Are you sitting (un)comfortably? Action-based supervision and supervisory drift.

Matthew Pugh

Central and North West London NHS Foundation Trust

Alexander Margetts

University of Leicester

Author Note

Matthew Pugh, Vincent Square Eating Disorders Service, Central and North West London NHS Foundation Trust, UK.

Alexander Margetts, School of Psychology, University of Leicester, UK.

Correspondence concerning this article should be addressed to Matthew Pugh, Vincent Square Eating Disorders Service, 1 Nightingale Place, London, SW10 9NG.

Contact: matthewpugh@nhs.net

Abstract

Action-based methods such as behavioural experiments, role-play, and (by extension) 'chairwork' are powerful techniques recommended by core texts for CBT supervision and are demonstrably effective. Despite this, experiential methods are seldom used by supervisors, suggesting that supervision often drifts from a 'doing process' to a 'talking process'. A number of factors contribute to this divergence from best practice, including limited confidence and a lack of familiarity with experiential procedures amongst supervisors. To address this, the current paper presents a variety of action-based techniques for enhancing supervisees' technical, perceptual, interpersonal, reflective, and personal competencies. Behavioural experiments, empty-chair, multi-chair, and role-playing exercises for maintaining treatment fidelity, enhancing empathic attunement, repairing therapeutic ruptures, resolving impasses, and working through negative countertransference are described, amongst others. Further research is needed to establish the nature and extent of supervisory drift, as well as the efficacy of action-based methods.

Keywords: chairwork; cognitive behavioural therapy; experiential; role-play; supervisory drift; training.

Key learning aims

As a result of reading this paper, readers should:

- Understand why supervision sometimes drifts from being 'doing' process.

- Appreciate the value of experiential, action-based supervisory methods.

- Feel competent using action-based methods to enhance supervisees' clinical skills.

Are you sitting (un)comfortably? Action-based supervision and supervisory drift.

Introduction

Clinical supervision refers to "the formal provision, by approved supervisors, of relationship-based education and training that is work-focused and manages, supports, develops, and evaluates the work of colleague/s" (Milne, 2008, p.15). Research indicates that supervision is vital to the provision of effective therapeutic interventions, improving client outcomes, enhancing continued learning, and promoting safe, client-centred care (Milne et al., 2011). It follows, then, that clinical supervision represents a core component in the implementation of evidence-based psychological therapies, including cognitive behavioural therapy (CBT) (APA, 2015; Roth & Pilling, 2008).

Mirroring the growing dissemination and utilisation of CBT in healthcare systems, increased attention has been paid to which methods are most effective in facilitating therapist training and development (Rakovshik & McManus, 2013; Shafran et al., 2009). A variety of educational and cognitive-behavioural models have been posited, incorporating cognitive tasks (e.g. case conceptualisation and treatment planning), behavioural tasks (technical skills acquisition and rehearsal), and emotional tasks (affective processing and self-reflection) (Bennett-Levy, 2006, Liese & Beck, 1997; Padesky, 1996; Milne, 2009; Milne & Reiser, 2017; Safran & Muran, 2001). While space does not permit a comparison of these frameworks, action-based and experiential supervisory methods such as role-play and (to a lesser degree) 'chairwork' have been consistently favoured in the training and supervision of cognitive therapists (Milne, 2009; Pugh, 2019a).

Action-based Supervision

Consensus indicates that CBT supervision should be at least partly experiential and 'action-packed' (Bennett-Levy, 2006; Kaslow et al., 2004; Milne, 2009; Milne & Reiser, 2017; Padesky, 1996; Ronen & Rosenbaum, 1998; Roth & Pilling, 2007). Action-based supervisory

methods represent a collective of enactive procedures which involve *simulated* interactions with other individuals (e.g. clients or colleagues), parts of the self, or both. These methods very much 'stand on the shoulders of giants' and are informed by the seminal works of Jacob L. Moreno (1987), George Kelly (1955), and Fritz Perls (1975). *Role-play* is the procedure most familiar to cognitive therapists, involving the within-session enactment of past, present, and future interactions which approximate real-life experiences. CBT supervision employs role-play for various purposes including: demonstrating the implementation of interventions ('modelling'); practising the application of techniques ('rehearsal'); exploring novel therapeutic strategies ('experimentation'); revisiting key interactions in therapy ('re-enactment'); and facilitating changes in perspective (e.g. 'role reversal' with other individuals).

In contrast to the pragmatic focus of role-playing, *chairwork* is a more creative and exploratory action-based method. Accordingly, these techniques are well suited to self-reflection and the resolution of evocative issues such as negative 'countertransference' and problematic therapist beliefs (Jenkyns, 2008, Pugh, 2019a). Chairwork has been categorised in different ways. 'Empty-chairwork' involves the supervisee engaging in an imaginal dialogue with an 'other' (in most cases, the client) who is held, symbolically, in an empty chair. 'Multi-chair' techniques, on the other hand, involve the supervisee speaking from several chairs representing different perspectives or parts of the self. Chairwork and role-play overlap considerably and are often blended to produce dramatisations which are evocative and memorable (Milne & Reiser, 2017; Pugh, 2017).

Finally, *behavioural experiments* (Bennett-Levy et al., 2004) are an effective medium for evaluating and implementing factors which impact upon clinical practice. These include supervisees' cognitive appraisals (e.g. about the self, the client, or CBT) or specific behaviours (e.g. how technical skills are implemented). Whilst this paper focuses on role-play and

chairwork (as these are likely to be least familiar to CBT supervisors), examples of how behavioural experiments are incorporated into CBT supervision are presented in Table 1.

Theoretical Basis for Action-Based Supervision

'Experiential learning' (i.e. learning through experience) represents the foundation of evidence-based CBT supervision; indeed, clinical supervision represents a fundamentally experiential approach to professional learning (Milne, 2018; Milne & Reiser, 2017). Kolb's (1984) model of experiential learning suggests that professional development requires a number of active components including experiencing (engaging in an activity), reflection (thinking about what happened), meaning-making or conceptualisation (creating a model on the basis of experience), and experimentation (testing one's theory through continued activity). Supervisors must, therefore, ensure that each mode of experiential learning is regularly incorporated into supervision. This includes the use of action-based procedures for enhancing professional development (Edmunds et al., 2013; Milne & Reiser, 2017).

Building on the work of Kolb, therapy-specific models of learning have proposed that effective psychotherapeutic practice relies upon a complex integration of declarative knowledge (factual information) and procedural knowledge (technical competency) (Bennett-Levy, 2006; Safran & Muran, 2001). To facilitate such integration, effective learning environments should mirror the contexts in which knowledge is to be applied. In other words, understanding cognitive-behavioural principles is maximised through a mixture of both discussion *and* performances involving simulated therapeutic interactions. This is particularly relevant to novice therapists, for whom action-based methods provide a bridge between declarative knowledge ("This is what I need to do") and the development of procedural knowledge ("This is how I do it") (Bennett-Levy, 2006). Indeed, research suggests that matching learning environments and 'real-world' clinical contexts increases the likelihood that new knowledge and skills will be implemented outside of supervision (Cross et al., 2011).

Lastly, information processing theory (IPT) has elucidated the process of learning through supervision (Tangden & Borders, 2017). IPT suggests that information is acquired, processed, stored, and retrieved through several stages involving sensory memory, short-term (working) memory, and long-term memory (Schunk, 2016). We suggest that action-based methods are effective in engaging each of these systems. Beginning with sensory memory, information must be attended to before it is passed to working memory for further processing. At this stage of learning, information which is presented in a novel, evocative, and kinaesthetic manner tends to be most salient (Tangden & Borders, 2017). Next, information is actively processed in working memory. Rehearsing information through enactment and imaginal implementation represents one of the most important strategies for encouraging such processing. Finally, information is transferred to long-term memory for storage through a process of encoding (the imprinting of information) and elaboration (linking new knowledge to past knowledge) (Schunk, 2016). New mental representations which are vivid, personally meaningful, and multisensory are believed to possess a 'retrieval advantage' from long-term memory (Brewin, 2006). Seen within this framework, action-based approaches to supervision appear to be advantageous in terms of the acquisition, processing, and recall of learning.

Practical Basis for Action-Based Supervision

Pragmatic grounds for advocating action-based supervision also exist. In terms of evaluation, standardised rating systems and reviewing video/audio recordings therapy represent the 'gold standard' methods for assessing clinical skill in CBT (Lewis, Scott, & Hendricks, 2014; Roth & Pilling, 2008), but are often expensive and time-consuming. Role-play is a cost-effective and feasible alternative, providing a 'middle ground' between onerous direct observations and imprecise indirect methods such as self-report and case discussion (Beidas, Cross, & Dorsey, 2014; Lewis et al., 2014). Action-based procedures also have the

advantage of flexibility and spontaneity, enabling supervisors to provide rapid assessments of learning and timely feedback on performance.

Regarding clinical development, action-based methods allow supervisees to safely work in simulated situations which are novel, challenging, or time-consuming to describe, as well enabling direct observations of supervisors' practice. In addition, enactive procedures tend to generate more affect than discussion alone. This has a trifold benefit. Firstly, supervisees are able to practice managing the higher levels of emotion which accompany real clinical encounters (Cross et al., 2011). Secondly, research suggests that evocative procedures enhance the elaboration and retention of new skills (Milne & Reiser, 2017; Ronen & Rosenbaum, 1998; Smeets, Wolf, Giesbrecht, Sijstermans, Telgen, & Joels, 2009). Thirdly, emotion arousal supports the modification of thoughts and beliefs which may impact on supervisees' practice (see section on self-competence) (Samoilov & Goldfried, 2000).

Evidence for Action-Based Supervision

Research has underscored the value of experiential approaches to learning and development. For example, several studies indicate that action-based methods maximise therapists' skill acquisition, improve the retention of learning, reduce treatment infidelity, and enhance clinical outcomes (Bellg et al., 2004; Cross et al., 2011; Edmonds et al., 2013; Lambert & Arnold, 1987; Lewis et al., 2014; Matthieu et al., 2008). Experiential methods also appear to be more effective than passive supervisory strategies such as case discussion. For instance, Bearman and colleagues (2017) reported that novice CBT therapists allocated to "active" supervision (incorporating role-play and modelling) demonstrated greater competence than individuals attending "supervision-as-usual". These results build on previous findings indicating that supervision which incorporated action-based methods predicted greater utilisation of cognitive-behavioural methods than discussion alone (Bearman et al., 2013). Meta-analytic reviews have reached similar conclusions, demonstrating that behavioural

modelling and rehearsal result in significant improvements in trainees declarative and procedural knowledge, with the latter remaining particularly resistant to decay (Taylor, Russ-Eft & Chan, 2005). These outcomes also translate into action, with another meta-analytic study identifying action-based learning (e.g. coaching, rehearsal, and feedback) as one of the most effect methods for ensuring that training affects clinical practice (Beidas & Kendall, 2010).

Overall, research supports the assertion that effective supervision should incorporate active-experiential procedures. It comes as no surprise, then, that action-based methods represent a common ingredient in effective therapy training programmes (Milne et al., 2011; Rakovshik & McManus, 2013; Roth, Pilling, & Turner, 2010). Moreover, action-based methods of learning are valued by therapists in training (Baum & Gray, 1992; Johnston & Milne, 2012; Rakovshik & McManus, 2013) and preferred over and above lecturing, discussion, and reading (Bennett-Levy, McManus, Westling, & Fennell, 2009). These findings beg the question: are supervisors utilising action-based methods, and if not, why not?

Supervisory Drift

In the same way that 'therapist drift' describes clinicians' divergence from evidence-based practice (Waller, 2009), we use the term 'supervisory drift' to refer to instances in which core components of supervision (e.g. outcomes monitoring, direct observation, mutual feedback) are omitted, avoided, or deprioritised, resulting in a gap between supervisory theory and practice. Despite promotion in leading supervisory texts, several reviews indicate that action-based procedures are absent in many supervisory encounters: modelling, role-play, and skill rehearsal are used relatively infrequently in CBT supervision and much less often than talk-based procedures such as instruction and discussion (Milne, 2008; Townend, Iannetta, & Freeston, 2002). Fortunately, the use of active methods does appear to be increasing (Reiser & Milne, 2016), although these strategies continue to fall outside of the 'top ten' interventions utilised by expert supervisors.

Why do supervisors tend to neglect action-based methods? Informed by the therapist drift literature (Meehl, 1986; Waller, 2009; Waller & Turner, 2016), we speculate that several conscious and non-conscious factors contribute to their omission. These include: supervisor knowledge (e.g. non-use supervision manuals); clinical experience (e.g. limited training in role-play and chairwork); attitudes (negative beliefs regarding experiential techniques or performance); emotions (shame-proneness or anxiety around enactments); social factors (motivation to protect the supervisory alliance); and contextual factors (restricted time for facilitating experiential procedures). Preliminary research supports some of these hypothesises. For example, many clinicians dislike role-plays despite their benefits (Fertleman, Gibbs, & Eisen, 2005), and many supervisors doubt their ability to utilise experiential procedures effectively (Owen-Pugh & Symons, 2013). Consequently, supervisees may be at risk of receiving supervision which is at best banal and at worst less effective than it could be. This not only does a disservice to the supervisee, but also the individuals that they work with.

Clearly, a range of human factors conspire to make action-based supervisory methods challenging to implement. Unfortunately, 'being nice' - either to ourselves as supervisors or those that we train - carries the very real risk of stifling supervisees' clinical and professional development. Indeed, research demonstrates that while the more popular, discursive methods of supervision contribute to effective practice, they often fail to influence therapists' subsequent behaviour or therapeutic competence (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010; Jensen-Doss, Cusack, & de Arellano, 2008; Rakovshik & McManus, 2010). Given that supervisees' self-reported practice does not always match actual behaviour, passive supervisory methods also risk the provision of inappropriate instruction, misguided self-reflection, and inaccurate appraisals of supervisee competence (Beidas & Kendall, 2010; Ronen & Rosenbaum, 1998). This provides some explanation as to why supervisors often overrate the abilities of their supervisees (Dennhag, Gibbons, Barber, Gallop & Crits-

Christoph, 2012). Consequently, novice therapists may believe they are implementing interventions with fidelity and skill when they are not, resulting in supevisees' drift mirroring that of their supervisors (Bellg et al., 2004; Townend et al., 2002).

To summarise, consensus indicates that CBT supervision should be both a 'doing' process and a 'talking' process. Unfortunately, supervisors are at risk of 'drifting away' from the use of active supervisory methods. This drift comes with considerable costs, potentially reducing supervisee's opportunities for technical, professional, and personal development. To both inform and encourage more systematic use of action-based methods in CBT supervision, we now present a framework for applying these experiential methods and describe a variety of procedures, focusing mainly on the application of role-play and chairwork.

Applications of Action-based Methods

The Declarative-Procedural-Reflective Model

The declarative-procedural-reflective model (DPR; Bennett-Levy, 2006) provides a useful theoretic framework for conceptualising therapist development. According to DPR, skill acquisition and professional development is guided by three interacting informative-processing subsystems: a declarative system composed of forms of knowledge (conceptual understandings), a procedural system which guides therapeutic practice (professional competencies), and a reflective system which enables clinicians to elaborate their conceptual and procedural competencies on an ongoing basis ('continued learning'). The model also incorporates a taxonomy of core therapeutic skills associated with effective practice including perceptual, interpersonal, and communicative abilities.

Procedural System

The procedural system is informed by both declarative knowledge and pre-existing interpersonal competencies, and represents the storehouse of therapists' skills and abilities. Procedural skills have been differentiated into specific subcomponents including discrete

technical skills (e.g. competent implementation of interventions), interpersonal perception skills (e.g. accurate empathy), and interpersonal relational skills which support the therapeutic alliance (e.g. attending to non-verbal communication) (Bennett-Levy, 2006). Role-play has been identified as the medium for procedural skills development *par excellence* (Bennett-Levy, McManus et al., 2009; Milne, 2009; Milne & Reiser, 2017). However, skills rehearsal represents just the start of action-based methods - not their limit.

Technical competence

Miller (1990) has described a hierarchical framework for building and evaluating technical competence (Figure 1). At the base of this hierarchy is 'knows' (supervisees' conceptual knowledge), followed by 'knows how' (application of conceptual knowledge), then 'shows how' (e.g. technical performance), and lastly, 'does' (e.g. clinical practice). It is at the level of 'showing how' that action-based supervisory methods are most readily applicable (Corrie & Lane, 2015).

Supervisors assess technical competence by inviting supervisees to demonstrate, through role-play, how they would go about implementing routine interventions (Supervisor: "*Show me how you would explain the cognitive-behavioural model to a client - I'll play the client and you play the therapist*"). Not only does this identify areas for skills development, but revisiting role-plays throughout supervision provides a measure of improvement in therapists' technical competence over time (Beidas & Kendall, 2010; Newman & Kaplan, 2016; Padesky, 1996).

Which experiential methods support therapists in enhance their technical ability? Behavioural skills training is a well-researched learning framework which has been applied to the development of clinical skills (Table 2) (Pugh, 2019a). In summary, technical skills training (TST) involves several stages of experiential learning including supervisor modelling, discussion, supervisee rehearsals, coaching, corrective feedback, and fine-tuning. Consistent

Figure 1

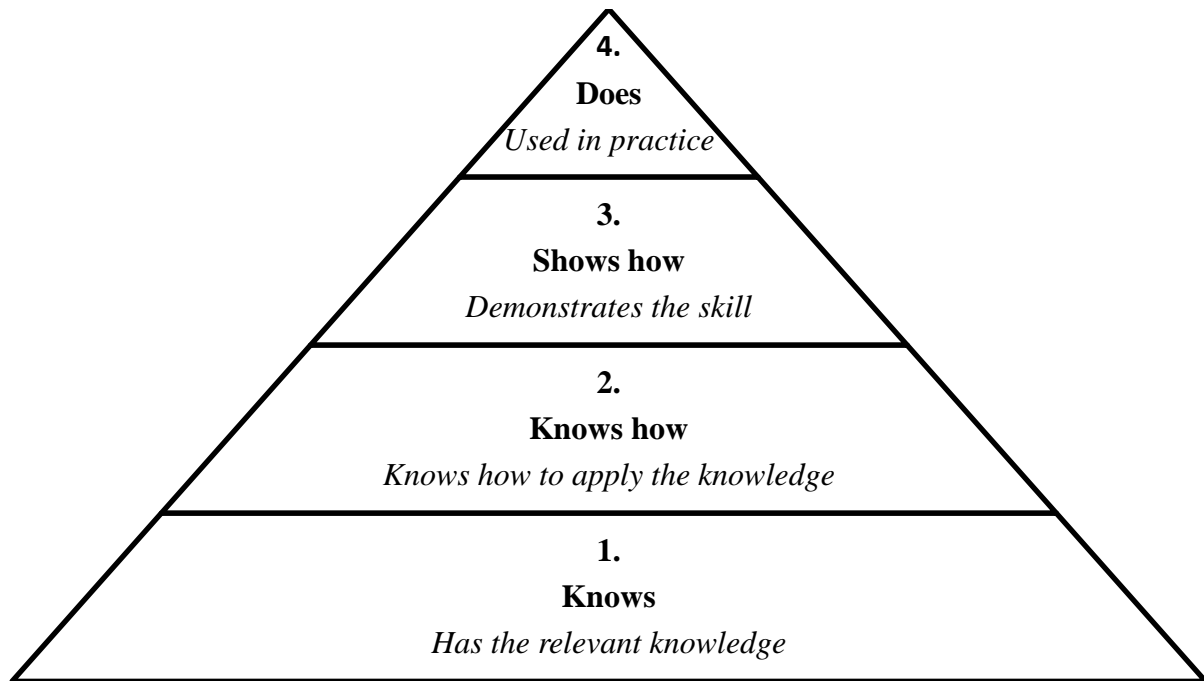*Miller's (1990) clinical skills hierarchy*

4.
Does
Used in practice

3.
Shows how
Demonstrates the skill

2.
Knows how
Knows how to apply the knowledge

1.
Knows
Has the relevant knowledge

Table 1

Example therapist beliefs and possible behavioural experiments

	Belief	Behavioural Experiment	Revised Belief
Overly negative	*I'm an ineffective therapist.*	Collect data on caseload recovery rates; create a pie-chart of positive outcomes.	*I have helped X% of clients, and I'd like to continue to improve to help the Y% that didn't get better.*
	My client is lazy.	Collect a dictionary definition of lazy; list all things the client has achieved.	*The client has not been motivated to do between-session tasks, but makes an effort to attend sessions.*
	Agendas are restrictive.	Survey ten clients for feedback on CBT agendas; review.	*Agendas can be helpful to structure therapy, as long as they retain flexibility.*
Overly positive	*I'm a good therapist because I don't interrupt clients.*	Compare client feedback following sessions in which they are, a). not interrupted, versus, b). kept focused.	*It's possible to sensitively interrupt clients and still be a good listener.*
	Detailed clinical notes improve the quality of therapy.	Compare performance and productivity in sessions preceded by, a). detailed note-taking, versus, b). brief notes.	*Detailed notes do not improve the quality of therapy sessions and might not be a productive use of time.*
	CBT works for everyone.	Survey recovery rates in outcome studies for a particular disorder.	*CBT does not always work, and when it does not, it's important to establish why.*

with the collaborative ethos of CBT, TST is most effective when supervisees bring their own clinical scenarios to role-play (Taylor et al., 2005).

Technical competence alone does not guarantee therapeutic efficacy or consistency, however. For this reason, technical role-plays are used across supervisory meetings to ensure that interventions continue to be implemented proficiently and with fidelity (Pugh, 2019a). Repeated role-plays also retain and maintain technical skills. Given that some CBT interventions are used relatively infrequently in routine practice (e.g. attention retraining), they are at risk of decay. Furthermore, therapists working in specialist settings have limited opportunities to practice other model-specific competencies (e.g. Roth & Pilling, 2007). Action-methods such as role-play enable therapists to practice technical skills which might otherwise be neglected.

Perceptual competence

Interpersonal perceptual skills guide therapists' attunement to clients' moment-by-moment "process-in-state" (Bennett-Levy & Thwaites, 2007; Greenberg & Goldman, 1988). Research suggests that training programmes for enhancing perceptual competence (e.g. empathy training) are most effective when they incorporate active methods such as modelling, rehearsal, and role-play (Teding van Berkhout & Malouff, 2016).

Empathic attunement enables therapists to understand the nature and experience of clients' distress. Role reversal is an evidence-based psychodramatic method which has been described as the optimal method for building empathy (Kipper & Ritchie, 2003; Yaniv, 2012). In the context of CBT supervision, role reversal involves the supervisee switching seats and 'becoming' the client. In doing so, the perspective of the other is fully experienced, generating empathic insights at both cognitive and affective levels. Supervisors facilitate role-reversal in two ways. First, the supervisee might be asked to adopt the client's role during the re-enactment of therapeutic encounters (Supervisor: "*Let's recreate what happened in your last session. You*

play your client and I will play you, repeating your behaviour as accurately as I can"). This method has the advantage of not only encouraging attunement, but also allowing supervisees to witness their behaviours from an external perspective. Alternatively, supervisees are asked to embody the client during imaginal interviews with the supervisor (Supervisor: "*Change chairs and speak as your client*. [Supervisee switches seats]. *Tell me about yourself. What brought you to therapy? What was your life like before then? How are you finding treatment? What is it like working with this therapist?*").

An equally important perceptual skill*, mindfulness* refers to the ability to attend to the clients' and one's own experience concurrently, establishing a 'double consciousness' of the therapeutic process (Bennett-Levy & Thwaites, 2007; Katzow & Safran, 2007). Awareness orientated role-plays (Safran, Muran, Stevens, & Rothman, 2007) provide an opportunity to practice mindful awareness of therapy interactions. This procedure involves the re-enactment of key client-therapist events, with the supervisee playing both roles. Role-play is paused intermittently to allow supervisees to focus their attention inwards to clarify their own, and the client's, unfolding cognitive-affective experience. In doing so, supervisees move from a position of 'reflection-on-action' (mindful attending *after* interactions with the client) and towards 'reflection-in-action' (mindful awareness *during* interactions) (Schön, 1991)

Relational competence

While perceptual competencies constitute therapists' receptive skills (e.g. attending to a client's communicative 'inputs'), *relational* competences represent therapists' 'outputs' (e.g. communications back to the client). *Empathic communication* is a core relational skill which enables therapists to convey their understanding of the client's cognitive, emotional, and interpersonal experience (Beck, Rush, Shaw, & Emery, 1979; Safran & Segal, 1990). Accurately communicating empathy in CBT is a complex skill which incorporates attunement (e.g. attending to the client's experience), conceptual knowledge (e.g. linking these

understandings to the case conceptualisation), and technical skills (e.g. summarising information) (Thwaites & Bennett-Levy, 2007). Role reversal (adopting the client's point-of-view during re-enactments), followed immediately by role-play (switching roles and conveying new insights back to the "client") allows therapists to practice empathic communication. Role-plays initially focus on 'simple' empathic communications (e.g. word-for-word reflections) before practising more complex responses (e.g. depth reflections and explorations of clients' 'felt senses') (Gendlin, 2003; Truax & Carkhuff, 2017).

Difficult conversations are unavoidable in CBT (e.g. late attendance, between-session task non-compliance), as are sensitive topics of discussion (e.g. assessing substance use and sexual practices). Supervisor modelling followed by rehearsal builds supervisees' confidence raising these issues with clients (see Table 2). Alternatively, contrasted role-plays (McNeilage & Adams, 1979) allow supervisees to discover more idiosyncratic ways of navigating challenging discussions. This procedure involves the supervisee enacting the 'extremes' of communication in order to identify an effective 'middle-ground'. For example, a supervisee who feels uncomfortable discussing a client's sexual difficulties might be asked to address this issue in three ways during role-play: first, a conversation about sex is initiated with a client (represented by an empty chair) in the most blunt and crass manner possible (chair one), followed by a cautious manner (chair two), before rehearsing a balanced approach combining empathy with sensitive matter-of-fact discussion (chair three).

Repairing alliance ruptures (discord between client and therapist) requires considerable relational skills (Safran & Muran, 2000) and has been associated with better therapy outcomes in CBT (e.g. Strauss et al., 2006). Bennett-Levy and Thwaites (2007) have described a staged model for exploring and resolving ruptures through role-play. First, the problematic interaction is recreated, with the supervisor enacting the therapist/supervisee and the supervisee enacting the client ('awareness raising') (Supervisor: "*Show me how this conflict*

Table 2

Technical skills training framework ('I-MARCHED') (Pugh, 2019)

1. Instruction	The supervisor describes how and why the intervention is utilised.
2. Modelling	The supervisor demonstrates the implementation of the intervention. Supervisors 'think aloud' during modelling to elaborate key procedural steps (Safran & Muran, 2001).
3. Assess learning	Specific elements of the intervention are discussed in detail after modelling (e.g. process, content, etc.).
4. Rehearsal	The supervisee practices implementing the intervention, with the supervisor playing the role of the client.
5. Coaching	Rehearsal is intermittently paused to provide supervisees with 'live' guidance and instruction, as required.
6. Helpful feedback	Constructive feedback and praise are provided after role-play. Possible adjustments in implementation are modelled by the supervisor.
7. Edited rehearsal	Role-plays which incorporate the supervisor's feedback take place.
8. Deepen learning	Supervisees' learning is consolidated through reflective questioning (e.g. implications for practice, links with conceptual knowledge, etc.).

unfolded. You play the client and I'll play you"). Second, reflective questioning is used to clarify the supervisee's cognitive-affective response after re-enactment ('experiential processing') (Supervisor: "*Let's pause this role-play. Having experienced this conflict once again, what are your thoughts and feelings about the interaction now?*"). Based upon these experiential insights, an interpersonal formulation of rupture is developed in stage three ('reflective processing') (Supervisor: "*Let's stand.* [Supervisor and supervisee stand up]. *Looking at this interaction from a distance* [gestures to the two chairs], *what do you see unfolding between these individuals? What's this conflict about?*"). In the final stage, role-plays are used to rehearse productive responses in the event that similar ruptures occur again ('procedural skills rehearsal').

Quite understandably, novice therapists sometimes struggle to formulate effective responses when ruptures occur. In other cases, multiple routes to resolution present themselves. 'Multi-modelling' involves the supervisor demonstrating different approaches to repairing ruptures in different chairs. For example, in response to a client becoming withdrawn during a discussion (enacted by the supervisee in chair one), the supervisor might demonstrate a variety of metacommunications (Muran, Safran, & Eubanks-Carter, 2010) including state observations (Supervisor [chair two]: "*You seem distant right now*"), interpersonal observations (Supervisor [chair three]: "*I sense we are less connected*"), or self-disclosure (Supervisor [chair four]: "*I'm aware of feeling detached from you*"). By experiencing these responses from the client's perspective, supervisees are also able to evaluate their relative accuracy, utility, and likely impact. Multi-modelling also provides opportunities for supervisors to model imperfection - supervisees are often reassured to see senior colleagues struggle with the clinical interactions they encounter (Safran et al., 2007).

Reflective system

Reflective practice is emphasised in CBT supervision (Haarhoff & Thwaites, 2016). From an information-processing perspective, the reflective system has been described as a content-free, representational system which is activated by therapeutic 'problems' or when clinicians' expectations do not match reality. Through a combination of focused attention, mental representations of the issue in question, and sophisticated cognitive operations, the reflective system is capable of generating novel solutions to therapeutic issues, which are then conveyed to the declarative and procedural systems (Bennett-Levy & Thwaites, 2007). Accordingly, the reflective system is central to the refinement of clinical skills, continued learning, and the emergence of 'expertise' (Bennett-Levy, Thwaites, Chaddock, & Davis, 2009). Reflection need not be as passive as the term would suggest either: action-based methods are often an effective means to facilitate reflective processing, work through impasses, and generate 'action insights' into therapeutic difficulties (Blatner & Collins, 2008; Kellerman, 1992).

Resolving impasses

Impasses refer to deadlocks or plateaus in therapeutic progress (Hill et al., 1996). Left unchecked, these 'stalemates' risk premature termination of therapy or damage to the therapeutic alliance. Impasses often require creative solutions garnered through self-reflection, supervisory discussion, and advice from professional peers (Pasko et al., 2010). Thus, impasses call upon the more 'experimental' forms of chairwork. 'Imaginal surveys' (Pugh, 2019b) involve 'seeking counsel' from any variety of individuals who are enacted by the supervisee. This might include expert authorities, past mentors, or one's wiser 'future self' (Supervisor: "*Let's get some advice on this block in therapy. If you could consult with three individuals - dead or alive, real or imagined - who would you chose?*"). To ensure that the therapist is sufficiently 'warmed-up' to enact these individuals, the supervisor initially 'interviews' the supervisee in each persona (Blatner & Blatner, 1991) (Supervisor: "*It's a pleasure to meet you,*

Albert Ellis. Tell me about yourself. What skills and experiences do you bring to this issue? Why do you think this therapist choose to seek advice from you? What guidance can you offer?"). Supervisors will be reassured to know that this procedure is not as far-fetched as it sounds: research indicates that embodying Sigmund Freud in virtual reality has the power to improve mood and well-being (Osimo, Pizzaro, Spanlang, & Slater, 2015), while reasoning about one's problems from a 'distanced' perspective generates wiser responses (Grossman & Kross, 2014).

'Egocentric-allocentric role-play' (Pugh, 2019a) applies a similar combination of perspective-changing and reflection to resolve impasses. In summary, the supervisee is invited to explore the therapeutic block from three embodied vantage points: a self-immersed perspective (chair one) (Supervisor: "*What is the difficulty you are experiencing in your work with this client? Why might it be arising? How might it be addressed?*"), followed by the client's perspective (chair two) (Supervisor: "*Speaking as the client - what challenges are you experiencing in your work with this therapist?* [Gestures to the supervisee's previous chair]. *Why is that occurring? How do you think it could be addressed?*"), and finally, the decentred perspective of an objective observer (standing or chair three) (Supervisor: "*Observing these individuals in their work together* [gestures to chairs one and two], *what obstacles do you notice are arising? Why does that happen? How might they address this issue?*").

The 'self' system

DPR conceptualises the therapist's sense of 'self' as a component of the procedural system which processes information in two ways: either in relation to therapists' self-schemas (the 'personal self') or professional schemas (the 'self-as-therapist'). We have chosen to categorise therapists' self system as a separate information-processing subsystem which incorporates elements of the declarative system (e.g. knowledge about one's self-beliefs), the perceptual system (e.g. the ability to communicate self-referential knowledge), and the

reflective system (e.g. ongoing awareness of how self-beliefs and communication influence one another). Because aspects of the therapist's selfhood impact upon the therapeutic process, cognitive therapists must be "*sensitive observers of their own thoughts, feelings, and beliefs*" (Beck & Freeman, 1990, p.252). Historically, personal therapy has been recommended as the principal means to minimise the impact of therapist's self on the practice and process of therapy (Macran & Shapiro, 1998). However, this is not a formal requirement for most CBT training courses, nor is there evidence to suggest that personal therapy improves the provision of CBT (Bennett-Levy et al., 2009). An alternative approach, action-based methods provide opportunities for personal development, self-supervision, and greater self-awareness.

Treatment-interfering beliefs about therapy

Negative assumptions about therapy sometimes prevent supervisees from implementing core CBT processes and interventions (Haarhoff & Kazantzis, 2007). Common examples might include the belief that clients will experience agenda-setting as stifling, cognitive interventions as mechanical, and structured interview methods as insensitive. Role-play provides an opportunity to 'test out' these evaluations through experimentation and build confidence in the cognitive approach (Padesky, 1996). To illustrate, a training CBT therapist disclosed the belief that soliciting feedback at the conclusion of therapy sessions would appear 'false'. To test this belief, the supervisor demonstrated how they would usually elicit feedback from a client (role-played by the supervisee). The supervisee subsequently concluded that seeking feedback could be a validating experience.

Treatment-interfering beliefs about the self

Most therapists doubt their competence at times. Unfortunately*, negative self-referential thoughts* (e.g. self-criticism and catastrophic thinking) compromises supervisees' capacity to learn, make decisions, and deliver therapy effectively (Friedberg, Gorman, & Beidel, 2009). Action-based procedures for addressing maladaptive thoughts and feelings have

been described elsewhere (Pugh, 2018, 2019a, 2019b) and are readily applicable to supervision. Three methods are worth highlighting. Supervisees who tend to ignore or explain away their successes (the cognitive distortions of 'discounting' and 'minimistation') are often heartened by 'appreciation dialogues' (Dayton, 1994; Pugh, 2019b). This strengths-focused procedure involves the supervisee speaking from the perspective of a client who has valued their input. The supervisor then proceeds to 'interview' the client in regards to the supervisee's strengths, talents, and abilities (Supervisor, speaking to the 'client': "*How did this therapist help you?* [Gestures to the supervisee's empty seat]. *What did you value most about their support? What does this therapist do well? Knowing that this individual sometimes doubts their ability, what would you like them to know and understand?*").

In other situations, supervisees might expect supervisors to respond to errors or misjudgements with criticism or humiliation (i.e. 'mind-reading'). Assuming (and hoping!) this is not the supervisor's modus operandi, the supervisee is asked enact this 'rejecting supervisor' in a second chair (Supervisor: "*Come and sit beside me.* [Supervisee changes seats]. *Show me how you feared I might respond to your disclosure.* [Gestures to the supervisee's empty chair]. *What's the worst thing I might have said? Say it as if you were me*"). Having enacted this catastrophic response, the supervisee then explores the discrepancy between fantasy and reality (Supervisor: *"Turn your attention to me.* [Supervisee shifts in their seat]. *Is this your experience of me, either now or in the past? If not, where are these self-judgments coming from?*"). In this way, chairwork helps supervisees 'take back their projections' (Perls, 1975). The dialogue ends with the supervisee returning to their original chair and counter-responding to their negative automatic thoughts (Supervisor: *"Now, let's practice responding to these NATs. In what ways are they untrue and unhelpful? Say that to your critical side.* [Gestures to the empty chair hold the 'rejecting supervisor'])".

Finally, supervisees who feel anxious implementing new or complex interventions are invited to role-play doing so 'as if' they had complete confidence. "Faking it until you make it", within a safe supervisory context can be a surprisingly effective way to install self-confidence prior to direct work with clients.

Countertransference

Countertransference refers to therapists' cognitive-affective reactions to the client, the therapeutic situation, or both (Holmes, 1993). Negative reactions to clients are not uncommon in CBT (or other psychotherapies) and tend to arise from clinicians' past experiences, interpersonal schemas, or appraisals of therapeutic events (Leahy, 2007; Moorey, 2014). Research indicates that negative countertransference is detrimental to the delivery of CBT (Safran & Segal, 1990; Westra et al., 2012) and that 'working through' these reactions is related to better therapy outcomes (Hayes, Gelso, & Hummel, 2011). Accordingly, supervision plays an important role in conceptualising countertransference, addressing negative thoughts and feelings, and moving supervisees from a position of frustration to compassion (Wolf, Abraham, & Muran, 2013; Milne & Reiser, 2017).

Cognitive-behavioural approaches to managing countertransference have emphasised the roles of formulation, self-reflection/insight, mindful acceptance, and the application of cognitive therapy techniques to oneself (e.g. cognitive restructuring) (Ellis, Schwartz, & Rufino, 2018; Hardy, Cahill, & Barkham, 2007; Leahy, 2007; Moorey & Lavender, 2019; Padesky, 1996; Pasko et al., 2010). Much less attention has been paid to utility of action-based methods in overcoming negative reactions to the client (Pugh, 2019a). Enactive approaches to countertransference are advantageous in several ways (Blatner & Collins, 2008; Chesner, 1999; Pugh, 2019b). These include clarifying supervisees' negative cognitive-affective reactions, concretising internal experiences which are otherwise unsaid or unknown, avoiding

psychological 'defences' such as avoidance and intellectualisation, and helping therapists to 'feel' the client's experience of the transference.

Awareness of countertransference is needed before such issues can be resolved. Unfortunately, clinicians are sometimes unaware of the automatic thoughts and feelings that arise in therapeutic situations (Bennett-Levy & Thwaites, 2017). Noted previously, awareness-orientated role-plays help clarify supervisees' countertransference through the recreation of within-session events (Safran et al., 2007). Witnessing these reconstructions will also inform the supervisor's understanding and 'felt sense' of countertransference processes (Chesner, 1999).

The 'voice dialogue' method (Stone & Stone, 1989) provides a useful tool for *exploring countertransference*. This involves the supervisee switching seats and 'speaking as' the voice of their countertransference. Here, the role of the supervisor is to simply 'get to know' this aspect of the supervisee's 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? What is it about them that bores you? Do you ever show up in other areas of this therapist's life?*"). The supervisee then returns to their original chair and reflects on what has been conveyed from a more decentred perspective (Supervisor: "*Come back to your original chair and, as you do that, allow 'Bored Side' to remain in the empty seat.* [Supervisee switches seats]. *Take a moment to notice how you can now experience 'Bored Side' from more of a distance now.* [Gestures to the empty chair representing boredom]*"*).

Ventilation is a deceptively simple but highly evocative method for *working through negative countertransference*. This procedure involves the supervisee (chair one) openly expressing their emotional reactions to the client as if this they were present (chair two) (Supervisor: "*Imagine your client were here with us.* [Gestures to the empty chair]. *Tell them*

how you feel about your work together")[1]. To encourage complete disclosure, supervisees are prompted to voice the full spectrum of their emotional reactions including anger, anxiety, boredom, envy, and so on (Perls, 1975). Once these emotions have been expressed, the supervisee switches seats again (chair three) and shares any positive emotional responses or 'appreciations' for the client; these are often surprisingly forthcoming once the supervisee's negative feelings have been shared (Supervisior: "*From this chair, tell your client what you value, respect, or appreciate about them*"). In this way, ventilation helps supervisees to 'leave negative feelings in supervision' and connect with their more affiliative reactions to the client. However, supervisors must be clear that this procedure is *not* a rehearsal for actual encounters with the client.

A final approach to resolving countertransference involves the supervisee describing their experience of the client from the perspective of relevant 'emotional selves', which are held in different chairs (i.e. Angry Self, Anxious Self, and Sad Self) (Gilbert, 2009). Here, the supervisor works to ensure that the cognitive, affective, and behavioural dimensions of each self are fully experienced and expressed (Supervisor: "*Speaking as Angry Self, where in your body does this part show up when you engage with this client?* [Gestures to the client's empty chair]. *What thoughts go with Angry Self? If Angry Self were in complete control, what would it do?*"). Emotional selves dialogues are concluded in two ways. First, the supervisee might practice relating to selves from a decentred, meta-observational point-of-view (Supervisor: "*Let's stand.* [Supervisor and supervisee stand up]. *Which selves are strongest during your sessions?* [Gestures to the empty chairs]. *Which is hardest to acknowledge? Do they point towards any potential solutions?*") Alternatively, supervisees can practice managing their emotional selves from the embodied perspective of their 'Compassionate Internal Supervisor'

---

[1] Combining ventilation with role reversal can be a productive - and often moving - supervisory procedure. For more details, see Kellogg (2015) for an illustration of the 'self-doubling' method.

(CIS) (Bell, Dixon, & Kolts, 2017): Bell (2015) has provided a useful imagery-based guide for constructing a CIS which is readily incorporated into chairwork.

Maintaining the Supervisory Alliance

Before concluding this section, we must acknowledge the importance of the 'supervisory alliance' when using action-based methods. Afterall, it is this crucial bond between supervisor-supervisee that enables risk-taking and disclosure in supervision (Bernard & Goodyear, 2014; Beinart, 2004). Enactive procedures can be powerful and anxiety-provoking for both the supervisor and the supervisee. This risks undermining the supervisory alliance, as well as interfering with supervisees' confidence, motivation, and information-processing (Lombardo, Milne, & Proctor, 2009). This is not to say that protecting the alliance justifies avoidance of action-based methods: a degree of anxiety encourages learning, while sedate supervision might indicate that supervisors are not being challenging enough (Corrie & Lane, 2015; Milne, 2008). Nonetheless, a robust supervisory alliance remains important. In order to protect this bond, supervisors should hold the following points in mind when using action-based methods, thereby respecting the strength of such techniques:

- *Transparency*: The rationale for utilising active procedures should be presented at the outset of supervision and included in the supervision contract and/or learning agreement (Milne & Resier, 2017).

- *Collaboration*: Action-based methods are introduced into supervision collaboratively. This includes respecting supervisees' preferred learning styles and acknowledging that experiential interventions are more useful at particular times, and with particular cases, than others.

- *Validation and normalisation*: Supervisors acknowledge that action-based methods are sometimes challenging and potentially exposing. This is particularly relevant when

working with countertransference. Supervisors should be supportive if this is the supervisee's experience of chairwork or role-play.

- *Attentiveness*: Supervisors must attend to supervisees' individual capacities for affective tolerance. This is important when facilitating action-based methods which are often evocative and emotionally demanding.

- *Imperfection*: Imperfect performance by supervisors, particularly in the context of modelling therapeutic procedures, are a valuable opportunity to demonstrate that supervision is a risk-free and 'safe to fail' environment (Corrie & Lane, 2015).

- *Feedback*: Positive feedback maximises supervisees' confidence and learning through action-based methods (Daniels & Larson, 2001). Equally, supervisors should encourage feedback on the quality of their demonstrations, facilitations, and enactments (Supervisor: "What worked? What didn't? What could be done differently next time?").

Discussion

Just as CBT should be an 'action-packed' experience for clients (Padesky, 2019), CBT supervision should be an action-based process for supervisees. Active supervisory methods have a strong theoretical basis and a growing evidence-base. Despite these merits, other research suggests that experiential procedures are used infrequently, suggesting that many CBT supervisors are 'drifting' from recommended practice. To address this issue, the present article has outlined some of the creative ways in which experiential procedures are applied to the development of cognitive therapists' technical, perceptual, reflective, and self-competencies.

As mentioned, therapist drift has been identified as an important factor in the delivery of ineffective talking therapies (Waller, 2009; Waller & Turner, 2016). This is likely to be partly related to supervisory drift: that is, the failure to provide the supervision that individuals have been trained to deliver, or a failure to deliver supervision competently. Preliminary research indicates that supervisory drift is not uncommon in CBT (Parker & Waller, 2019;

Townend et al., 2002). This is understandable given that many supervisors have received little or no supervisory training, while the numbers of clinicians attending CBT-specific supervisory training or supervisory supervision are likely to be even lower. As a result, there is a real risk that the quality of guidance CBT therapists receive is less than optimal, potentially limiting the quality of treatments they provide. Fortunately, evidence-based guidelines for supervision have been presented (Milne & Resier, 2017), alongside the development of core supervisory competencies (Roth & Pilling, 2007). This has gone some way towards improving current practice - when clinicians are motivated to use such guidance. Fully addressing supervisory drift is likely to require a number of additional strategies including greater access to specialist training, routine supervision-of-supervision, and use of competency ratings. Services must also ensure that supervisors have access to these resources to support evidence-based practice. Further studies are now needed to establish the extent of supervisory drift in CBT, how this impacts clinical practice, and which interpersonal, intrapersonal, and systemic factors contribute.

Existent research indicates that didactic instruction and reflective discussion are necessary, but not sufficient, to produce sustained improvements in therapist behaviour (Rakovshik & McManus, 2010). Other supervisory methods are also needed. This paper has focused on the importance and application of action-based procedures in CBT supervision. While the effectiveness of role-playing methods such as behavioural rehearsal is fairly established, much fewer studies have examined the impact of behavioural experimentation and chairwork (e.g. role-reversal and ventilation). Studies are needed to ratify the utility and efficacy of these procedures. Other important questions include the following:

- What makes action-based procedures effective? For example, does the strength of technical skills training lie in the observation of more experienced clinicians, direct enactment, or individualised feedback?

- What threshold of active learning is required to optimise learning and skill development? For example, what is the ideal frequency and length of role-play?

- Can supervision be improved by taking into account supervisees' preferred learning styles? Which methods work, for whom, and under what circumstances (Edmunds et al., 2014; Kolb, 1984)?

- Do contextual factors influence the effectiveness of action-based methods? For example, are experiential interventions more effective in individual or group supervision formats?

We hope that supervisors will find this paper useful and encouraging in terms of making use of action-methods. However, supervisors should also hold in mind that experiential methods are remarkably potent. Blatner (1996) has likened these evocative procedures to an electric saw: a powerful tool which necessitates considered application. Given that any form of feedback can impact positively or negatively (e.g. Hattie & Timperley, 2007), we recommend that supervisors apply these methods with care and discretion, particularly when working with emotive issues such as countertransference. In the interests of collaboration, mutual respect, sensitivity to supervisees' learning needs, enactive methods should be framed as invitations, rather than directives. Timing is equally important: chairwork and role-play cannot be rushed, and sufficient time should be aside for thorough debriefing after enactments. Finally, supervisors are always encouraged to undertake appropriate training and supervision in order to use these methods safely and skilfully. For in the words of advice given to Spider-Man, '*...with great power there must also come - great responsibility*' (Lee, 1962, p.12).

Regarding future directions for practice, there is a clear need for more (action-based) training in the application of enactive methods (Pugh, 2019a). Without this, it seems likely that supervisors and supervisees will continue to 'tell' rather than 'show' in supervision. Indeed,

concerted efforts are needed to encourage supervisors and supervisees out of their chairs and their comfort zones.

Key practice points

(1) For several reasons, CBT supervision often drifts from being a 'doing' process, potentially limiting opportunities for supervisees' development.

(2) Consistent with cognitive and learning theories, research indicates that action-based supervisory methods positively influence clinical practice.

(3) Action-based methods can be flexibly and creatively applied to many aspects of supervision, including fine-tuning supervisees' technical competency, enhancing interpersonal skills, and facilitative reflective practice.

(4) Research is needed to establish the extent of supervisory drift, its impact on clinical practice, and ways to ensure it is minimised.

Further reading

Bennett-Levy, J. (2006). Therapist skills: A cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, *34*, 57-78.

Milne, D. (2018). *Evidence-based clinical supervision: Principles and practice* (2nd ed.). Chichester, UK: John Wiley and Sons.

Pugh, M. (2019a). *Cognitive behavioural chairwork: Distinctive features*. Abingdon, UK: Routledge.

References

American Psychological Association (APA) (2015). Guidelines for clinical supervision in health service psychology. *American Psychologist, 70*, 33-46.

Baum, B. E., & Gray, J. J. (1992). Expert modelling, self-observation using videotape, and acquisition of basic therapy skills. *Professional Psychology: Research and Practice, 23*, 220-225.

Bearman, S. K., Schneiderman, R. L., & Zoloth, E. (2017). Building an evidence base for effective supervision practices: An analogue experiment of supervision to increase EBT fidelity. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*, 293-307.

Bearman, S. K., Weisz, J. R., Chorpita, B. F., Hoagwood, K., Ward, A., Ugueto, A. M., ... & Research Network on Youth Mental Health. (2013). More practice, less preach? The role of supervision processes and therapist characteristics in EBP implementation. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*, 518-529.

Beck, A. T., and Freeman, A. (1990). *Cognitive therapy of personality disorders* (1st ed.). New York, USA: Guildford Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, USA: Guilford Press.

Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Boston, USA: Pearson.

Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice*, *17*, 1-30.

Beidas, R. S., Cross, W., & Dorsey, S. (2014). Show me, don't tell me: Behavioral rehearsal as a training and analogue fidelity tool. *Cognitive and Behavioural Practice, 21*, 1-11.

Beinart, H. (2004). Models of supervision and the supervisory relationship and their evidence base. In *Supervision and clinical psychology: Theory, practice and perspectives* (ed. I. Fleming & L. Steen), pp. 36-50. Hove, UK: Brunner-Routledge.

Bell, T., Dixon, A., & Kolts, R. (2017). Developing a compassionate internal supervisor: Compassion-focused therapy for trainee therapists. *Clinical Psychology and Psychotherapy, 24*, 632-648.

Bellg, A. J., Borrelli, B., Resnick, B., Hecht, J., Minicucci, D. S., & Ory, M. (2004). Enhancing treatment fidelity in health behavior change studies: Best practices and recommendations from the NIH behavior change consortium. *Health Psychology, 23*, 443-451.

Bennett-Levy, J. (2006). Therapist skills: A cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, *34*, 57-78.

Bennett-Levy, J., McManus, F., Westling, B. E., & Fennell, M. (2009). Acquiring and refining CBT skills and competencies: Which training methods are perceived to be most effective? *Behavioural and Cognitive Psychotherapy, 37*, 571-583.

Bennett-Levy, J., & Thwaites, R. (2007). Self and self-reflection in the therapeutic relationship: A conceptual map and practical strategies for the training, supervision and self-supervision of interpersonal skills. In *The therapeutic relationship in the cognitive behavioural psychotherapies* (ed. P. Gilbert & R. L. Leahy), pp. 255-281. East Sussex, UK: Routledge.

Bennett-Levy, J., Thwaites, R., Chaddock, A., & Davis, M. (2009). Reflective practice in cognitive behavioural therapy: The engine of lifelong learning. In *Reflective Practice*

in Psychotherapy and Counselling (ed. R. Dallos & J. Stedmon), pp. 115-135. Maidenhead, UK: Open University Press.

Bennett-Levy, J., Westbrook, D., Fennell, M., Cooper, M., Rouf, K., & Hackmann, A. (2004). Behavioural experiments: Historical and conceptual underpinnings. *Oxford guide to behavioural experiments in cognitive therapy*. Oxford, UK: Oxford University Press.

Blatner, A. (1996). *Acting-in: Practical applications of psychodramatic methods* (3rd ed.). New York, USA: Springer.

Blatner, A., & Blatner, A. (1991). Imaginative interviews: A psychodramatic warm-up for developing role-playing skills. *Journal of Group Psychotherapy, Psychodrama and Sociometry, 44*, 115-120.

Blatner, A., & Collins, J. G. (2008). Using psychodrama and dramatherapy methods in supervising dramatherapy practicum students. In P. Jones & D. Dokter (Eds.), *Supervision of dramatherapy* (pp. 144-159). Hove, East Sussex: Routledge.

Brewin, C. R. (2006). Understanding cognitive behaviour therapy: A retrieval competition account. *Behaviour Research and Therapy, 44*, 765–784.

Chesner, A. (1999). Dramatherapy supervision: Historical issues and supervisory settings. In E. Tselikas-Portmann (Ed.), *Supervision and dramatherapy* (pp.39-61). London, UK: Jessica Kingsley Publishers.

Corrie, S., & Lane, D. A. (2015). *CBT supervision*. London, UK: Sage.

Cross, W. F., Seaburn, D., Gibbs, D., Schmeelk-Cone, K., White, A. M., & Caine, E. D. (2011). Does practice make perfect? A randomised control trial of behavioral rehearsal on suicide prevention gatekeeper skills. *Journal of Primary Prevention, 32*, 195-211.

Daniels, J. A., & Larson, L. M. (2001). The impact of performance feedback on counseling self-efficacy and counselor anxiety. *Counselor Education and Supervision*, *41*, 120-130.

Dayton, T. (1994). *The drama within: Psychodrama and experiential therapy*. Deerfield Beach, USA: Health Communications.

Dennhag, I., Gibbons, M. B. C., Barber, J. P., Gallop, R., & Crits-Christoph, P. (2012). Do supervisors and independent judges agree on evaluations of therapist adherence and competence in the treatment of cocaine dependence*? Psychotherapy Research, 22,* 720-730.

Edmunds, J. M., Kendall, P. C., Ringle, V. A., Read, K. L., Brodman, D. M., Pimentel, S. S., & Beidas, R. S. (2013). An examination of behavioral rehearsal during consultation as a predictor of training outcomes. *Administration and Policy in Mental Health, 40*, 456-466.

Ellis, T. E., Schwartz, J. A., & Rufino, K. A. (2018). Negative reactions of therapists working with suicidal patients: A CBT / mindfulness perspective on "countertransference". *International Journal of Cognitive Therapy*, *11*, 80-99.

Fertleman, C., Gibbs, J., & Eisen, S. (2005). Video improved role play for teaching communication skills. *Medical Education, 39*, 1155-1156.

Friedberg, R. D., Gorman, A. A., & Beidel, D. C. (2009). Training psychologists for cognitive-behavioral therapy in the raw world: A rubric for supervisors. *Behavior Modification*, *33*, 104-123.

Gendlin, E. T. (2003). *Focusing: How to gain direct access to your body's knowledge*. London, UK: Random House.

Gilbert, P. (2009). *Overcoming depression: A self-help guide using cognitive behavioral techniques*. London, UK: Robinson.

Greenberg, L. S., & Goldman, R. L. (1988). Training in experiential therapy. *Journal of Consulting and Clinical Psychology, 56*, 696-702.

Grossmann, I., & Kross, E. (2014). Exploring Solomon's paradox: Self-distancing eliminates the self-other asymmetry in wise reasoning about close relationships in younger and older adults. *Psychological Science*, *25*, 1571-1580.

Haarhoff, B. A., & Kazantzis, N. (2007). How to supervise the use of homework in cognitive behavior therapy: The role of trainee therapist beliefs. *Cognitive and Behavioral Practice*, *14*, 325-332.

Haarhoff, B., & Thwaites, R. (2016). *Reflection in CBT*. London, UK: Sage.

Hardy, G., Cahill, J., & Barkham, M. (2009). Active ingredients of the therapeutic relationship that promote client change. In P. Gilbert & R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 24-42).

Hattie, J., & Timperley, H. (2007). The power of feedback. *Review of Educational Research, 77*, 81-112.

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy, 48*, 88-97.

Herschell, A. D., Kolko, D. J., Baumann, B. L., & Davis, A. C. (2010). The role of therapist training in the implementation of psychosocial treatments: A review and critique with recommendations. *Clinical Psychology Review, 30*, 448-466.

Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology, 43*, 207-217.

Holmes, P. (1993). *The inner world outside: Object relations theory and psychodrama*. Hove, UK: Routledge.

Jenkyns, M. (2008). Transference and countertransference in relation to the dramatic form in supervision training. In *Supervision of dramatherapy* (ed. P. Jones & D. Dokter), pp. 99-110. Hove, UK: Routledge.

Jensen-Doss, A., Cusask, K. J., & de Arellano, M. A. (2008). Workshop-based training in trauma-focused CBT: An in-depth analysis of impact on provider practices. *Community Mental Health Journal, 44*, 227-244.

Johnston, L. H., & Milne, D. L. (2012). How do supervisee's learn during supervision? A Grounded Theory study of the perceived developmental process. *The Cognitive Behaviour Therapist, 5*, 1-23.

Kaslow, N. J., Borden, K. A., Collins, F. L., Forrest, L., Illfelder-Kaye, J., Nelson, P. D., & Rallo, J. S. (2004). Competencies conference: Future directions in education and credentialing in professional psychology. *Journal of Clinical Psychology, 60*, 699-712.

Katzow, A. W., & Safran, J. D. (2007). Recognizing and resolving ruptures in the therapeutic alliance. In *The therapeutic relationship in the cognitive behavioural psychotherapies* (ed. Gilbert & R. L. Leahy), pp. 90-105. East Sussex, UK: Routledge.

Kellerman, P. F. (1992). *Focus on psychodrama: The therapeutic aspects of psychodrama*. London, UK: Jessica Kingsley Publishers.

Kellogg, S. (2015). *Transformational chairwork: Using psychotherapy dialogues in clinical practice*. Lanham, USA: Rowman and Littlefield.

Kelly, G. A. (1955). *The psychology of personal constructs: Volume one*. New York, USA: Norton.

Kipper, D. A., & Ritchie, T. D. (2003). The effectiveness of psychodramatic techniques: A meta-analysis. *Group Dynamics: Theory, Research, and Practice, 7*, 13-25.

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs, USA: Prentice Hall.

Lambert, M. J., & Arnold, R. C. (1987). Research and the supervisory process. *Professional Psychology: Research and Practice, 18*, 217-224.

Leahy, R. L. (2007). Schematic mismatch in the therapeutic relationship: A social-cognitive model. In *The therapeutic relationship in the cognitive behavioral therapies* (ed. P. Gilbert & R. Leahy, pp. 229-254. Hove, USA: Routledge.

Lee. S. (1962). *Amazing Fantasy #15 – Introducing Spider Man* [Cartoon]. New York, USA: Marvel.

Lewis, C. C., Scott, K. E., & Hendricks, K. E. (2014). A model and guide for evaluating supervision outcomes in cognitive-behavioral therapy-focused training programs. *Training and Education in Professional Psychology, 8*, 165-173.

Liese, B. S., & Beck, J. S. (1997). Cognitive therapy supervision. In *Handbook of psychotherapy supervision* (ed. C. E. Watkins), pp.114-133. New York, USA: John Wiley and Sons.

Lombardo, C., Milne, D., & Proctor, R. (2009). Getting to the heart of clinical supervision: A theoretical review of the role of emotions in professional development. *Behavioural and Cognitive Psychotherapy*, *37*, 207-219.

Macran, S., & Shapiro, D. A. (1998). The role of personal therapy for therapists: A review. *British Journal of Medical Psychology, 71*, 13-25.

Matthieu, M., Cross, W., Batres, A., Flora, C., & Knox, K. (2008). Evaluation of gatekeeper training for suicide prevention in veterans. *Archives of Suicide Research, 12*, 148-154.

McNeilage, L. A., & Adams, K. A. (1979). The method of contrasted roleplays: An insight-orientated model for role-playing in assertiveness training groups. *Psychotherapy: Theory, Research and Practice, 16*, 158–170.

Meehl, P. E. (1986). Causes and effects of my disturbing little book. *Journal of Personality Assessment, 50,* 370-375.

Miller, G. E. (1990). The assessment of clinical skills/competence/performance. *Academic Medicine*, *65*, S63-7.

Milne, D. (2008). CBT supervision: From reflexivity to specialization. *Behavioural and Cognitive Psychotherapy, 36*, 779-786.

Milne, D. (2009). *Evidence-based clinical supervision: Principles and practice* (1st ed.). Chichester, UK: John Wiley and Sons.

Milne, D. (2018). *Evidence-based clinical supervision: Principles and practice* (2nd ed.). Chichester, UK: John Wiley and Sons.

Milne, D. & Reiser, R. P. (2017). *A manual for evidence-based CBT supervision*. Chichester, UK: John Wiley and Sons.

Milne, D. L., Reiser, R. P., Cliffe, T., Breese, L., Boon, A., Raine, R., & Scarratt, P. (2011). A qualitative comparison of cognitive-behavioural and evidence-based clinical supervision. *The Cognitive Behaviour Therapist, 4*, 152-166.

Moorey, S. (2014). "Is it them or is it me?" Transference and countertransference in CBT. In *How to become a more effective CBT therapist: Mastering metacompetence in clinical practice* (ed. A. Whittington & N. Grey), pp. 132-145. Chichester, USA: John Wiley and Sons.

Moorey, S., & Lavender, A. (2019). Interpersonal schemas: Understanding transference and countertransference in CBT. In *The therapeutic relationship in cognitive behavioural therapy* (ed. S. Moorey & A. Lavender), pp. 31-48. London, UK: Sage.

Moreno, J. L. (1987). *The essential Moreno: Writing on psychodrama, group method and spontaneity*. New York, USA: Springer.

Muran, J. C., Safran, J. D., & Eubanks-Carter, C. (2010). Developing therapist abilities to negotiate alliance ruptures. In *The therapeutic alliance: An evidence-based guide to practice* (ed. J. C. Muran & J. P. Barber), pp. 320-340. New York, USA: Guilford Press.

Newman, C. F., & Kaplan, D. A. (2016*). Supervision essentials for cognitive-behavioral therapy*. Washington, USA: American Psychological Association.

Osimo, S. A., Pizarro, R., Spanlang, B., & Slater, M. (2015). Conversations between self and self as Sigmund Freud - A virtual body ownership paradigm for self counselling. *Scientific Reports*, *5*, 13899.

Owen-Pugh, V., & Symons, C. (2013). Roth and Pillings competence framework for clinical supervision: How generalizable is it? *Counselling and Psychotherapy Research, 13*, 126-135.

Padesky, C. A. (1996). Developing cognitive therapist competency: Teaching and supervision methods. In *Frontiers of Cognitive Therapy* (ed. P. Salkovskis), pp. 266-292. New York, USA: Guildford Press.

Padesky, C. A. (2019). *Action, dialogue, and discovery: Reflections on Socratic questioning 25 years later*. Paper presented at the 9th World Congress of Behavioural and Cognitive Psychotherapies, Berlin, Germany.

Parker, Z., & Waller, G. (2019). Psychotherapists' reports of technique use *when treating anxiety disorders: Factors associated with specific technique use. The Cognitive Behaviour Therapist, 12*, 1-12.

Pasko, J., Diveky, T., Grambal, A., Kamaradova, D., Mozny, P., Sigmundova, Z., Slepecky, M., & Vyskocilova, J. (2010). Transference and countertransference in cognitive behavioral therapy. *Biomedical Papers, 154*, 189-198.

Perls, F. (1975). *Legacy from Fritz*. Palo Alto, USA: Science and Behavior Books.

Pugh, M. (2017). Chairwork in cognitive behavioural therapy: A narrative review. *Cognitive Therapy and Research, 41*, 16–30.

Pugh, M. (2018). Cognitive behavioural chairwork. *International Journal of Cognitive Therapy, 11*, 100-116.

Pugh, M. (2019a). *Cognitive behavioural chairwork: Distinctive features*. Abingdon, UK: Routledge.

Pugh, M. (2019b). A little less talk, a little more action: A dialogical approach to cognitive therapy. *The Cognitive Behavioural Therapist*, e47, 1-24.

Rakovshik, S. G., & McManus, F. (2010). Establishing evidence-based training in cognitive

behavioral therapy: A review of current empirical findings and theoretical

guidance. *Clinical Psychology Review*, *30*, 496-516.

Rakovshik, S. G., & McManus, F. (2013). An anatomy of CBT training: Trainees'

endorsements of elements, sources and modalities of learning during a postgraduate

CBT training course. *The Cognitive Behaviour Therapist, 6*, 1-12.

Reiser, R. P., & Milne, D. L. (2016). A survey of CBT supervision in the UK: Methods,

satisfaction and training, as viewed by a selected sample of CBT supervisor leaders.

The Cognitive Behaviour Therapist, 8, 1-14.

Ronen, T., & Rosenbaum, M. (1998). Beyond direct verbal instructions in cognitive behavioral

supervision. *Cognitive and Behavioral Practice, 5*, 7-23.

Roth, A. D., & Pilling, S. (2007). *The Competencies Required to Deliver Effective Cognitive

Behavioural Therapy for People with Depression and with Anxiety Disorders*. London,

UK: HMSO, Department of Health.

Roth, A. D., & Pilling, S. (2007). *A competence framework for the supervision of psychological

therapies*. Retrieved from: https://www.researchgate.net/publication/265872800

_A_competence_framework_for_the_supervision_of_psychological_therapies

Roth, A. D., & Pilling, S. (2008). Using an evidence-based methodology to identify the

competences required to deliver effective cognitive and behavioural therapy for

depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy*, *36*, 129-

147.

Roth, A. D., Pilling, S., & Turner, J. (2010). Therapist training and supervision in CBT in major trials for depression and anxiety. *Behavioural and Cognitive Psychotherapy, 38*, 291-302.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, USA: Guilford Press.

Safran, J. D., & Muran, J. C. (2001). A relational approach to training and supervision in cognitive psychotherapy. *Journal of Cognitive Psychotherapy: An International Quarterly, 15*, 3-15.

Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. Lanham, USA: Jason Aronson.

Safran, J. D., Muran, C., Stevens, C., & Rothman, M. (2007). A relational approach to supervision: Addressing ruptures in the alliance. In *Casebook for clinical supervision: A competency-based approach* (ed. C. A. Falender & E. P. Shafranske), pp. 137-157. Washington, USA: American Psychological Association.

Samoilov, A., & Goldfried, M. R. (2000). Role of emotion in cognitive-behavior therapy. *Clinical Psychology: Science and Practice, 7*, 373–385.

Schön, D. (1991). *The reflective practitioner: How professionals think in action*. Aldershot, UK: Ashgate Publishing.

Schunk, D. H. (2016). *Learning theories: An educational perspective* (7th ed.). Boston, USA: Pearson.

Shafran, R., Clark, D. M., Fairburn, C. G., Arntz, A., Barlow, D. H., Ehlers, A., & Wilson, G. T. (2009). Mind the gap: Improving the dissemination of CBT. *Behaviour Research and Therapy, 47*, 902-909.

Smeets, T., Wolf, O. T., Giesbrecht, T., Sijstermans, K., Telgen, S., & Joels, M. (2009). Stress selectively and lastingly promotes learning of context-related high arousing information. *Psychoneuroendocrinology, 34*, 1152-1161.

Stone, H., & Stone, S. (1989). *Embracing our selves: The voice dialogue manual*. Novato, USA: Nataraj Publishing.

Strauss, J. L., Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J. P…, & Beck, A. T. (2006). Early alliance, alliance ruptures, and symptom change in a nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology, 74*, 337-345.

Tangden, J. L. & Borders, L. D. (2017). Applying information processing theory to supervision: An initial exploration. *Counselor Education and Supervision, 56*, 98-111.

Taylor, P. J., Russ-Eft, D. F., & Chan, D. W. L. (2005). A meta-analytic review of behavior modeling training. *Journal of Applied Psychology, 90*, 692-709.

Teding van Berkhout, E., & Malouff, J. M. (2016). The efficacy of empathy training: A meta-analysis of randomized controlled trials. *Journal of Counseling Psychology*, *63*, 1-10.

Thwaites, R., & Bennett-Levy, J. (2007). Conceptualizing empathy in cognitive behaviour therapy: Making the implicit explicit. *Behavioural and Cognitive Psychotherapy, 35*, 591-612.

Townend, M., Iannetta, L., & Freeston, M. (2002). Clinical supervision in practice: A survey of cognitive behavioural psychotherapist accredited by the BABCP. *Behavioural and Cognitive Psychotherapy, 30*, 485-500.

Truax, C. B., & Carkhuff, R. (2017). *Toward effective counseling and psychotherapy: Training and practice*. Abingdon, USA: Routledge.

Waller, G. (2009). Evidence-based treatment and therapist drift. *Behaviour Research and Therapy, 47*, 119-127.

Waller, G., & Turner, H. (2016). Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track. *Behaviour Research and Therapy, 77*, 129-137.

Westra, H. A., Aviram, A., Connors, L., Kertes, A., & Ahmed, M. (2012). Therapist emotional reactions and client resistance in cognitive behavioral therapy. *Psychotherapy, 49*, 163–172.

Wolf, A. W., Goldfried, M. R., & Muran, J. C. (Eds.). (2013). *Transforming negative reactions to clients: From frustration to compassion*. Washington, USA: American Psychological Association.

Yaniv, D. (2012). Dynamics of creativity and empathy in role reversal: Contributions from neuroscience. *Review of General Psychology, 16*, 70-77.