

PSYCHOTHERAPY

Countertransference During Supervision in Cognitive Behavioral Therapy

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This paper was supported by the research grants IGA MZ ČR 10301-3/2009

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Submitted: 2010-11-16 Accepted: 2010-12-02 Published online: 2010-12-25

Key words: **therapeutic relationship; supervision; countertransference; schemata; cognitive behavioural therapy**

Act Nerv Super Rediviva 2010; 52(4): 253–262 ANSR520410A01

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Abstract

Many experts claim that transference and countertransference analysis has no place in cognitive behavioural therapy (CBT) and should be used solely in psychodynamic psychotherapy. However, attention paid to emotional and cognitive reactions to the patient or supervisee is the basic component of cognitive behavioural therapy and its supervision, especially if work with difficult patients is supervised. Countertransference reaction may be observed especially in our behaviour, but also in our thoughts, emotional experiences and physical symptoms. The essence of countertransference is usually previous experiences of the supervisor which were not adequately processed and thus tend to be projected into current relationships. They may be recognized in work with core schemata and derived rules themselves. They lead to behaviour which may be avoidance (e.g. lack of openness or congruence) or compensatory (e.g. excessive help, competition, showing off). Self-reflection or realizing countertransference during supervision aids in overcoming countertransference reactions and may be crucial for establishing a more real relationship and more objective work in both therapy and supervision. Adequate self-reflection and supervision of one's own work is one of prerequisites for adequate development of the supervisor's competences.

INTRODUCTION

In the traditional psychoanalytic view, countertransference is a term describing the therapist's unconscious reaction to the patient's transference whereas the therapist's transference to the patient means the therapist's unconscious reaction to the patient which is related to his/her experience with similar people in the past (in particular childhood). In common practice, it is very difficult to separate the therapist's transference from countertransference. Therefore, for simplification purposes, both reactions will be referred to as

countertransference. Unconscious countertransference reactions may lead to failure of the therapy since the therapist may unintentionally want to solve his/her own problems at the expense of the patient. Countertransference also occurs during supervision and is an important part of the supervisor's reaction to the supervised person or supervisee. Countertransference may be seen in any therapy and any supervision and its awareness is one of the tasks in self-reflection, supervision and supervision of supervision.

Table 1: Examples of countertransference reactions during supervision

<p>Cognitive:</p> <p>To the supervisee:</p> <ul style="list-style-type: none"> • Labelling one's personality (rigid, incorrigible, personality disorder, immature, sloven, dilettante, anancastic, etc.) • Labelling one's behaviour (it is beyond him, he is incompetent, manipulative, he does it on purpose, he is showing off, he is exaggerating, he doesn't have a clue, etc.) <p>To oneself:</p> <ul style="list-style-type: none"> • Assessing the level of acceptance, appreciation, safety by the supervisee (he admires me, he resists, etc.) • Assessing one's own abilities in supervision, managing and not managing (I'm at a loss, I have to teach him because I know best, etc.) <p>Emotional experiences (self-complacency, pride, aloofness, predominance, helplessness, uncertainty, powerlessness, sadness, anger, fear, shyness, etc.)</p> <p>Physical reaction (muscle tension, palpitations, upset stomach, headache, breathlessness, urge to defecate, etc.)</p> <p>Behaviour:</p> <ul style="list-style-type: none"> ▪ Hypercompensation (excessive criticism, finding mistakes, moralizing, ordering, depreciating, contemptuous behaviour, aggressive confrontation, excessive protection, control, stenization of the supervisee, showing one's superiority, coldness and distance, etc.) ▪ Avoidance and safety (avoiding confrontation, exposures, putting off controversial topics, postponing supervision sessions, keeping a safe distance, referring to another supervisor, passivity, pandering, depreciating oneself, etc.)
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Unconscious countertransference reactions in supervision may lead to serious doubts of the supervisee about himself/herself, undermine his/her self-esteem and discourage him/her from working with patients, or conversely, boost the unmanaged problems related to his/her behaviour towards the patients. Similar to the therapist having enormous power over the patient, in problematic supervision, the supervisor may have enormous power over the supervisee. Therefore, it is essential for the supervisor to learn how to recognize and process his countertransference reactions. (*Table 1*)

COUNTERTRANSFERENCE FROM THE POINT OF VIEW OF COGNITIVE BEHAVIORAL THERAPY

Many experts claim that transference and countertransference analysis has no place in cognitive behavioural therapy (CBT) and should be used solely in psychodynamic psychotherapy. This is one of the most common mistakes made by external judges of cognitive behavioural therapy. Issues related to transference and countertransference have been mentioned by various authors since cognitive behavioural therapy was first used (Beck *et al* 1979; Beck 1995; Persons 1989; Gluhoski 1994). Transference and countertransference are valuable sources of information about the patient's, therapist's and supervisor's inner worlds. Unlike in psychoanalysis, transference analysis and interpretation are not the central tools in cognitive behavioural therapy. However, automatic thoughts and emotions related to the dynamics of psychotherapeutic relationship have become a part of treatment for more complex disorders (e.g. personality disorders), providing a valuable opportunity to test and modify dysfunctional attitudes to people

(Young *et al* 2003). Additionally, countertransference reactions and their behavioural and functional analysis are an important tool in supervision, in particular for overcoming resistance in therapy (Leahy 2003).

Table 2: Examples of countertransference and possible strategies for a change (Praško *et al* 2003, 2010)

Although the creators of cognitive behavioural therapy were aware of the therapist's unconscious reaction to the patient, they were hesitant to call it countertransference and preferred the term "schematic reaction" (Beck *et al* 1979; Beck 1995). They both tried to self themselves apart from psychoanalysis and stressed that countertransference is not merely "transference" of a previous experience with parents or important people but the reaction is contributed to by numerous influences from the later development maintaining the schemata as well as current circumstances of the therapeutic relationship and the patient's reactions as such. The relationship with the patient or supervisee is always established with the help of numerous specific manifestations typical only of that particular relation. Moreover, many undesirable aspects appear in the relationship with the patient which the therapist is aware of but unable to control fully. From this point of view, "transference" and "countertransference" are reducing and incomplete terms. In this text, countertransference will be dealt with in the most general context. It means both conscious and unconscious reactions of the therapist to the patient, or the supervisor to the supervisee, which is out of the person's free control, appears in his/her therapy or supervision and may led to unexpected reactions, blockade of the desirable therapeutic change, or even damage to the patient or supervisee. This reaction may have cognitive, emotional, behavioural and

Table 2: Examples of countertransference and possible strategies for a change (Praško et al. 2003, 2010)

TYPE OF COUNTER-TRANSFERENCE	EXAMPLES OF TYPICAL THOUGHTS	EMOTIONAL REACTIONS	BEHAVIOUR	STRATEGIES OF CHANGE
Moderate positive	I like him, he is nice, good cooperation with him, he will do well.	Nice tune	Cooperation, support, empathy.	None
Admiring	That person is special (especially beautiful, original, intelligent, etc.)	Admiration, fascination	The therapist does not make appropriate assessment, does not conduct the therapy. Possible non-compliance of the patient is deprecated, does not require the patient's homework, tends to talk about the exceptional properties of the patient.	Clarify own attitudes, their background, the effect on the behaviour, advantages + disadvantages for the therapy. Supervision needed. "Normalization of the therapy": conduct the same way like the others. In case that the behaviour is impossible to change and make a standard therapy, necessary to open that problem with the patient or the patient should change the therapist.
Overprotective	He cannot make decisions on his own, needs help, advice, it will be my fault, if something wrong happens to him.	Fear, insecurity	He gives advice, protects, ensures, takes control over the patient, does not allow the patient's independent decision making, doubts the patient's abilities.	Clarify own attitudes, their background, the effect on the behaviour, advantages + disadvantages for the therapy. Supervision needed. Stop the directive leading of the therapy, let the patient plan things, stop ensuring. Otherwise the patient should change the therapist.
Erotic	He/she is attractive. I would feel nice with him/her. The only problem is his/her lack of tenderness (sex, attention). Has sexual dreams (imagination) about the patient.	Fascination, "trance" or depersonalization during the time they meet	He flirts, is overprotective, "unwilling" touches, speaks often about sex, offers "sexual therapy" in the worst case and has an affair with the patient.	Stop rationalization of the seductive behaviour, stop it completely, admit own counter transference, find supervision. Realize own motives, their background, the effect on the behaviour, advantages + disadvantages for the therapy. Otherwise the patient should change the therapist. Even after the change, the therapist should not have a sexual affair with the patient.
Apprehensive	He can hurt me, make fun of me, rouse me, show me I am worthless, stupid, etc.	Fear, anxiety, shame	He speaks quietly, cannot keep the distance, the leading of the therapy leaves on the patient, is not active in the therapy (he calls it "empathic leadership". He is afraid to say what he thinks, does not discuss the alternatives with the patient.	Work on the self-confidence and self-acceptance, help the patient to process the transference reaction. Supervision always needed. Otherwise the patient should change the therapist.
Aggressive (invasive)	He is a psychopath, an ignorant person (does not try hard enough, wants only advantages, secondary benefits, etc). He is annoying. I will show him!	Anger, resonance	He moralizes, preaches, minimizes the needs of the patient, does not have time for the patient. He is rude to the patient, yells at him.	Realize his own aggressive attitudes and behaviour, stop to deny or rationalize them. Clarify their background, the effect on the behaviour, advantages + disadvantages for the therapy. Otherwise the patient should change the therapist.
Distrustful	What does he want actually? He has some hidden intentions against me!	Apprehension, tension, anger	Withdrawal, only "formal" cooperation with the patient, waiting for hidden motives, tries to cancel the therapy.	Work on the self-confidence and self-acceptance. Supervision needed. To process own attitudes, their origin and effects. If necessary, let the patient change the therapist .
Competitive	Do not let him think he will overtop me.	Tension changes with the pride (vanity)	Competition with the patient in the opinions, in "who is right", prides himself, he is not very supportive, empathic.	Work on the self-confidence and self-acceptance. Supervision needed. To process own attitudes, their origin and effects. If necessary, pass the patient to another therapist.
Derogatory	He is a jackass, weakling, dumb, hysterical person, etc.). I am fed up with him bored, I wish he would not annoy me.	Contempt, boredom, anger, vanity	He gives conceptive advice, minimizes the attitudes and problems of the patient, makes fun of him, does not have the time for him, is very impatient, does not let the patient finish what he wanted to say, does not listen properly.	To work on his/her own relationships, attend the psychotherapeutic training or to attend a new one in case experience from the previous is not sufficient enough. To process own attitudes, their origin and effects. If necessary, pass the patient to another therapist.

often physical components (or some of the components are dissociated) and may be related to deeper attitudes, the so-called core schemata to oneself, others and the world and to conditional rules compensating for the core schemata (Praško *et al* 2010).

There are very few studies assessing the impact of countertransference on treatment outcome. No studies assessing the role of countertransference from the supervisor to the supervisee (his/her self-esteem, therapeutic skills or therapeutic effectiveness) have been published. Hoffart *et al* (2006) examined whether therapists' emotional reactions to their patients mediate the effect of personality disorders and interpersonal problem behaviours on the treatment outcome in axis I disorders, and whether therapists' reactions mediate the effect of personality disorders on the course of interpersonal problems. Therapists completed a checklist of emotional reactions to individual patients with panic disorder with agoraphobia prior to and after cognitive therapy for 46 patients. The severity of personality disorder was related to therapists' insecurity feelings. A higher level of therapists' insecurity feelings was related to less reduction in agoraphobic during treatment. Therapists' insecurity feelings partly mediated the relationship between patients' severity of personality disorder and persistence of patients' interpersonal dominance and nurturance problems. Rossberg *et al* (2008) studied the relationship between patients' personality characteristics, therapists' countertransference reactions and treatment outcome. Eleven therapists filled in the Feeling Word Checklist 58 for patients admitted to a day treatment programme. At admission and discharge, patients completed the Circumplex of Interpersonal Problems (CIP). Therapists reported fewer feelings of rejection and being on guard in patients who reported high avoidant, exploitable and intrusive CIP subscale traits at the start of treatment. At the end of treatment, the CIP subscales of being domineering, vindictive and cold strongly correlated with negative countertransference. Severe countertransference reactions correlated with poorer treatment outcome.

Betan *et al* (2005) studied a national random sample of 181 psychiatrists and clinical psychologists in North America. Each of them completed a battery of instruments on a randomly selected patient in their care, including measures of axis II symptoms and the Countertransference Questionnaire designed to assess cognitive, affective and behavioral responses in interacting with a particular patient. Factor analysis of the questionnaire revealed 8 clinically and conceptually coherent factors independent of clinicians' theoretical orientation: (1) overwhelmed/disorganized, (2) helpless/inadequate, (3) positive, (4) special/overinvolved, (5) sexualized, (6) disengaged, (7) parental/protective and (8) criticized/mistreated. These factors were associated in predictable ways with personality pathology. Countertransference patterns were systematically related to patients' personality pathology regardless of

therapeutic orientation. Clinicians seem to make diagnostic and therapeutic use of their own responses to the patient, independent of their theoretical orientation.

SOURCES OF COUNTERTRANSFERENCE

The essence of countertransference, either during therapy or during supervision, is usually previous experiences of its carrier which were not adequately processed and thus the carrier tends to project them into current relationships. Usually, these are, at least partly, experiences with important people in his/her childhood such as parents, grandparents, siblings or teachers. If the carrier's basic needs in these relationships (security, acceptance, appreciation) were not met, or if he/she experienced frustration, hurt or rejection, he/she tends to set out rules in relationships with other people to be protected from further direct distress, albeit at the cost of reduced openness of relationships and development of compensatory or avoidance behaviour. Subsequent relationships later in childhood and adulthood strengthen the original perspective of relationships that becomes automatic, mostly unconscious and unreflected. However, it may also be a reaction to repeated problems or failures concerning a certain type of patients. This automatic "schematic" perspective in turn affects behaviour to other people. Such behaviour may be avoidance (e.g. lack of openness, congruence, fear of using certain techniques) or compensatory (e.g. excessive care or help, competition, showing off). Given the fact that hardly anybody's needs in childhood were fully satisfied, compensatory or avoidance relationship schemata are very frequent in the population and may also appear in therapists and supervisors, albeit reduced by long-term self-experience training.

A supervisor, very popular with therapists, who regularly supervises therapeutic work, has the gift of empathy and creates an atmosphere of security. She strengthens development in those supervised by her who succeed in creating their own therapeutic style. This is apparent from session videos. Nevertheless, she often experiences anxiety before supervisions. She especially fears one of the therapists who is very well-read and a perfectionist. He demands that she consults complicated formulations of cases that he produces in his patients. This therapist has obvious problems establishing warm therapeutic relationships which he does not reflect on. And yet she is unable to communicate this to him. When talking to him, she feels inferior and incompetent. In particular when he talks about what he has recently read and how similar cases are dealt with by various world-famous experts. He wants her to discuss models she does not know since her English is not good enough to read the articles. Therefore, she tends to postpone or avoid supervisions with this therapist. The situation reminds her very much of her spouse relationship. Her husband, having

a degree in engineering, tended to explain to her how to best understand politics and finance and how to raise their children in an upright manner. During her training, she managed to delimit herself from the husband and yet to maintain good relationship. He was similar to her father who criticized her and put stress on her duties and good school performance. Since her childhood she felt she was not good enough for her father. So she tried to do well at school and she did. But her father always tried to prove that her general knowledge was poor. Since she was the oldest of four siblings, she learned very well how to care for the others' needs and how to protect them. Her mother was anxious and often succumbed to feelings of helplessness. That is why she often took care of the family instead of her mother and her father appreciated that. Similarly, she has always tended to be too caring about her patients. Although many patients appreciated that, in her own supervision, she repeatedly considered discontinuing therapy and feared too intelligent and controlling patients. The core schema she revealed during her training was the conviction that she was incompetent and the derived rule was associated with the conviction that if she takes a lot of care for others, they will like her and will not reject her. Realizing how the core schema and derived conviction work in her supervision relationship with the well-read therapist has helped her to relax. She is able to communicate her feelings to him and to tell him that although she will probably not be able to discuss various models of disorders with him she will be able to help him treat his patients, discuss the therapeutic relations or even help him release his empathy and warmth.

A supervisor whose self-confidence was alternately overrated (You are from a better family. You will become a doctor. You are more clever than others.) and underrated (You are useless. You are very lazy. You will not succeed.) has created an instable core schema of I am better – I am worse and a derived premise Not to be worse (which is unbearable) I have to be the best at everything I do. Because he always had to be the best, he was a good student and he did well in psychotherapy training. There he realized his excessive needs for success (and he reduced them to a great extent). On the other hand, those needs were responsible for his promotion to a supervisor. In this position, however, his need to be the best was completely out of control. In fact he is not aware of it. He has a tendency to criticise the supervisees, to pick on them (They are worse – he is better) and to show them how he would deal with particular issues in a much more sophisticated manner. He is unable to devote himself to them enough to provide them with adequate support, freedom and security needed for their growth and development.

During training, a supervisor resents supervision of her own work, she easily feels hurt and misunderstood, then becomes angry or withdrawn. In

supervision training, she is dedicated and caring, tries to be friendly but also to show that she knows her job well. For her, it is difficult to give the supervised therapists enough freedom. If some of them express different opinions, she feels disrespected and offended. Although leading supervision of supervision is very kind, encouraging and nonconfrontational, she is extremely anxious about supervision of her own supervision, constantly fearing criticism. To her, even the slightest negative feedback means that she has failed or that her supervisor trainer does not like her. She either fights for the truth or wears sackcloth and ashes. Despite the fact that, in the past, she took two psychotherapy training courses and logically understands her situation, she has difficulties controlling her emotions of anxiety or hurt during supervision of her own supervision. She was the youngest child in a large family and because she was often ill her mother used to protect and spoil her. The older brothers and sisters as well as her father, however, indicated to her that she would not succeed because she did not have to do anything, being mummy's little girl. For her entire life, she has tried to counter the core schema (I am useless, others have to help me) by an attitude of I have to show everybody that I am independent and able to manage everything. Therefore, for her entire life, she has tried very hard to show others how competent she is. She graduated with the best results and was one of the most productive participants in the two courses. However, she has resented any criticism, confrontation or different opinions, considering them a proof of her own incompetence. She has had difficulties with any sort of testing. Psychotherapy training seemed to repair the core schema (she even accepted the participant's criticism or confrontation very well and did not have to assert herself), However, it was reactivated during supervision training, probably due to the fact that, unlike in psychotherapy training, there is a constant feedback concerning her handling of supervision.

Figure 1: A chart of countertransference in supervision

Understanding one's own countertransference reactions and their management is one of the main purposes of supervision. Self-reflection or realizing countertransference during supervision aids in overcoming countertransference reactions and may be crucial for overcoming stagnation in therapy. However, the supervised therapists are able to understand countertransference reactions only if the supervisor understands his/her own countertransference reactions. Therefore, adequate self-reflection and supervision of one's own work (supervision of supervision) is one of prerequisites for adequate development of the supervisor's competences.

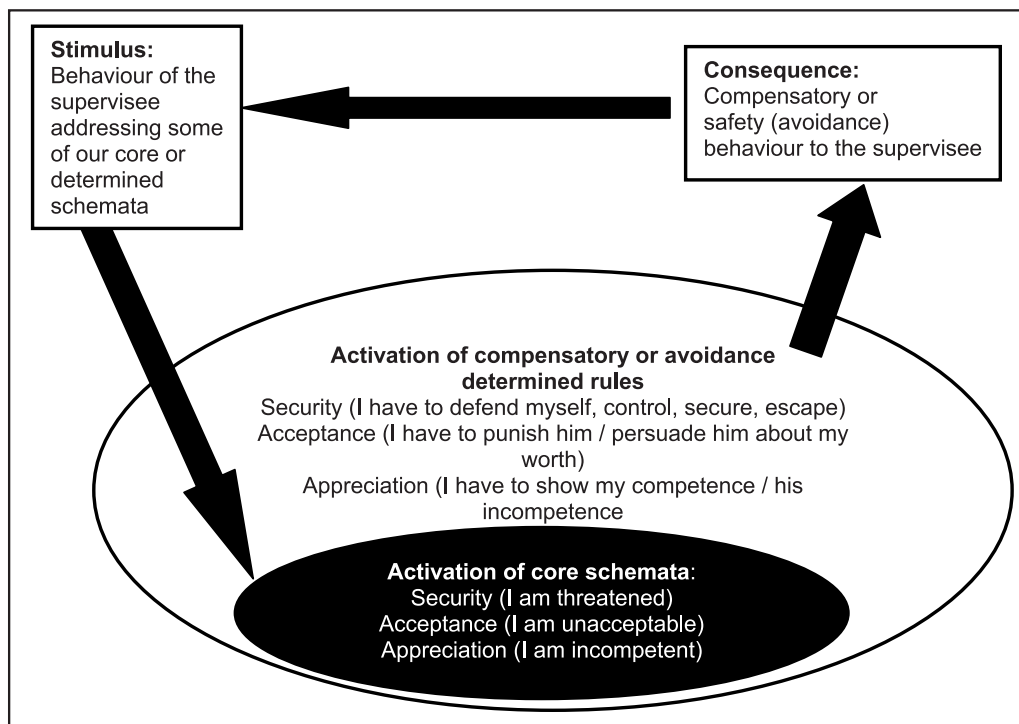


Figure 1: A chart of countertransference in supervision

COUNTERTRANSFERENCE TYPES AND ROOTS

Countertransference during supervision may be manifested in many ways. Generally, these manifestations may be classified into positive (positive feelings towards the supervisee prevail, manifested by thinking, experience and behaviour, with a clear predominance of fondness, affection, support, willingness, etc.), negative (negative feelings towards the supervisee prevail, in thinking, experience and behaviour, there is anger, hostility, disappointment, fear and mistrust, etc.) and ambivalent (both are present).

Some people are attracted by the roles of a therapist or supervisor since they give them feelings of authority, superiority and power. This illusion of authority may unconsciously lead to the fulfillment of other goals such as the need for being in power or control, or to projecting one's own problem onto others. Thus, the therapist

or supervisor may avoid his/her personal problems or shift the problems onto the patient or supervisee (Leahy 2003).

Table 3: Circumstances of countertransference

Attention paid to emotional and cognitive reactions to the patient or supervisee is the basic component of cognitive behavioural therapy and its supervision, especially if work with difficult patients is supervised (Praško *et al* in press). Despite step-by-step procedures in therapy and emphasis put on techniques, countertransference is ubiquitous. It is a part of all therapeutic and supervisory relationships. To be able to guide patients or supervisees through revelation of their thoughts and emotional reactions, both the therapist and supervisor have to be able to recognize, label, understand and express their own emotions (Beck *et al* 2004). Understanding one's own limitations and resistance to change is essential for understanding the

Table 3: Circumstances of countertransference

- Personality** (traits, humanity, openness, congruence, preferences, values, transcendence, level of self-reflection, burnout, etc.)
- Attractiveness/unattractiveness** of the supervisee (personality, appearance, position, connections, third persons, payments, etc.)
- Influence of the organization** (attitudes to certain problems, requirements for the supervisor, his/her appreciation, loyalty, etc.)
- Influence of education** (trainers, theory, training and its doctrines, etc.)
- Influence of the family**
- Life situations and problems** (e.g. one's own divorce, problems with an insurance company, lack of time, etc.)
- Other social influences**
- Somatic influences** (illness, fatigue, etc.)

patient, supervisee and oneself (Leahy 2003). As we recognize what emotional reactions the supervisee produces in us we can consider the way he/she reacts to the patient, at least to a certain extent. Sometimes this is referred to as parallel process – the reactions produced by the patient in the therapist are the reactions produced by the therapist in the supervisor. However, this view has to be taken with a grain of salt since it has never been scientifically proven and individual reactions are influenced by additional aspects of therapy and many personality traits of the participant. Countertransference reaction may be observed especially in our behaviour, but also in our thoughts, emotional experiences and physical symptoms. Cognitive behavioural therapy involves full expression of emotions during therapy. Among other things, the therapist is an example to the patient of how to behave in a natural and spontaneous yet cultivated and mature manner. The same is true for supervision. In many respects, the supervisor is an example to the therapist, especially if the supervisee is receiving training and only begins to create his own therapeutic style. Similar to the therapist encouraging patients to take notice of their physical reactions, it is important that he/she pays attention to his/her own reactions since they may make him/her aware of unconscious processes in the therapeutic relationship. The supervisor needs to do the same thing. Physical reactions often disclose emotional motives that we either are not aware of or automatically divert attention away from since they are unbearable for us for some reason. Every change in physical and emotional experiences or the therapist's behaviour to the patient (or the supervisor's behaviour to the supervisee) suggests the presence of automatic thoughts. A change in the tone of voice, feelings of insecurity, urgency, bossing, aversion to supervision, prolonging or shortening sessions may be typical manifestations of countertransference reactions. In countertransference, all cognitive distortions may appear in automatic thoughts: "This patient is a hypochondriac" (labelling), "He strives for secondary goals" (mind reading), "She will never improve" (fortune telling), "He is not doing anything" (all-or-nothing thinking), "She does this on purpose" (personalization), "He should try harder" (musturbation), "She keeps making the same mistakes" (overgeneralization), etc.

Most frequently, countertransference is influenced by the therapist's or supervisor's core beliefs and conditional rules. Different patients or supervisees may activate different schemata. In this context, Leahy (2003) described the following schemata:

Excessive demands

Supervisors or therapists with anancastic traits often see their patients or supervisees as irresponsible, spoiled or lazy. They believe that expressing emotions or insecurity may be threatening or devastating. They have difficulties expressing warmth and empathy for the patients

or supervisee and put too much stress on "logic" and "rationality". The patients or supervisees may feel that the supervisor uses supervision as an opportunity to show that he/she is brighter than they are. The perfectionist supervisor may try to compensate for his/her underlying feelings of a lack of competence by demanding perfect performance from himself/herself or the supervisee. A typical sequence of automatic thoughts may be as follows: "The supervisee makes mistakes → I'm not doing my job → I'll be exposed as a fraud → I'm a failure → I can't accept any failure in myself." In some cases, supervisors with excessive standards may compensate for their perfectionism by being excessively critical of and demanding more and more from their supervisees.

Abandonment

The supervisor with inadequately processed abandonment schema may worry that if she/he confronts the supervisee with something negative, then the supervisee will leave therapy. Any premature termination of therapy is interpreted as a personal rejection of the supervisor. Under the influence of abandonment, the supervisor may behave in various ways reflecting the schema. The forms may be, for example, excessive caretaking of the patient on the one hand or avoidance of entering into a meaningful therapeutic relationship on the other hand. Excessive caretaking may take the form of trying to protect the supervisee from any difficulties, constant advice, hesitating about negative feedback or taking on the supervisee's problems as the supervisor's own to solve. The supervisor concerned with avoidance often focuses on conceptualization and techniques rather than on meaningful discussions about creating the relationship. Such a therapist avoids more difficult topics and anxiety-provoking interventions. He/she often personalizes the supervisee's different opinion, failure to show up for sessions or lack of interest in supervision. The supervisee's resistance is viewed as personal rejection.

High need for approval

The "pleasing" therapist may be highly skilled in showing empathy for the supervisee. He/she believes the supervisee should feel good regardless of what is going on. The therapist's warmth and empathy are appreciated by many supervisees because he/she never expresses negative emotions and does not confront with faults. Such a supervisor usually avoids questions on the supervisee's negative emotions. These topics are viewed as too disturbing and therefore as not appropriate. The supervisee may miss sessions, show up late or not do homework but the high-need-for-approval therapist does not want to cause a "conflict" and tolerates this. If the therapist fails, the supervisor tends to accuse himself/herself of his/her own incompetence. His attitude is: "If the therapist is not doing well then it means I'm doing something wrong."

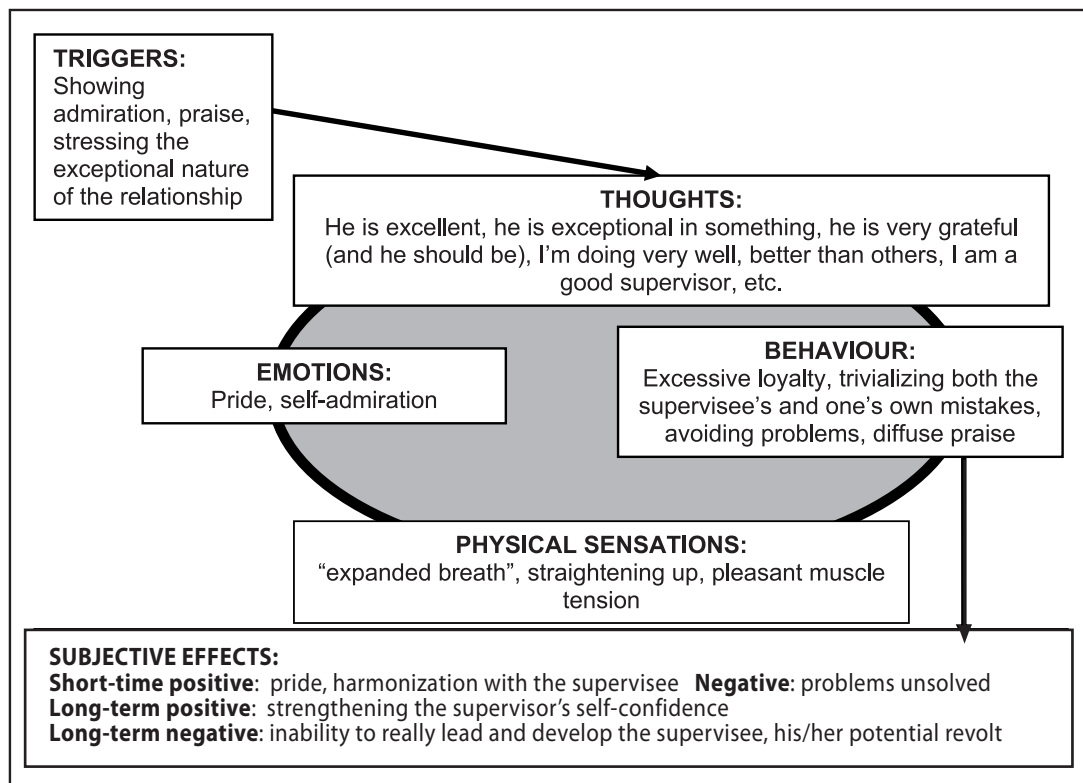


Figure 2: Example of a vicious circle of excessive positive countertransference reaction.

Need for superiority

The narcissistic supervisor views supervision as an opportunity to show off his/her special talents. Supervision of a difficult case may begin with grandiose hopes expressed by the supervisor that the supervisee has finally found "the right supervisor" who will help to solve everything. He/she likes to give advice and knows everything best. The supervisor's investment in his/her own image of being a superior, special supervisor may result in vilifying all the other therapists who have "failed" the patient. Such a supervisor feels entitled to having cooperation and adulation of the supervisee. This may result in the supervisor encouraging boundary violations by the supervisee, using surprising interventions or he/she may initiate these boundary violations. The supervision itself may not work, the supervisor may grow bored with, angry at or punitive toward the supervisee. Rather than empathize with the supervisee's understandable frustration with lack of progress in the therapy, the supervisor may turn on the supervisee, blaming him/her for a lack of desire to improve, etc. To change the narcissistic perspective, we need to ask ourselves: "How would I feel in the place of the supervisee?"

OPTIONS FOR MANAGEMENT

Ongoing discussion of the therapy with colleagues is valuable (even for experienced therapists) and in empirically validated therapies, it is considered to be

essential (Gunderson & Links 2008). Such interviews rapidly increase the therapist's ability to clearly see the patient's transference and to rapidly understand his/her countertransference anger or disappointment (Gabbard & Wilkinson 1994; Marginson *et al* 2000). Supervision may support the therapist, show him/her a different perspective on the situation and its solution, and help him/her in difficult situations. In supervision, it is easier to separate the therapist's unmet needs from the patient's problems and to see when the therapist, rather than the patient, solves his/her problems. For the therapist, good supervision is also an example of how to behave during therapy, how to remain open to other options and views, how to be tolerant, non-condemning, understanding, sensitive and yet firm. Good supervision creates a secure, accepting and yet appreciating place where the therapist may open all his feelings and attitudes (Gunderson & Links 2008).

The supervisor himself/herself needs regular assessment of his/her thoughts and behaviour towards the supervisee that may stem from his/her own dysfunctional attitudes (Linehan & Kehrer 1993; Williams *et al* 1997).

Figure 2: Example of a vicious circle of excessive positive countertransference reaction

If the supervisor pays attention to his/her possible countertransference reactions, he/she has a chance to recognize and manage them. This decreases the risk of negative effects for supervision (Young *et al* 2003). During supervision, however, the supervisor needs to

Table 4: Therapist's dysfunctional thought record

Situation	Emotion	Automatic thoughts	Rational response
Supervisee arrives late; persists with dramatic story-telling; breaks into sobs when I redirect to agenda setting.	Frustrated Disappointed Uncertain Embarrassed	He/she will never get it! My supervision has no sense! I am an incompetent supervisor! I don't know what to do next. I must be ineffective with this approach.	To realize that my pressure has no sense and to avoid judgments, to try to be more sympathetic and focus on the supervisee rather than my feelings of disappointment. The supervisee is better at labelling his/her own emotions and understanding reactions of his/her patient. Also, I am focusing more on techniques than on interpersonal support. I need to respect his/her values, help him/her learn to define problems with patients. Just because I feel uncertain and embarrassed does not mean I am ineffective or I should be ashamed. My frustration stems from excessive expectations that all therapists have to work with their patients directly and perfectly. If they don't it's m fault. Does it make sense that a good supervisor never feels embarrassed or uncertain? I can brainstorm some options to try next or even go for my own supervision.

monitor its process, in particular his/her stronger emotional reactions to the supervisee, both positive and negative, and the flow of his/her own internal speech. Subsequently, he/she needs to compare these reactions with similar ones in the past and to try and find his/her attitudes towards oneself and other people they stem from. The supervisor monitoring his/her own positive and negative feelings needs to be aware in particular of the following reactions:

- concerns or excessive joy related to the forthcoming session with the supervisee;
- excessive anger/hate or feelings of affection for the supervisee;
- a wish to terminate or prolong the session;
- a strong wish to terminate supervision or concerns about its termination;

The first step to managing countertransference is that the supervisor realizes that his feelings towards the supervisee are striking, in either positive or negative way. It is advisable to take some time, preferably outside the supervision setting, to patiently answer a few questions:

- What is my emotional reaction to the supervisee?
- Isn't that a bit over the top?
- Why do I dislike or like the person so much?
- Which are the things I clearly want or do not want to discuss with the supervisee?
- What produces my feelings of discomfort?
- Are there any signs of the supervisee's problems that I have overlooked? What does that tell about me?

Another step may be seeking out consultation with a supervisor to help delve deeper into addressing and potentially resolving the source of strong countertransference feelings. To assess countertransference, the supervisor may examine his/her own life problems he/she experiences. Has he/she experienced rejection or abandonment in his/her own life? Then the supervisor

may examine to what extent similar feelings appear in the contact with the supervisee. Does it happen that he/she always has to be "right"? Then it is necessary to realize whether he repeatedly "defeats" the supervisee in their debates since this would decrease the supervisee's self-confidence. Isn't he/she too concerned about failing or being criticized in his/her life because he/she thinks that success or failure is related to his/her value as a person?

The way the supervisor deals with thoughts related to supervision may result in the need for cognitive restructuring to reduce negative or excessively positive emotions so that supervision may continue. It is useful to confront any fear of making a supervision mistake and try to understand what preceded these concerns. The supervisor's reactions may come from various sources, including cultural attitudes and values, view of his/her own professional role and unique life experiences including training, or may be triggered by interaction with the supervisee and his/her behaviour (Kimmerling *et al* 2000).

Table 4: Therapist's dysfunctional thought record

CONCLUSION

The only way of recognizing countertransference during supervision is consistent awareness of our own thoughts and attitudes that influence our response to the supervisee's behaviour. Rather than to controlling his/her own emotions, the CBT supervisor is guided to notice them in himself/herself and to consider the form they have in his/her supervision and which thoughts and attitudes they are related to.

ACKNOWLEDGEMENT

Supported by the Czech Ministry of Health grant project no. IGA MZ ČR NS 10301-3/2009

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