it really like working with this therapist?* [Gestures to the supervisee's empty chair]. *If your therapist could know one truth about you, what would it be?*"). In stage three, the supervisee returns to their original chair and reflects on the implications of this dialogue (Supervisor: "*How do you understand what your client has shared with us?* [Gestures to the client's empty chair]. *What do feel towards this individual now? Is there anything you would like to say to them?*"). Used in this way, role-reversal can be a powerful means to generate empathy, cultivate insights into the client's lived experience of therapy, and ensure that supervisees' negative feelings 'are left in supervision'. As with awareness-orientated role-plays, additional chairs representing key MTMs are introduced at the end of role-reversal.

An alternative approach, 'MTM dialogues' involve the supervisee describing their experience of the countertransference from the perspective of their MTMs, held in different chairs (Pugh, 2019). As with role-reversal, this exercise begins with the supervisee imaging the client in the empty seat. Next, the supervisor explores the cognitive, affective, and motivational aspects of each MTM as fully as possible (Supervisor: "*Let's begin by checking in with your demanding mode.* [Supervisee moves to chair one]. *Speaking as this mode, where in your body does it show up when you work with this client?* [Gestures to the client's empty chair]. *What thoughts go with the demanding mode? If this mode were in complete control, what would it have you do? What does the demanding need to settle in the company of this client?*"). Exploring memories associated with each MTM will often illuminate the autobiographical origins of supervisee's countertransference reactions (Supervisor: "*What memories go with the demanding mode? What does this part remember in the presence of this client?*").

‘Self-doubling’ and ‘MTM dialogues’ are concluded in two ways. First, the supervisee can practise relating to their modes from a decentred (i.e. standing) perspective (Supervisor: *“Let’s stand... Which of these modes is strongest during sessions with this client? [Gestures to the empty chairs representing the supervisee’s modes]. Which is most problematic? Which is hardest to acknowledge? Do the needs and intentions of your modes highlight ways in which this issue could be resolved?”*). Alternatively, supervisees practice managing their MTMs from the embodied perspective of the HIS (Supervisor: *“Let’s move to the chair of your internal supervisor. [Supervisee changes seats]. Speaking as this part of your self, how these modes make sense in the context of your life and the associated with working with this client? [Gestures to the empty chairs]. Is there anything you would like your demanding mode to understand? [Gestures to chair one]. What can you say to it to help it to settle?... Turning to your detached protector mode now [gestures to chair two], what would you like this mode to know?...”*).

### **Discussion**

Just as ST should be an ‘action-packed’ experience for clients, ST supervision should also be an action-based process. This article has outlined some of the ways action-experiential procedures are applied in this context. However, it is also acknowledged that some MTMs are too entrenched or inflexible to manage through supervision alone. If so, personal therapy may be advisable. Studies are now needed to ratify the utility and efficacy of these methods. Other important questions include:

- Which intrapersonal factors (e.g. supervisor anxiety) and which interpersonal factors (e.g. concerns about the supervisory alliance) generate supervisor drift?
- What makes action-experiential procedures effective (e.g. the supervisee’s level of emotional engagement or immersion)?

- Do contextual factors influence the effectiveness of action-experiential methods? For example, are these procedures most effective in individual or group supervision settings?

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Table 1

*Prompts for supervisory dialogues with MTMs.*

	Nice to meet you, [MTM name]. Tell me about your self. What do you do for this individual?
<i>Triggers:</i>	What leads you to come out in the presence of this client? Do you appear in other situations in this therapist's life?
<i>Content:</i>	What do you tend to say or do in situations like those?
<i>Functions:</i>	What do you achieve by performing this role? How do you help?
<i>Relating style:</i>	How do you feel towards this client? How about this therapist?
<i>Underlying vulnerability:</i>	What do you think would happen if you weren't around when this therapist meets with this client? What about if you weren't around at all?
<i>Developmental origins:</i>	When did you come into this therapist's life? Do you take after anyone they've known?
<i>Consequences</i>	Are you aware of any problems you might be causing this therapist?
<i>Imagery:</i>	If I could see you as you really are, how would you appear?
<i>Label:</i>	What would you like us to call you?

*Dialoguing with the 'Healthy Internal Supervisor' (adapted from Bell, 2015; Bell, Dixon, & Kolts, 2017).*

Supervisor: *"Let's begin our dialogue with your Healthy Internal Supervisor (HIS) by changing seats and embodying this part of yourself. [Supervisee changes seats]. Close your eyes and allow your mind to slow. (Pause). Starting with the outward characteristics of your HIS, find a rhythm of breathing that feels calm and soothing. (Pause). Now, bringing attention to your posture, find a position that feels centred and strong. (Pause). Take on a facial expression that captures this sense of care and understanding, perhaps by adopting a half-smile, as if you're meeting someone you care about. (Pause).*

*Let's move on to the inward characteristics of your HIS. This is the part of you that brings wisdom and understanding to your work, and is committed to being helpful to you. (Pause). Imagine being filled with this wish to be supportive, kind, and caring. (Pause). Your supervisor also understands the challenges that come with being a therapist and wants you to be the best therapist you can be (Pause). It appreciates that difficult emotions are a perfectly normal and acceptable part of our work. (Pause). Your supervisor also has the strength to contain these feelings and is confident in your ability to manage the struggles that arise in your work. (Pause). Your supervisor also carries the wisdom to see these experiences in the context of your life and has the courage to embrace the conflicts you encounter. (Pause).*

*Now, open your eyes and bring your HIS with you. (Pause). Seeing this therapist through the eyes of your HIS [gestures to the supervisee's previous chair], how do you understand their experience of working with this client? [Supervisee responds]. In what ways does this therapist's feelings / modes make sense? [Supervisee responds]. What does this therapist*

*need to know in order feel supported and encouraged in their work? Say that to them.*

[Supervisee responds]. *Is there any guidance or advice that you would like to offer?*

[Supervisee responds]. *How can this therapist call upon you in the future?* [Supervisee

responds]. *Do you have any parting words before we end this dialogue for now?...*