ORIGINAL ARTICLE

Countertransference, schema modes and ethical considerations in cognitive behavioral therapy

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Submitted: 2013-05-02 Accepted: 2013-05-18 Published online: 2013-08-30

Key words: **psychotherapy; therapeutic relationship; countertransference; schema modes; ethics**

Act Nerv Super Rediviva 2013; **55**(1–2): 33–39 ANSR551213A06

Abstract

BACKGROUND: Transference and countertransference could be significant sources of insight about the patient's, therapist's and supervisor's inner worlds. Transference phenomena are viewed as a reenactment in the treatment relationship of key elements of previous significant relationships. Countertransference occurs in CBT when the relationship with the patient activates automatic thoughts and schemas in the clinician, and these cognitions have the potential for influencing the therapy process. Countertransference also occurs during supervision and is an indispensable part of the supervisor's response to the supervisee. CBT is typically short-term treatment – intensity of transference is usually much lower than in longer-term, dynamically oriented psychotherapy. Nevertheless during the long-term CBT of the personality disorder or other complex cases, high intensity of transference and countertransference can develop.

SCHEMA MODES AND COUNTERTRANSFERENCE: Schema therapy shares the view that schemas are crucial to understanding of personality disorders, but also can help to understand the emotional reaction of therapist. A mode is the set of schema operations that are in one moment functioning for a person. It is a circumscribed complex pattern of emotional, cognitive a behavioral experiences, which operate in typical situations. When therapist suspects that countertransference may be developing, he/she could try to identify her/his automatic thoughts and schemas. More comprehensive approach is to quickly identify in which mode him/her are at that moment and reflect it such reaction is for the patient benefit or not. Understanding therapist countertransference reactions and theirs management are a significant point of supervision. Self-reflection and realizing the countertransference can therapist help to overcome it and may be necessary for overcoming stagnation in therapy.

CONCLUSION: Understanding own mode and their flipping into the therapeutic session is an important tool in psychotherapy and supervision.

Introduction

Both patients and psychotherapists can experience intensive emotional reactions towards each other. We talk about transference and countertransference within therapy. Memories, mostly images and emotionally laden recalls can be triggered by the situation in the present time which evokes the emotional reminiscence and the subject will respond in a similar manner as they did then (Goin 2005; Prasko *et al*

2010). Transference and countertransference could be significant sources of insight about the patient's, therapist's and supervisor's inner worlds. Transference phenomena are viewed as a reenactment in the treatment relationship of key elements of previous significant relationships (such as parents, grandparents, teachers, bosses, and peers). Focus is not on unconscious components but on automatic ways of thinking and acting that are recapitulated in the treatment setting. For example, if a man has a deeply held core belief „I must be in control" and has long-standing behavioral patterns of controlling others, he may play out these similar cognitions and behaviors in the therapeutic relationship. CBT is typically short-term treatment – intensity of transference is usually much lower than in longer-term, dynamically oriented psychotherapy. Nevertheless during the long-therm CBT of the personality disorder or other complex cases, high intensity of transference and countertransference can develop. In addition, transference is not seemed as a necessary or primary mechanism for learning and change. Nevertheless, an awareness of transference responses in patients and an ability to use this knowledge to improve treatment relationships and modify dysfunctional thought patterns are noteworthy parts of CBT.

The therapist should pay careful attention to emotionally negative or positive reactions of the client towards him/ her but should not deliberately cause or ignore those (Prasko *et al* 2010). He/she should be alert to signs of powerful negative emotions, such as an anger, anxiety, disappointment, sadness, and helplessness experienced in the therapeutic relationship by the client. Similarly, he/she should be vigilant for excessive positive emotions such as love, excessive idealization, and approval or attempts to divert the attention of treatment onto the therapist. These reactions can help to a better understanding the patient's past and existing relations. Countertransference refers to transference from therapist to patient. Countertransference occurs in CBT when the relationship with the patient activates automatic thoughts and schemas in the clinician, and these cognitions have the potential for influencing the therapy process. Countertransference also occurs during supervision and is an indispensable part of the supervisor's response to the supervisee. Unconscious parts of countertransference may lead to failure of the therapy since the therapist may unintentionally need to solve his/her own problems at the detriment of the patient. The therapist should consider his/her own reactions that indicate countertransference.

Both conscious and unconscious reactions of the therapist to the patient, or the supervisor to the supervisee, which is out of the person's voluntary control, may trigger unexpected reactions, blockade of the therapeutic change, or even harm the patient or supervisee (Prasko & Vyskocilova 2010). These reactions may include cognitive, emotional, behavioral and often physical components (or some of the components are dissociated) and may be related to deeper attitudes, the presumed core schemata to oneself, others and the world and to conditional rules compensating for the core schemata (Prasko *et al* 2010).

Countertransference can be recognizing during the therapy and supervision, and its realization is one of the tasks of self-reflection, supervision and supervision of supervision (Prasko & Vyskocilova 2010). Additionally, countertransference reactions and their behavioral and functional analysis is a powerful tool in supervision, in

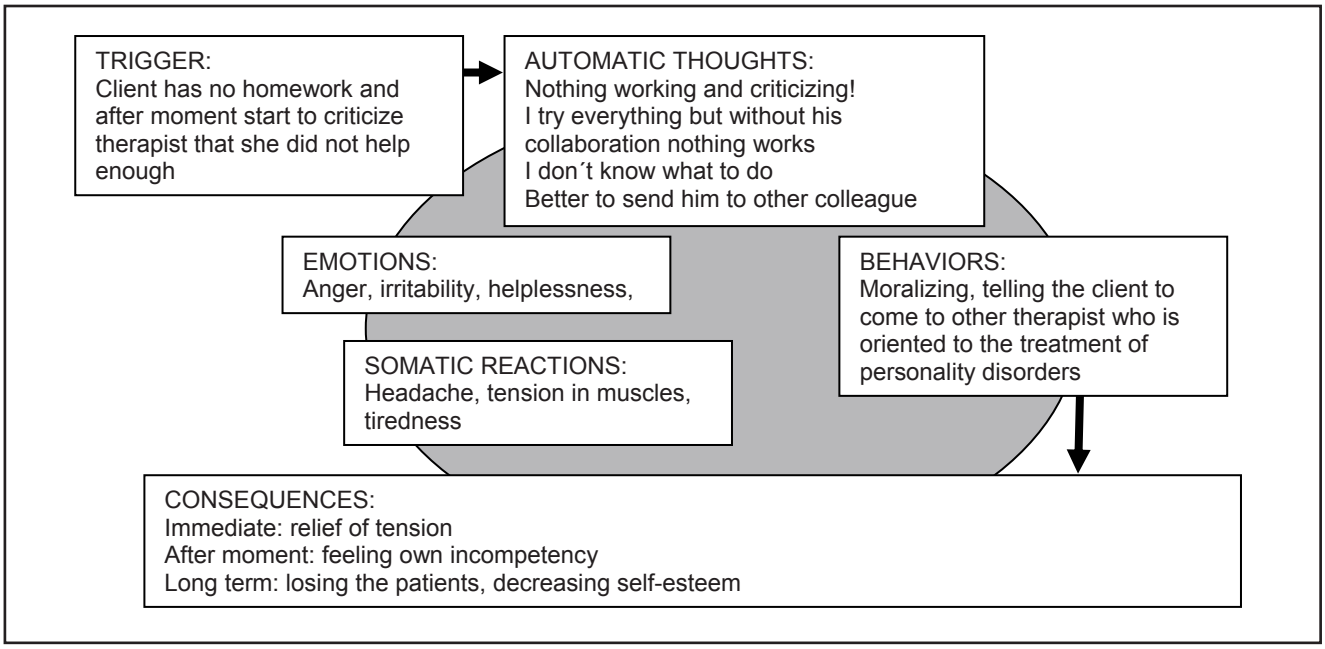

Fig. 1. Vicious circle of countertransference reaction of the therapist to the client.

particular for overcoming resistance in therapy (Leahy 2003). Automatic thoughts and emotions of therapist related to the dynamics of psychotherapeutic relationship have become a part of treatment for more complex disorders, providing a valuable opportunity to explore and modify dysfunctional attitudes to people (Young *et al* 2003). Countertransference also occurs during supervision and can be a critical part of the supervisor's response to the supervised person or supervisee.

Schema therapy is an extension of Beck's model and has grown to become a unique integrative treatment for the entire spectrum of personality disorders and other difficult patients (Rafaeli 2009; Rafaeli *et al* 2010). A controlled randomized multicenter trial demonstrated that schema therapy leads to recovery from borderline personality disorder in about half of the patients, and to significant clinical improvement at two thirds of them (Giesen-Bloo *et al* 2006). In this article schema therapy proved to be more than twice as effective as a psychodynamic therapy in terms of recovery rates. Schema therapy has been adapted for work with different populations besides borderline personality disorder (e.g., Homeless substance abusers, individuals with borderline personality disorder or anti-social personality disorder in forensic settings; Ball *et al* 2005; Bernstein *et al* 2007). Schema therapy shares the view that schemas are crucial to understanding of personality disorders, but also can help to understand the emotional reaction of therapist (Prasko & Vyskocilova 2010). Schema therapy holds that there exists a set of universal core emotional needs (needs for safety, stable base, predictability, security, love, nurturance, empathy, validation, autonomy, spontaneity, guidance and protection, and reasonable limits) and that schemas emerge when these needs go unmet or are met inappropriately or excessively (Young *et al* 2003). Schema therapy conceptualizes schemas somewhat differently than cognitive therapy. Schema is not only cognitive issue but also include images, memories, emotions and bodily sensations. Early maladaptive schemas are a relative stabile pervasive negative pattern that develops during childhood or adolescence and are self-perpetuating throughout life. They contain feeling, meaning and beliefs about oneself, others and the environment and subject adopts them without questioning. Schema therapy proposes a taxonomy of early maladaptive schemas; currently, 18 are identified, including regularly occurring ones such as emotion deprivation, defectiveness, abandonment, and subjugation (Arntz & van Genderen 2009). In addition to universal child needs and to schemas, schema therapy devotes significant attention to modes, the predominant emotions, schemas, or coping reactions involved for an individual at a certain time (Young *et al* 2003; Arntz & van Genderen 2009).

Schema modes

A mode is the set of schema operations that are in one moment functioning for a person (Rafaeli *et al* 2010). It is a circumscribed complex pattern of emotional, cognitive a behavioral experiences, which operate in typical situations. The person reacts characteristically in each mode (Young *et al* 2003). Modes are functioning temporary. A person is predominantly in one particular mode at any given moment. There are four types of modes: child modes, maladaptive coping modes (avoidance, over-compensation, and surrender), dysfunctional internalized parental modes (such as punitive or critical

Tab. 1. Most frequent modes.

MODUS	CHARACTERISATION OF THE MODE
Vulnerable / abandoned child	Function: Display helplessness, sadness, anxiety to get needs met or call security Signs & Symptoms: Depressed, hopeless, needy, frightened, victimized, worthless, unloved, lost, frantic efforts to avoid abandonment, idealized view of nurturers
Angry / impulsive / irritable child	Function: Acts impulsively or angry to get needs met or vents feelings in inappropriate ways, act irritable Signs & Symptoms: Intensely angry, with shouting, impulsive, demanding, devaluing, "manipulative," controlling, abusive, suicidal threats, promiscuity
Punished / Demanding parent	Function: Punishes the child for expressing needs, feelings, behavior, display emotions or for making mistakes in relations Signs & Symptoms: Self-hatred, self-punishment, self-criticism, self-denial, self-mutilation, anger at oneself for neediness
Detached protector	Function: Cuts off needs & feelings; detaches from people Signs & Symptoms: Depersonalization, emptiness, boredom, substance abuse, binging, self-mutilation, psychosomatic complaints
Hypercompensator	Function: defend vulnerable child by overworking, over carrying, etc. Sign & Symptoms: Hypercompensator is competitive, ostentatiously demonstrate how much works or control, fights with others, must still prove something to himself and others to no fall in the mode of Vulnerable/injured child
Healthy adult	Function: understand context, meta-position, thinking about consequences, learn new things Sign & Symptoms: obviously interesting, asking, self-reflecting
Nurturing/tolerant parent	Function: heal s the vulnerable / abandoned child Sign & Symptoms: display empathy, kindness, tolerance to himself/herself and others, rewarding, helping him/her self to feel autonomously

parental voices), and a healthy adult mode (Young *et al* 2003; Arntz & van Genderen 2009). Young *et al* (2003) described a total of 10 schematic modes, which can be grouped into four broad categories:

- children's modes;
- dysfunctional coping modes;
- parental dysfunctional modes;
- modus healthy adult.

Three modes of the child were described: Vulnerable child, Angry / undisciplined / impulsive child, and Happy child. Vulnerable child's modus is a manifestation of early maladaptive schemas: lonely, abused, distressed or abandoned child. Angry child is an passionate part of a person who is angry because of unmet needs of which are triggered in the present situation. Angry / impulsive / undisciplined child expresses strong emotions. It desires for a sudden fulfillment of needs. A happy child is a mode that reflects the fact that the basic emotional needs are met.

There are three dysfunctional coping modes: Flexible/compliant surrenderer, Detached protector and Hypercompensator. These three modes correspond with the three coping styles – survival, avoidance and hypercompensator. Compliant surrenderer acts as a passive, helpless child, trying to meet the needs of others. Emotionally distant Detached protector distances, avoiding closeness, often abuses alcohol or substances, use sarcasm and distance in relations or other safety behaviors no to feel Vulnerable child. Hypercompensator is competitive, ostentatiously demonstrate how much works or care, fights with others, must still prove something to himself and others to no fall in the mode of Vulnerable/injured child. Frequent use of maladaptive coping modes leads to further confirmation and maintenance of early maladaptive schemas. Two described dysfunctional parental modes are: Punitive parents and Demanding parent. In these modes, people react to themselves but also to others like their parents behave to them. The parental behavior was internalized. Punitive parent punishes the child uses remorse, branding and explain how the "child" is wrong. Demanding parent mode always demands higher standards from inner "child". Finally, Healthy adult is the tenth mode. It is the rational, does not use avoidance or defense coping strategies. We added eleventh mode – Nurturing parent – which is empathetic, cure and rewarding for the children modes. These modes alternate in response to stimuli and situations in which the client occurred.

In collaboration with the client, modes get labeled their origin is explored and linked to current problems, and the possibility of modifying them is explored (Rafaeli 2009). Following such arrangements, dialogues between modes are initiated.

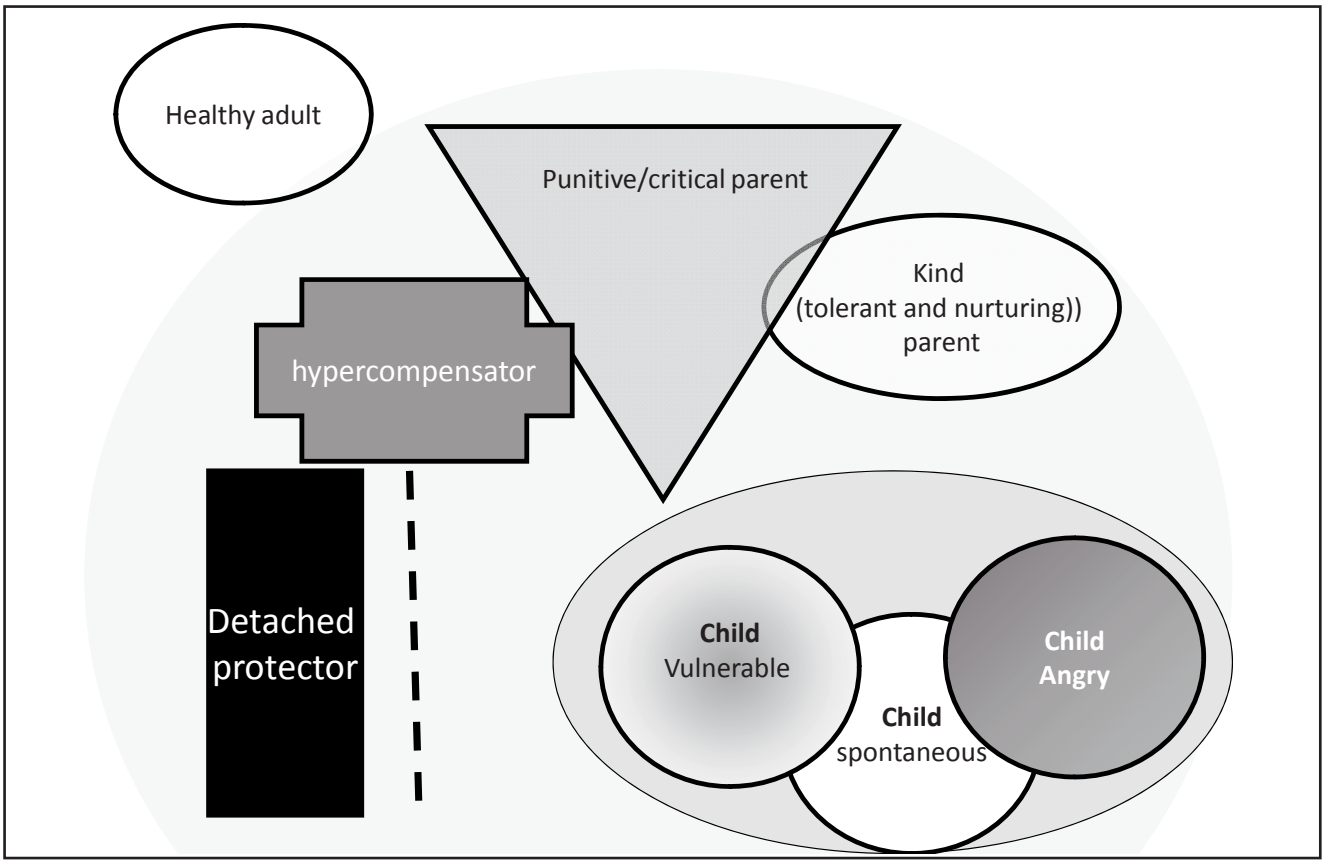

Fig. 2. Schema of the modes.

Therapist schema modes triggered during therapy session

Understanding therapist countertransference reactions and theirs management are a significant point of supervision. Self-reflection and realizing the countertransference can therapist help to overcome it and may be necessary for overcoming stagnation in therapy. Because automatic thoughts and schemas can operate outside therapist full awareness, a good way to detect potential countertransference reactions is to identify emotions, physical sensations, or behavioral reactions that may be stimulated by cognitions. Common indicators that countertransference may be occurring the negative feelings as an anger, tension, or frustration with the patient. Therapist becoming boring into the therapy; relieving when the patient is late or cancels the appointment; having repeated difficulties working with a particular type of illness, symptom cluster, or personality dimensions; or finding particularly attracted or drawn to a certain patient.

When therapist suspects that countertransference may be developing, he/she could try to identify her/his automatic thoughts and schemas. Then if, it is clinically indicated and feasible, he/she can work on modifying the cognitions. For example, if a therapist has the automatic thoughts such as „This patient has no motivation…all he does is whine through the entire session… this therapy is going nowhere," he could try to identify his/her cognitive errors (e.g., all-or-nothing thinking, ignoring the evidence, jumping to conclusions) and change thinking to reflex a more balanced view of the patient efforts and future. More comprehensive approach is to quickly identify in which mode him/her are at that moment.

Supervisor schema modes triggered during supervisory session

The primary goal of supervision is to increase the value of the therapeutic process in the client's best interest. That why supervision is focused on improving the supervisee's skills to understanding actively solving and adequately emotionally experiencing both therapeutic work and himself in the role of a therapist (Prasko *et al* 2012b). The supervisor's mission is to find balance between supporting the supervisee's experience and necessary changes in his/her therapeutic understanding so that (Waltz *et al* 1993; Armstrong & Freeston 2003). To meet these goals, supervision needs to focus on increasing the therapist's competencies, i.e. improve knowledge, abilities and skills, and learn to recognize his/her own reactions (Prasko *et al* 2012a). Supervision is a comprehensive approach involving the patient, therapist and supervisor, each with one's own attitudes, experiences and ordinary thinking and behavioral patterns. It seems clear that if supervision does not pay enough attention to self-reflection of supervisee, he/she may remain trapped in misunderstanding of the patient, and psychotherapy fail (Orchowski *et al* 2010; Vyskocilova & Prasko 2012).

Tab. 2. Examples of typical countertransference problems.

Ambivalence to use some obvious approaches because of worries about freezing of therapeutic relation
Guilty feelings, anger of fear with the patient
Feelings of inferiority with the patient
Tension from patient sexual attraction
Problems in border building in situations with patients provocative sexual or hostile behavior
Prolongation or cut short of treatment sessions
Bondage to talk about intimate issues
Anger to the patient to phone between sessions
Slander /foul/ the patients with colleagues

Blocks in self-reflection prevent the understanding of the situation of the countertransference and may limit the ability to establish a solid therapeutic relationship because the therapist is not aware of his/her own participation in it (Prasko *et al* 2010; Prasko & Vyskocilova 2010; Prasko *et al* 2012a,b). For supervision to be helpful, it should be inspiring, safe, open, authentic and creative (Prasko *et al* 2012a). Schema mode model can help in this task.

Countertransference during the process of supervision can be occurred in various manners. These manifestations can be sorted 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).

Guided discovery aids in realizing the context based on both past experiences and improved cognitive and emotional understanding (Vyskocilova & Prasko 2012).

Ethical considerations

There are no definitive answers to the numerous of ethical questions that psychotherapists may encounter in the therapy of clients. Principles-based medical ethics is a valuable tool for resolving ethical dilemmas in psychiatry and psychotherapy (Robertson *et al* 2007). Main four principles of bioethics, formulated by Beauchamp (1994) in general are following: (1) autonomy; (2) benefit; (3) harmless; (4) justice. These principles could serve as a basis for practical dilemmas in the therapy, but practical dilemmas in the therapy session are complex, dynamic, nuanced, and highly personally and based on a broader context (Jain & Roberts 2009). In many situations, psychotherapist must respond quickly.

Tab. 3. Clients modes, countertransference mode response and cure mode response from the therapist.

CLIENT MODE	REACTION FROM THERAPIST COUNTERTRANSFERENCE	CURE RESPONSE FROM THERAPIST MODE
Vulnerable/ abandoned child Complaining, crying, display sadness, anxiety, helplessness, hopelessness	**Hypercompensator** Overemphasize empathy, sorrow, give advices **Detached protector** Detaches, use cliché, talk about need for medication, labeling **Punitive/critical parents** Speaks about bed collaboration, lack of homework, little endeavor, criticize, pressing **Vulnerable/abandoned child** Have guilty feeling, sadness, think about personal competencies, display helplessness, **Angry child** Impulsively criticize client, punished him/her, feel anger, advice other therapist, immediate hospitalization	**Healthy adult** Asks what happened, try to gather information, use inductive question to help client change the mode to healthy adult **Kind/nurture parent** Empathically recognize state, display sorrow, valid feelings, asks for the antecedents
Angry child Reproaching, opposition in everything, shouting, display anger, hostility, impulsivity	**Detached protector** Display irony and detachment, cold, labeling **Punitive parent** Criticize, punish, moralize **Angry child** Reproaching and shouting back, feels anger, hostility **Hypercompensator** Speaking to much, apology, promise **Vulnerable/abandoned child** Feeling fear, sadness, apology, explain, speaks about personal inability to help, wounded feelings	**Healthy adult** Validation, agree with real, negative questioning. Search for understanding, helping client change mode to healthy adult by developing meta-position **Kind/ nurture parent** Agrees with true, accepts anger, Empathizes with vulnerable child
Punitive/critical parent Criticize, pointing mistakes from up position, controlling, moralize	**Detached protector** Irony or silent, detachment, detract from, **Punitive/critic parent** Criticize back, moralize **Vulnerable/abandoned child** Explain, apology, promise **Angry child** Explode, angrily silent, stop therapy, later traduce client **Hypercompensator** Try to show how much worked, offers more possibilities	**Healthy adult** Accept what is right, asks further details, asks about suggestions **Nurture parent** Accept what is right, empathize vulnerable child, question needs
Hypercompensator Bragging, display workaholism, over exercising, over carrying, hypomania, pride, over rewarding	**Hypercompensator** Hyper rewarding, also bragging, demonstrated personal workaholism, compete **Detached protector** Irony, disqualify with contempt speaking about consequences, detract from **Punitive parent** Criticize hyperactivity and critically question consequences **Vulnerable/abandoned child** Compare and feel guilty, adoring, rewarding from down position **Angry child** Reproaching hyperactivity, angrily scoff, devalue success, jealous	**Healthy adult** Accept and helps to recognize advantages and disadvantages, connections and context, asks the needs which are hyper compensated **Nurture/kind parent** Valued, empathize with pride, but also with disadvantages, like tiredness and asks unsatisfied needs, consider how much vulnerable child must do to avoid or compensate pain and vulnerability
Nurture/kind parent Display kindness, tolerance, acceptance, interest, peace, closeness	**Detached protector** Mistrust, detached, try to avoid **Punitive parent** Persuades that everything cannot be all right, Warning for future changes **Vulnerable/abandoned child** Accept with admiration and devotion **Angry child** Firstly angrily devalue, then calm down **Hypercompensator** Try to speaks about much how he/she help client	**Healthy adult** Accepts, interest, asks for connections and context **Nurture parent** Accepts, share satisfaction
Healthy adult Interesting, rationally think, pointing connection, discussing for and against, look for context and consequences	**Hypercompensator** **Try to be the same or better** **Detached protector** Don't understand, distancing **Punitive parent** Impeaches, warning for future **Vulnerable/abandoned child** Adore, asks for help **Angry child** Jealous, anger because lose of competencies	**Healthy adult** Accepts, interests **Nurture parent** Heart's content, celebrate

Although basic principles of bioethics and psychotherapeutic ethic codes provide guidance on optimal standards of behavior, but they do not always help to understand the dynamic changes during the sessions. Good understanding that the therapist himself sometimes protects his vulnerable child and used complementary maladaptive modes into the therapy and quick orientation in his/her and client's modes is valuable skill for effective therapeutic action. What therapist says or how he/she reacts to client sentence could have hurt or curative and require high level of self-reflection of the therapist at this moment (Prasko *et al* 2012 a).

The patient may be hurt by therapeutic silence, critique, rejection, which is not point of patient changes, but therapist's need for gratifications (Adshead 2004). Ethically behaving psychotherapists serve the well-being of their clients above all other interests. Helping to grow up and develop independent mature individuals are among the most frequently cited goals of psychotherapy (Holmes & Adshed 2009). Therapist who is attentive to the ethical issues can build various strategies to increase his/her ethical competence. They can include constant reflection of own emotions, cognitions, behaviors and attitudes, engaging in dialog and developing opinion in relation to ethics questions, and demonstrating an openness to dialogue with supervisor (Prasko & Vyskocilova 2010). Schema mode model can be useful for self-reflection of therapist and client positions and type of theirs interactions in rapidly changing situations.

Conclusions

Understanding own mode and their flipping into the therapeutic session is an important tool in psychotherapy and supervision. During the conversation in circumstances of changes of the own mood the therapist or supervisor can use self-reflection to know in which mode actually operated and in which mode client is. From the meta-position of the Healthy adult can decide which tactics can use to help the client the best way. This process can help the therapist or supervisor clarify adequate processes in treatment or supervision and realize transference and countertransference phenomena.

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