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ORIGINAL ARTICLE

Therapeutic and supervision relationship in cognitive behavioral supervision

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Abstract

The therapeutic relationship between the therapist and the patient is an integral part of the supervision. The supervisory relationship between the supervisor and the therapist is also important, as the supervisor can help to realize, strengthen, or hinder the supervisory work. If supervision is to be an effective tool for improving the quality and competence of therapists, it must provide a safe space based on a kind and understanding relationship between the supervisor and the supervisee. While guiding the consultation, the supervisor helps the supervisee by questioning to recognize the broader framework of the case formulation, to clarify fitting therapy strategies, and to understand what is happening in the therapeutic relation, particularly to bring awareness to transference and countertransference matters. To guide the supervisee well in revealing their thoughts and emotional responses, the supervisor must have the ability to recognize, label, understand and express his / her own emotions. Understanding one's own limitations, one's own resistance to change, is necessary to understand both the supervisee and himself/herself.

Introduction

Cognitive-behavioral therapy has recently emphasized the role of the therapeutic relationship as a necessary basis for the application of specific strategies and overall providing therapy. The main reason for this is the clients in the treatment with increasingly challenging issues. Medical models of psychopathology had big impact in development of CBT. The idea that clients (and on other hand supervisees) willingly comes to therapy to fix some of their "broken parts" was popular. Some recent developments in CBT have suggested that the model of CBT can be practiced to more relationship-focused way (Wills & Sanders 2013). New formulations and insights of the therapeutic relationship were brought mainly by representatives of the third wave of CBT (Young 1994, Gilbert & Leahy 2007, Gilbert 2010) and other model developers (Wills & Saunders 2013, Egan 2013, Katzow & Safran 2007). In CBT as in other therapies client and

therapist brings to therapy their personal strength, weaknesses, history, gender, other biological factors, ethnicity, culture) and creates place to formal exchange in therapy as well for informal exchange (mostly relational), include those key elements - their problems, behavioural patterns and their crucial links to social and relational contexts. Many authors refer to deprivation of basic emotional needs in most clients who unsuccessfully use avoidant or compensatory strategies to meet those (Young *et al.* 2003). Also, Bowlby's model of attachment (Holmes 1993) has proved a powerful idea across different models of therapy. The therapeutic relationship between the therapist and the patient becomes an integral part of the supervision, because the therapeutic relationship is the basis upon which the therapy takes place. The supervisory relationship between the supervisor and the supervisee is very important, as in the supervision they can promote better understanding and help to the client, strengthen or hinder supervisory work and development of awareness, reflection and skills in this area.

An older woman suffering from generalized anxiety disorder admires the therapist. She is convinced that no one else can help her, does not feel self-reliant, and therefore requires advice from the therapist. The flattered therapist responds complementarily by counter-transference, providing advice. He is pleased with himself and feels needed. The client praises him at every session. The client, however, remains dependent, still brings more and more problems, which she is unable to solve. The therapy does not continue well, rather becomes a never-ending conversation and advising. During a supervision session, the therapist refers about this client as treatment resistant, with the need for lifelong guidance.

Relational exchanges and therapeutic relationship in CBT

Therapy takes place in field where relational exchanges between client and therapist (also supervisor) occur. Key elements both client and therapist bring in the therapy along with their personal strengths, weaknesses, challenges, gender, ethnicity, culture, include those of their problems and their links to social and relational contexts. Also, we need to include links that therapeutic relationship exists within an organisational, legal, social and cultural context (Figure 1).

Examining therapeutic relationship in supervision or self-work, we can explore those sources of influence and their links, increase awareness of relational responses (especially automatic) and help the therapist as well as the client to de-centre (step back) from their automatic reactions/responses and offer more prospect of choosing to do things differently – a key element in change (Wills 2015). Creating therapeutic relationship and choosing appropriate relational responses can be useful Bowlby's "working model" of model of attachment which helps to understand and discuss relationship work. For human beings' secure attachment bonds have evolutionary survival value and appear to be linked with responses from the early life moments. The lack of secure base leaves humans less confident to explore and may lead to negative modes of attachment (Wills 2015). Rational collaboration breaks down in a therapy relationship then clients may revert to and use previous modes of negative attachment (Liotti 2007). If clients feel misunderstood on basic level change in therapy will not happens. Therapist goal develop secure attachment bonds to promote later secure detachment in appropriate time. Discussions, work with "here and now" material and behavioural experiments designed with explicitly interpersonal aims can be forms of relationship exploration from secure base of therapy relationship to new, functional relational responses and patterns, which meet client's needs. Those ideas and attachment concept language is useful in supervisory process, putting more emphasis on therapist autonomy (assertiveness) developing therapist self.

Negative or unhelpful behaviour often seems to exert a pull that draws others into a "complimentary response" that turn merely confirms the first person's worst fears (Safran & Moran 2000). For example, client with social anxiety isolation, shy and detached behaviour pattern can draw unwanted attention and hostility from others, things anxious clients most fear, resulting in self-fulfilling prophecy, frustrated basic emotional needs and emotional suffering. Those unhelpful relational responses so well established that they seem natural, but for therapist (and supervisor in supervision) they became obvious. Rather than react to them as usual and maintain self-fulfilling patterns and beliefs, therapist can step back, de-centre (first with help of supervision) and respond in appropriate and functional way.

Two main sources of interpersonally significant information are: relationship signals (sometimes referred as 'dissonant notes') and relationship breakdowns. Relationship signals ('interpersonal markers') are smaller incidents that reveal underlying interpersonal patterns. They are samples of behaviour that are 'window into understanding the whole cognitive-interpersonal style' of the client (Safran & Segal 1990; Wills 2015). Relationship breakdowns (alliance ruptures) occur when relationship between client and the therapist begins to weaken. They are not necessarily big dramatic events, but clear emotionally intensive event in therapy. Therapist and supervisor need skills to become aware, formulate, monitor and appropriately respond to them.

Therapeutic relation in supervision

Integral part to provide CBT is therapeutic relationship which should be reflected in supervision process and one of the therapist development goals are good enough relation competencies. While guiding the

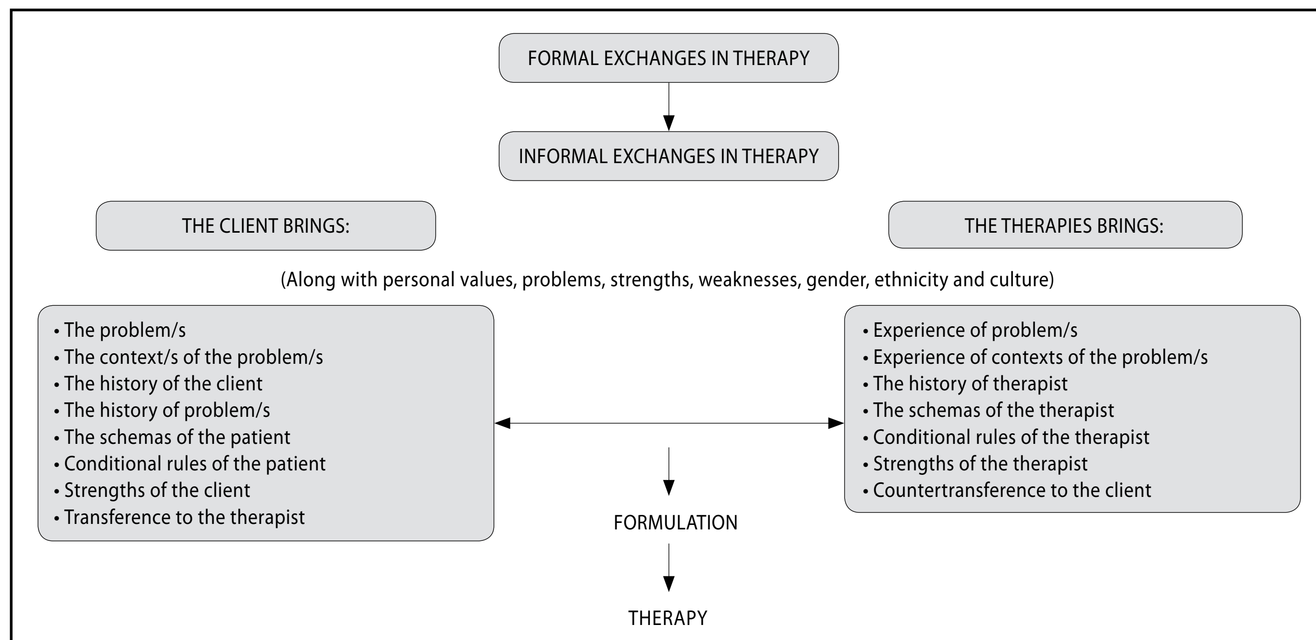

Fig. 1. Relational elements within the therapeutic relationship (adapted according Wills 2015)

interview the supervisor helps the therapist by asking questions, using other supervisory interventions, to understand the broader context of the case conceptualization, to clarify appropriate treatment strategies, and to understand what is happening in the therapeutic relationship, what in relational exchanges can be helpful what is not helpful in therapy. One of the important goals is to bring awareness about transference and countertransference issues. The therapeutic relationship is the basis for therapy, without its precise establishment the specific therapeutic interventions are not possible (Hoffart *et al.* 2006, Linehan & Kehrer 1993, Swales & Heard 2009) and relational competencies and skills are essential for good enough CBT therapist.

Difficulties in establishing a therapeutic relationship usually reflects may reflect the client's difficulties in interpersonal relationships in his/ her life one transfers to the therapy. Examining them can help reveal both the client's beliefs and his usual compensation strategies. Therapists often do not have enough distance and are not objective in assessing their relationship with the patient (Yalom & Leszcz 2007, Vyskocilova & Prasko 2013). The reason is not because they don't want to, but the story or conflict can emotionally engulf them, or they do not have skills to do it. The supervisor's task is to help the therapist understand the situation and map his own countertransference to the patient. Supervision goal is to help understand situation, increase awareness on relational exchange processes, help to develop necessary relational skills for example map own counter-transference to the patient and choose functional relational response. Also, therapy for the client as the supervision for the therapist is secure place where new relational responses can be tested, learned and corrective emotional experience get (by meeting basic emotional needs) promoting later secure detachment (autonomy).

Therapist Louis says he wants to find the strategies in the treatment of a client with obsessive-compulsive disorder, where, in his opinion, exposure does not work to prevent neutralization. During the supervisor's inquiry, it turns out that the client is reluctant the exposure because he does not trust the therapy. Louis responds to it by the helplessness and reassurance of the client, which repeatedly lasts the whole session. The supervisor helps Louis to discover that the problem may be in the client's lack of confidence in the therapy, as well as in Louis's response to that statement, which may be problems related to the therapeutic relationship.

A client with a depressive disorder develops a dependent admiration transference to a therapist who, however, feels overloaded and frustrated by the needs of the dependent client, and confronts him with it. He uncompromisingly says that the client has to figure out everything himself, that he does not need to be dependent on other people. A client who is not yet able to function without unambiguous support, falls into despair and commit a suicide attempt.

The client worked very hard with the therapist and achieved partial success in the treatment of agoraphobia. During treatment, however, he fell in love with the therapist and tried to show how well he handled the individual exposures. But the more demanding exposures of traveling outside the city had raised his fears so much that he had stopped doing them. He could not disclose it in therapy but had lied about successfully managing them. The therapist is enthusiastic about her success, even though she noticed that the client is more attentive to her than usual. She is surprized by flowers or chocolates at each

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Tab. 1. Examples of typical countertransference problems

• Ambivalence in the use of some common practices due to concerns about disrupting client / therapist relationships
• Guilt, anger or fear towards the patient
• Feeling inferior when working with a patient
• Tension when the patient is sexually attractive
• Failure to set boundaries in patient´s sexually provocative or hostile behavior
• Failure to do emphatic confrontation and set boundaries on other unhelpful, dysfunctional behaviour.
• Extending individual sessions and therapy
• Stiffness and embarrassment when the patient talk about intimate things
• Anger in patients calling or requesting outside of established appointments
• Defamation of patient in front of health care staff
• Reticence towards patients' emotional needs
• Advising too much to the client
• Doing exercises, tasks, summarization for the client
• Lack of reassurance, validation and normalisation
• Lack of appropriate self-disclosure

session. The client is remarkably sweet-smelling with perfume. The therapist does not consider these signals important when the treatment goes so well. She is surprised and irritated about the client's wife, who calls in for advice on how to help her husband go on vacation to the other end of the country. Wife refers that he has not yet been able to leave the city. Last time he had to get drunk a lot, just to be able to travel. She asks whether it would be better for him to get some medication to calm down.

Supervision helps to gain understanding (Macakova 2001). Mere experience is not enough, because without continuous supervision and evaluation, the original mistakes can be strengthened by repetition. Forming a therapeutic relationship requires the therapist to create a safe atmosphere, to understand, to listen, to reflect, to strengthen, to appreciate, to maintain hope, etc. (Bennett-Levy *et al.* 2009). Poor preparation and care of the therapeutic relationship may result in client resistance (Leahy 2003). The therapist therefore needs to regularly examine his / her thoughts and behavior towards the client, which may be based on his / her own dysfunctional attitudes. Investigating the therapeutic relationship is therefore an important part of supervision (Wachtel 1977, Prasko *et al.* 2011). It can help the supervisor recognize what is happening in the relationship between the therapist and the client, both from the therapist's report about the client, also through guided discovery, imagination, or role-playing. The most common approach to discovering the context is guided discovery, during which the supervised person can realize what he/she hadn't thought about before. His/her understanding of the client expands and, if necessary, can fundamentally change.

Therapist: I think there's nothing I can do about the client. She has a personality disorder, she has already ruined her family, she has one child in foster home. Whoever cared for her and was kind to her, ultimately suffered for it.
Supervisor: I understand that you don't feel like she can be helped. Sounds like she's going to destroy everything ...! Can we somehow try to understand, why does she do it? What happened to her in her life?
Therapist: Well, she didn't have a very good childhood, but that can be said about many people. That is no reason to destroy her surroundings. Even in the ward, she immediately has the conflicts, both with other patients and with nurses. I think she's full of evil.
Supervisor: You may be right, if she acts like that ... I just wonder, what happened to her ... that she is behaving like that?
Therapist: Uhm, I don't know exactly… just that her mother criticized her a lot and her father was an alcoholic, but more I don't know anything more in depth .... I focused mainly on what was happening here and now .... and so, ... partly I neglected her childhood…. it's a pity ... I really don't understand why she's behaving like that ... for some reason I haven't done a good conceptualization ... I guess I'm annoyed .... that's probably the main reason ...
Supervisor: Occasionally, we become angry or unsympathetic about a client and then it may prevent us from fully understanding him. But Radek, I have to say that I like that you are honest and able to admit it.
Therapist: You're right. I'm ashamed. I made my opinion on her because she was recommended by the psychiatrist. And from what she said about her husband, I develop such a prejudice that she's actually bad ... and I also felt angry with her, so I didn't ask her about childhood or the causes of behavior much ... I just thought if my wife did to me what she did to her husband…. I don't know… I would either leave her or collapse. So, I got mad at her.
Supervisor: You seem to have projected a bit of yourself into that story… sometimes it happens to us… what do you think, does it have any effect on how you understand her?
Therapist: I say, I misunderstand her completely. I guess it's counter-transference ... I didn't realize it at all ... I'll try to discuss her childhood with her properly and look at her without prejudice ... projecting my own marriage into her ...
Supervisor: Fingers crossed ... you managed to admit it and you stopped rationalizing your attitude.

Supervision helps the therapist to deal with negative feelings about the client or himself / herself in the

Tab. 2. Recording of therapist's automatic thoughts - self-reflection

SITUATION	THOUGHTS	EMOTIONS	ARGUMENTS FOR	ARGUMENTS AGAINST	CONSTRUCTIVE REACTION
• The client tells that the therapy does not help him in any way.	• I've given him so much effort, and he says it's not helping him! • He does little, otherwise he would make better use of it! • I don't know what to do with him!	• Disappointment 80% • Wrath 60% • Helplessness 90%	• It is true that I have given him enough time and effort, and he says it does not help. • Occasionally he did not do homework and missed 2 sessions. • His progress is slow.	• Last time he said that it helps and objectively handles disproportionately more things. • What he says may reflect his own disappointment or other negative emotions. • He tries hard enough and do most of the tasks. He is active in the sessions. • Sometimes the client's reaction takes me by surprise, but I can usually find another meaningful way.	**Impact of discussion:** • My emotions decrease to half. Rather, I wonder what is happening to him. **Action:** • I appreciate that he communicates what he is experiencing. • I will offer a list of what has been done and what is still missing.

My own schemes that have been activated:
- I have to be successful in everything, otherwise I fail and I'm useless.
- When I experience strong emotions in response to a client, I can't handle myself and I'm not a good therapist.

Discussion with schemes:
- I may not always do everything perfect, and that does not mean that I have failed or that I am useless. Most things are going well.
- I can have all sorts of reactions to a client, I'm human, just like everybody else. The important thing is that I can understand and work with them, and sometimes find benefits in therapy.

therapeutic situation, understand the broader context of therapy, overcome the therapeutic blocks and encourage him / her to look after himself / herself.

A client with generalized anxiety disorder falls in love with her therapist during therapy, like she has fallen in love with her teachers and supervisors in the past. She says she has a "weakness for older men". The therapist perceived her long glances, striking make up and sighing, occasional dreamy states during the session. The therapy went very well at first, the client worked with automatic thoughts, learned to relax, elaborated several catastrophic scenarios and developed coping strategies that reduced the incidence of excessive worries and anxieties, learned to communicate better in difficult working situations. The therapist considered also her developing erotic transference as transient episode and decided not to focus on it. The client did all the homework and relatively easily achieved set goals. The client's admiration was pleasing to the therapist. Even more because in his own marriage he went through a crisis. However, when they got to solving the marital problem associated with the start of symptoms, the treatment began to stagnate. The client said that her husband was uninteresting, actually too young and still immature. She could not play him a mother, did not love him, even considered divorced. It contrasted significantly with the goal she had set at the beginning of treatment - less arguing with her husband, better understanding him and herself in the relationship, and to enrich the relationship with common pleasant activities. Therapy stagnated, turned into "chatting", quite pleasant meetings for client and therapist, discussing the novels they liked, sometimes the situation at work, how the children are doing and the therapist gradually began to open up about himself. However, in a situation where she suggested that they could meet in a café or restaurant, he realized they are outside the limits of therapy. He decided to seek supervision with this therapy process. Initially, he insisted that all went well, then admitted that the therapy was now stagnating, but the client was well, she was managing her job and household, she was no longer anxious, she was only in a marital crisis - so she needed support in it. During the guided discovery by the supervisor, therapist realized that he is feeling very well with the client admiration, and that he didn't want to give it up a bit, moreover, he felt her support as he talked about his fatigue and overwork. He does not receive such support at home, his wife criticizes him for being long at work. In the end, he gets the client support instead of helping her to solve her marriage problem. During supervision, he

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Tab. 3. Supervisor´s questions for countertransference

• How do you feel in the presence of this client?
• What feelings do you have in your body?
• What automatic thoughts usually arise?
• Do you have any similar feelings, body reactions, thoughts in the past? With your significant others?
• Which emotions arouse you?
• Are they different from what you normally experience with other clients?
• In which situation can you recall it and in which not?
• How do you respond physically to it?
• Which last situation do you recall with the client?
• What do you want to tell him / her and was not said?
• Which topic do you avoid with this client?
• What do you like and what do you dislike on this client?
• Do you hesitate to ask for some parts of his medical history or problems?
• If you are experiencing discomfort with this client, in which situations is this happening?
• Is there something that you perceive to be important to other clients and that you do not give so much emphasis to this client?

considered how to change the situation. He didn't want to concede his own counter-transference to the client. It would be better to discuss sensitively her transference and lead her to an analogy of relations with authorities in the past. But then he wondered how she would feel. He realized that it could shame her, and he would hurt her by "just throwing it all at her." Nor will it be fair, because he himself participated in the development of its transference largely by his own counter-transference. Finally, he decided to try to tell the truth by telling her what he felt from her side, then how pleasant it was until he began to confide in himself, thus they deviated from therapy. He apologizes for this and asks her how she experienced their interaction. If she tells him that she loves him and asks if he loves her as well, he will say that he values her, but he is not in love with her. He expects it could be painful to hear it, but if she is willing to talk about it, he hopes that the pain will decrease and dissipate. Then they can look at how this happens to her in relation to authorities in past and what disappointment she is experiencing. Also, it may help her tp engage into a better relationship with her husband. They then played this role with the supervisor in role-playing.

Transference in therapy

From the history of psychotherapy, we recognize of psychodynamic concept of transference which can sound rather complicated term in CBT. But simple explanation is possible – People sometimes (because of their life experiences, core beliefs other cognitive, emotional, physiological components etc.) misread one situation by reacting to it as if it were more like another situation than it actually is. According to Hedges (2013) the important postulation of psychotherapy is that early conditioning in the context of emotionally significant connections with peoples and impactful experiences deeply influences the ways we construct our following perception and lives. Difficulties in establishing a therapeutic relationship can reflect the client's difficulty in non-therapy relationships and examining them can help reveal both the client's beliefs and his usual compensation strategies (Raue *et al.* 1997, Andersen & Przybylinski 2012). The therapist himself needs to regularly examine his / her thoughts and behavior towards the client, which may be based on his / her own dysfunctional attitudes (Zepf & Hartmann 2008, Prasko & Vyskocilova 2010). Supervision is therefore very important (Knox *et al.* 2008, Prasko *et al.* 2012a).

If the therapist is aware of the client's transference, he / she can use it in therapy for the benefit of the client either indirectly, not letting the client look into the transference process, or directly helping him/her to discover it (name the expectations) and realize its context (historical and current), influence on therapy and relationships outside of therapy and treat it so that the client can better understand them in his/her life and use more adaptive behavior (Raue *et al.* 1997, Prasko & Vyskocilova 2010). Awareness of the transference relationship requires the therapist's tact and empathy, knowing the potential injury to the client. Direct confrontation can increase transference, so a discovery strategy is usually used to help the client figure it out (Padesky 1993, Vyskocilova & Prasko 2013).

Countertransference in therapy

Countertransference is characterized by attitudes, thoughts and feelings that the client evoked in the therapist. Unconscious countertransference reactions can lead to therapy failure because the therapist may inadvertently solve his problems at the expense of the client. In the classical view, countertransference is a term that describes the unconscious reaction of the therapist to the client's transference, while the therapist's transference to the client is the unconscious reaction of the therapist to the client related to his experience with similar people in the past (especially in childhood). More holistic concept now sees counter-transference primarily as a complete (conscious and unconscious) response of the therapist to the client (Gelso & Bhatia

2012, Wongpakaran & Wongpakaran 2012). Since it is very difficult to separate the therapist's transference from countertransference in practice, we will call both these reactions countertransference in this article for simplicity. The classical approach defined countertransference as a pathologic reaction of a therapist to a client that stems from the therapist's own unresolved conflicts. It has been seen as an obstacle to treatment that needs to be eliminated (Kimmerling *et al.* 2000). Later, it has been shown that countertransference is present in every therapeutic relationship (Table 1). The therapist's reaction to the client can be a valuable source of information that can be effectively used as a driving force for treatment. However, it requires that the therapist has gone through a process of self-knowledge and minimized his own "blind spots" (Prasko *et al.* 2010).

Awareness and understanding of countertransference, constant monitoring it in therapy session help the therapist not only to avoid hurting the client, but can help client even more, thus affecting basic ethical premises (Prasko *et al.* 2012a). Supervisor´s goal to find the therapist appropriate complementary relational response to client's interpersonal behaviour. Socratic dialogue with the therapist helps to find constructive reaction (complementary relational response) to the patient in case of negative automatic thoughts. As a homework, supervisor can ask the therapist to work with the automatic thought's records of the situations with patient (Table 2).

The therapist may map countertransference to the patient using self-reflection, but self-work at the novice therapist may be limited. The following supervisor's questions can be helpful (Table 3).

It could be helpful if the supervisor helped the therapist to be aware about his own and the client`s schemas mismatch. The therapist`s behavior and used strategies have impact on the client and can confirm the client`s schemas. Leahy (2007) describes some examples of schematic mismatch in the therapeutic relationship (see the table 4).

Countertransference as a therapist's response also raises a number of ethical questions about helping the client, his / her safety, undamaged and abusive, fairness and confidentiality (Haškovcová 2007).

Supervision relation in supervision

Supervision in a cognitive behavioral model is understood as a systematic management of supervisee by a supervisor, in which the supervisor is responsible for teaching the supervisee to understand and treat the client in a way that ensures the best outcome of therapy in the broadest possible context and, if necessary, teaches him/her to change attitudes, thoughts, behaviours or emotions regarding the countertransference (Beck *et al.* 2008, Linehan & McGhee 1994, Prasko *et al.* 2010).

The CBT supervisor must have the competencies that the CBT therapist has, but must also be able to create a supervisory relationship that is different from a therapeutic relationship in a number of parameters (Praško *et al.* 2010a). Empowering the supervisee while giving him enough space for independent growth, to be well aware of his / her influence and power over the supervisee, to be clearly aware at which stage of his / her therapeutic development is supervised (Kaslow *et al.* 2008). The supervisor's role in the supervisory process is to find a balance between supporting the supervisee's experience and making the necessary changes in his / her therapeutic understanding and behavior to the client in such a way that the therapist feels support, encourages his / her strengths, naturally learns new skills and removes bad habits (Armstrong & Freeston 2003).

If supervision is to be an effective tool for improving the quality and competence of therapists, it must provide

Tab. 4. Examples of schematic mismatch in the therapeutic relationship

Strategies	Therapist`s reactions	Patient's possible experience
Avoidant	• Does not bring up difficult topics, avoids discussing patient's dependent behaviour, does not set limits on patient • avoids using exposure techniques	Patient`s thought: *"My emotions must be overwhelming to other people."* *"Doing new things will be risky and terrifying."* *"My therapist must think I am incapable of doing things on my own."*
Compensatory	• Constantly reassures patient • Prolongs sessions, apologizes for absence	Patient's thoughts: *"I need to rely on others to solve my problems."* *"I can't get better on my own."* *"The only way to get better is to find someone to take care of me and protect me."*
Demanding-coercive strategy	• Views patient's lack of progress as "personal" resistance • Demands agenda and task compliance • Critical of lack of progress • Labels patient as "dependent"	Patient's thoughts: I can't count on my therapist • I will be abandoned if I don't improve • My emotions are not important to my therapist • I am a failure in therapy • I can't solve any problems

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a safe space based on a kind and understanding (not primarily evaluating) relationship between the supervisor and the supervisee (Havrdová 2000). It is most effective if the supervisor is able to tune into the therapist, follow his main concerns, capture the essence of his narration, transfers him/her through clinical dilemmas, and show personal interest and support. Supervision, which is excessively focused on criticism, is shaming or disregarding the supervisee's main concern, not only does not encourage him/her to grow, but effectively discourages it. During supervision, the therapist should feel safe, understood, accepted, strengthened and at the same time be encouraged to further discern the context. Through questions, encouragement and summaries, guided discovery deepens the client's understanding, conceptualizes the case, and discovers his own therapeutic process. As the therapist matures, supervision gradually becomes more challenging and at the same time freer. From the relative greater dominance, directivity and supervisor's support to emerging therapists, where the main goal is to conceptualize the client's story and to propose appropriate change in strategies in coherence with conceptualization, supervision gradually turns into free dialogue between two experts dealing with more discovery, authenticity and ethical issues. Supervisor behavior can also raise ethical issues.

A therapist who is irritated and angry at his client comes under supervision. He is a psychiatrist who is at the beginning of his psychotherapy training. Today, he wants advise from supervision on how to end therapy with a single client who is reported to have a personality disorder.

If the supervisor conducts the interview morally, because he thinks that the therapist is inexperienced and unable to get rid of the client, the interview might look like this:

Therapist: I just need advice on how to get rid of him, somehow nonchalantly, so that he doesn't know I'm angry with him

Supervisor: And you don't even think about how your client will feel? Do you think we can do this to our clients?

Therapist: (ashamed) Well, I guess you're right, so I'll keep him, but I don't know what it will do, because he bothers me and I still think nothing will help him. It's a personality disorder.

If the supervisor sees this ethical problem as the therapist's uncertainty and helps him discover what is worth getting rid of the patient, the therapist can resolve the ethical dilemma and act in the interests of the client's welfare. The interview can look like this:

Therapist: I just need advice on how to get rid of him, somehow nonchalantly, so that he doesn't know I'm angry with him.

Supervisor: Ah, so you're angry with him, so you don't want to do therapy with him Why do you mind, Petra having a personality disorder?

Therapist: Well, I think it's a waste of my time, you can't do anything with a personality disorder!

Supervisor: I understand. And what does do anything with a personality disorder mean to you?

Therapist: Well, in two months he just leaves and won't come back.

Supervisor: Hmmm. What feelings do you have when a client improves, leaves within two months and does not return, and what happens when the opposite is true?

Therapist: Well, I feel like I did a lot of work, but when someone's been there for a long time or coming back, I feel like I'm not good, that I screwed up something, that I didn't do what I was supposed to. That I just do not do therapy. I have no idea what to do next.

Supervisor: So, if I understand it well, it's not that a person has a personality disorder, but rather that you're afraid of having to do more with him and not knowing what?

Therapist: Exactly. I feel like I need some help from an experienced colleague at the moment.

Supervisor: So, if you had any advice, would you keep the client with personality disorder in therapy?

Therapist: Yes, if I knew what to do with him, it would go smoothly.

Supervisor: What about the anger and rage at him?

Therapist: Well, I guess I shouldn't, not really wearing myself, that I'm so incapable.

Supervisor: So, what could you do when a person with a personality disorder comes to therapy?

Therapist: Well, I guess I need to say that it will be for a long time, but that it is fine, that is just how it goes with them.

Supervisor: Well, you're thinking about it. Is there anything else you need when you think you've already used all your strategies with him? Try to think what helps you with other clients who may not have a personality disorder.

Therapist: Well, I always try to conceptualize there, and when a new problem comes up, I put it into conceptualization again so I can understand it.

Supervisor: Perfect! So, can we apply this rule to someone who comes to you repeatedly?

Therapist: Well, I guess I should circle back to the fact that the essence of returning is that it has a stronger attitude and maladaptive behavior than others without a personality disorder, and that's why he came back again. Maybe this would help me in not turning it on myself and my inability, and not then upsetting him and not blaming him for coming back or for the therapy not going as fast as others.

Supervisor: Ah, well. So, Petra, if I get back to your job of getting rid of a client with a personality disorder nonchalantly, is there anything that gave you an answer during our conversation?

Therapist: Well, I don't think I should give up that fast with them. I probably understood more that it wasn't about diagnosis, but rather about the intensity of those emotions and patterns. But maybe I should go to supervision more often, because I don't know if this point of view will last (laughs).

Supervisor: I understand, it's up to you. It is true that supervision can help us with belief that working with personality disorders is difficult, but it pays off and that it may not be so much that we are failing as therapists.

Therapist: That's when I think about it, that's what I'm taking away today, such a reassurance that maybe I can handle it.

The formation of a supervisor-supervisee relationship is based on similar principles to a therapeutic relationship (Aubuchon & Malatesta 2003, Beck *et al.* 2008, Henry *et al.* 1993, Greben & Ruskin 1994). This relationship

Tab. 5. Basic difference between supervision and therapy

PSYCHOTERAPY	SUPERVISION
• The goal is to benefit the client who has entered therapy • Therapy is a therapeutic process • The client gradually reveals the truth • Very carefully with criticism, we prefer not to criticize • Tolerance to client's regressive manifestations such as dependence, resistance, rivalry. If they occur, they are processed one by one with a view to understanding the potential of the client. • Client support, acceptance and valuation • The boundaries can vary and be shifted • Transference is used the therapy therapeutically • The client may not always be ready • The speed of the process is determined by the client	• The aim is to benefit the client as well as the supervised • Supervision is an educational process • We can tell the truth directly in the feedback • Criticism - we ask whether the supervised person cares for her • Regressive manifestations are not supported and are processed immediately if they occur • Support of the supervisee in his work • The boundaries are respected • We do not support transference • Therapist should be prepared to supervision • The speed of working together is often determined by the current situation in the work with the supervisor's client

mirrors the therapist-client relationship in many ways, but greater emphasis is placed on equality between the two and on the supervisor's freedom and independence from the start of the supervisory process. It's not therapy. However, a supervisee, like a client, should feel safe, understood, accepted, and at the same time encourage a more differentiated discovery of the context, guided discovery of therapeutic process (Persons 2008, Linehan & McGhee 1994). The basis of the supervisory relationship is a clear contract, empathy, positive empowerment, emphasis on the characteristics of the relationship. Just like working with a client, we support our own search process. To be effective, supervision should be discoverable. However, the transfer relationship between supervisor and supervisee is not strengthened in CBT supervision. Nevertheless, we can expect a similar development in the supervisory process as in all other relationships. There are defensive mechanisms, resistance, transference and countertransference that they tend to evolve, and it is important that they be reflected in the supervisory relationship, because the therapist learns to handle them (Linehan & McGhee 1994, Prasko *et al.* 2010). The supervisor can also serve as a role model for the supervisee in a number of ways. Therefore, the supervisor's behavior should include the virtues required of the therapist such as respect, safety, acceptance, empathy, encouragement and appreciation, congruence, straightforwardness and optimism in behavior towards others (Greben & Ruskin 1994). The paradigm can also happen in promoting freedom and tolerance for individual differences and styles.

Supervision cannot be imposed or dictated to the supervised person. The supervisor discusses the supervised case conceptualization, leads the supervisee to further study, shows him the resources, discusses the alternatives to the approach, teaches him new skills and techniques, gives him the opportunity to practice these skills (e.g. working in imagination or playing role in supervisory meetings) (Kuyken *et al.* 2009, Prasko & Vyskočilová 2011). The supervisor's task is to teach the supervisee to understand and treat the client in a way that ensures the best outcome of the therapy, support the development of the therapist's own style, encourage the supervisee´s self-confidence, help him / her to understand to the world, to the organization, to teach him to understand attitudes, ideas, behaviours, or emotions about transference and countertransference (Armstrong & Freeston 2003, Shafranske & Falender 2008).

Basic differences between supervision and therapy

During the supervision process, it may happen that the personal problems of the supervised person are so negatively affected by his professional work that their change exceeds the possibilities of the supervision process (Horská 2008). For a supervisor who is also a psychotherapist, it may sometimes be tempting to start with psychotherapy. Especially when supervisory work is hampered by significant countertransference phenomena (Behr & Hearstová 2005). This need is more urgent when the supervised therapist is not on his own. If it turns out that the supervised person cannot talk anywhere else about the problems that concern him and mainly concern himself, the recommendation of psychotherapy is appropriate. There is also a tendency to "smuggle" therapy into the supervisory group. The supervisor should in no way assist in such tendencies. It would be a mistake to believe that supervision replaces psychotherapy - the supervisor should recommend psychotherapy if necessary, and the supervisor has the right to freely decide whether to enter personal psychotherapy. It should be borne in mind that the supervisor does not and should not have any therapeutic contract with the supervisee and therefore is not entitled to therapeutic interventions (Table 5).

The line between supervision and therapy is that in supervision, emotional conflicts are only dealt with in the field of employment, while therapy refers to the whole life of the supervisee. This dividing line is sometimes difficult to see or blurs. However, if the supervisor finds that he is already too far away in the supervisee's personal affairs, he or she should draw attention to this and return the dialogue back to supervision.

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Tab. 6. Examples of countertransference reactions in supervision

Cognitive:
To the supervisor:
- Personality labelling (rigid, unusable, personality disorder, histrionic, narcistic, too nice and too stupid, immature, sloppy, dilettante, anankastic…)
- Behavior labelling (is incapable, has no ability, manipulates, does it on purpose, shows off, exaggerates, does not understand…)

To himself/herself:
- Evaluation of acceptance or appreciation from supervisee (he admires me, he rebels ...)
- Evaluation of own skills in supervision, coping and not coping (I do not know how to do it, I have to learn it because I know best ...)

Emotional experiences (complacency, pride, detachment, power superiority, helplessness, insecurity, helplessness, sadness, anger, fear, shame…)
Physical reactions (muscle tension, palpitations, stomach upset, headache, narrowed breath, stool urge, etc.)
Behaviour:
- Hypercompensation (excessive criticism, error-finding, moralizing, conducting, degrading, contemptuous behavior, offensive confrontation, over-protection, over-caring, control, supervisee´s asthenization, showing superiority, cool distance, etc.)
- Avoiding and securing (avoiding confrontation, exposures, postponing controversial topics, postponing supervisory sessions, creating a safe distance, sending to another supervisor, passivity, pandering, self-destruction, etc.)

Countertransference in supervision relation

Understanding and managing one's own countertransference is one of the main purposes of supervision. Self-reflection or awareness of countertransference in supervision helps to overcome the countertransference reaction and may be critical to overcoming stagnation in treatment. However, in order to be able to understand the countertransference reactions of supervised therapists, the supervisor must first of all understand them in himself/herself. Therefore, adequate self-reflection and supervisor self-work (supervision of supervision) is one of the basic prerequisites for adequate development of the supervisor's competences. Even if he has years of experience as a supervisor.

Unconscious countertransference in supervision can lead to serious doubts of the supervisee about himself, reduce his self-confidence and discourage him from working with clients, or, on the contrary, strengthen his unmanaged problems in behavior towards clients. Like a therapist power over a client, the supervisor has a great power over a supervisee. It is therefore desirable for the supervisor to learn to recognize and process his countertransference responses during supervision.

Attention to emotional and cognitive responses to a client or supervisee is an essential component of supervision, especially when supervising difficult clients. To guide the supervisee well in revealing their thoughts and emotional responses, the supervisor must have the ability to recognize, label, understand and express his / her own emotions (Beck *et al.* 2004). Understanding one's own limitations, one's own resistance to change, is necessary to understand both the supervisee and himself (Leahy 2003). As we recognize what emotional reaction a supervisee elicits in us, we can wonder how he probably responds, at least in part, to his/her client. Sometimes we talk about the so-called parallel process - what reactions a client in a therapist elicits, so does a therapist in a supervisor. However, this view should be taken with caution, as it has never been accurately proven, and there are a number of personality characteristics of the participants and other circumstances of the therapy involved in the individual reactions.

As far as I could understand, the case you want to present today is a 22-year-old man who has been suffering from obsessions about hurting someone for about 7 years. The client came to your therapy a month ago and underwent 5 sessions. He grew up without a father with a caring but at the same time critical and tragedy haunting mother. Obsessions first appeared when he went to high school and began to live in a boarding school, where he met a bullying for his body. He has been going to work for 3 years now, but obsessions and compulsions are increasingly common, reaching 26 points at Y-BOCS and occupying more than 4 hours a day, which limits him both at work and in a partner relationship and limits his free time. Praying appears as a compulsion by which he "atones" for his aggressive thoughts about co-workers, girlfriend, but also random strangers. Furthermore, he compulsively makes sure that his girlfriend does not leave him. The problem you want to focus on at the moment is that his narrative about the content of the obsession, his compulsive notion of how he strangles people, scares you, because you are alone in the office and it evoked your memory from your childhood when your older brother choked you with the pillow, and that you were angry with him because he repeatedly tells you how many times he has been hospitalized and how many therapists have failed him and in what ways. You're afraid you'll be next in line. On the other hand, you are convinced that this person is very troubled and in need of help, further hospitalization would not make sense, and in your city, you have no other therapist to send him to. In the first two sessions, you discussed his life story, performed a behavioral and functional analysis, and identified problems and goals. In the next two sessions, you worked on cognitive restructuring of his guilt feelings for the content of the obsession, and at the last session you tried to expose the imagination to a catastrophic scenario that the client ended at the start, afraid that if he imagined it the risk to do it increases. Did I understand that well?

We can capture the countertransference reaction mainly in our behavior, but also in our thoughts, emotional experiences and bodily symptoms. Physical reactions are often revealed to us by emotional motives that we are not aware of, or we divert attention from them automatically because they are difficult to bear for some reason. Any change in the supervisor's physical and emotional experience or behavior indicates the presence of automatic thoughts. Changing the tone of voice, feelings of insecurity, urgency, commands, unwillingness to supervise, dragging or shortening of meetings can be typical manifestations of countertransference reactions. Countertransference is most often affected by supervisor core beliefs and conditional rules. In this context, Leahy (2003) described the following schemes:

Excessive demands

Supervisors with anankastic features often see supervisee as irresponsible, unprepared, under-trained or lazy. They believe that expressing one's own emotions, or uncertainty, can be threatening or devastating. They have difficulty in expressing warmth and empathy towards the supervisee, and they put excessive emphasis on "logic" and "rationality". They often refer to theory, evidence-based approaches, studies and little speak for themselves. They look for mistakes and point them out, often with a moralistic connotation. Supervisees may feel that supervision is an opportunity for the supervisor to show that he is more educated or brighter than themselves. A perfectionist supervisor may try to compensate for his/her deeper feelings of lack of competence by demanding perfect performance from himself or the supervisee. In some cases, supervisors with excessive standards can compensate for their perfectionism by over-criticizing and demanding more and more from the supervisee. They can extend the supervisory session to infinite. A typical chain of automatic thoughts might look like this: "These are scholarly mistakes! - He should be more prepared! - What on earth teaches them in the training!? He/she will never be a good therapist! etc.

Abandonment

A supervisor with an abandonment scheme may be concerned that if he confronts the supervisee with something negative, the supervised individual will abandon him/her or dislike him/her. Premature termination of supervision is understood as a supervisor's personal rejection. A supervisor under the influence of an abandonment scheme can behave in different ways that reflect the abandonment scheme: for example, on the one hand, he can over-care, explain, apologize to the supervisee, but on the other hand can avoid concluding a meaningful contract. Excessive care can take the form of protecting the supervisee from any difficulties, constant advice, delaying negative feedback, or a preferential solution to the supervisee's problems that he/she has in common with the supervisee. A supervisor who avoids establishing a relationship often focuses on conceptualization and techniques rather than meaningful discussions about forming a relationship. Such a supervisor avoids more difficult topics and anxiety-provoking interventions. He often takes painfully personally the supervisee's differing views, missed sessions or lack of interest in supervision. The supervisee's resistance is seen as a personal rejection.

Excessive need for acceptance

The "pleasing" supervisor can be very proficient in the manifestations of empathy towards the supervisee. He/she believes the supervisee should feel good about whatever happens. The warmth and empathy of such a supervisor are appreciated by many supervisees because they never express negative emotions and confront weaknesses. This type of supervisor usually avoids questions about the supervisee's negative emotions. These topics seem too exciting to him/her and therefore unaccept-

Tab. 7. Record of supervisor's dysfunctional thoughts

SITUATION	EMOTIONS	AUTOMATIC THOUGHTS	RACIONAL RESPONSE
• The supervisee came late; does not cease to be dramatic; in vain I try to direct him to the creation of a session program.	• Frustration • Disappointment • Uncertainty • Embarrassment	• He will never improve! • My supervision doesn't make sense! • I'm an incapable supervisor! • I don't know what else. • My approach is meaningless.	• To realize that my pressure is meaningless and to avoid blaming, try to be more understanding and focus on the supervisee, not the feelings of disappointment. • Supervisee can better identify his own emotions and understand his client's reactions better. • I also focused more on techniques than relationship support. • I need more respect for his strengths and values, to help him learn to better define problems with the client. • Because I feel insecure and embarrassed, it does not mean that I am incapable. • My frustration is related to my exaggerated expectation that all therapists have to work perfectly with their clients right away, if they doesn't, it's my fault. • Is it even true that a good supervisor never feels embarrassment and uncertainty? Until next time I can think of other solutions and go on my own supervision.

Tab. 8. Useful methods and interventions working with relational exchanges in therapy and supervision

Cognitive:
- Cognitive restructuration
- Guided discovery
- Socratic questioning
- Thought records
- Relationship and interpersonal cycles formulation
- Case conceptualisation from historic perspective
- Prognosis of relational responses from historical formulation
- Cognitive content for significant others
- Flash cards, schema flash cards

Experiential:
- Interpersonal behavioural experiments
- Role play
- Immediacy and meta-communication approach ???????/
- Imagery work / rescripting
- Exposure
- Chair work
- Emphatic confrontation
- Limit setting
- Mindful communication

Reflective:
- Self-reflection
- Self-practice
- Supervision
- Reflective writing

able. Supervisees can skip meetings, go late, do not do homework, but a supervisor with excessive need for acceptance does not want to “trigger conflict”, and so he/she tolerates it all. If the therapist fails, the supervisor tends to blame himself. His attitude tells him that "if the therapist fails, it is my failure."

Need for excellence
A supervisor with narcissistic personality traits sees supervision as an opportunity to show his exceptional talent. Supervision of a complex case can begin with grandiose hopes, expressing the supervisor that the supervisee has finally found a "true supervisor" to help him/her solve everything. He likes to advise and knows everything best. He invests in his own image of the best, special supervisor, and it can lead to defamation of all therapists who have “failed” to treat a difficult client. Such a supervisor feels called to work with and been admire from the supervisee. This can lead to encouragement for the supervisee to disrupt borders, take surprising interventions, or the supervisor himself / herself disrupts borders. Because the therapy itself may not work, the supervisor becomes bored, angry or starts to criticize the supervisee. Rather than empathizing with the understandable frustration of the supervisee for having no result, the supervisor turns against the supervisee, accusing him/her of lack of effort, etc. Changing the narcissistic perspective is difficult because it tends to see mistakes in others. To change the narcissistic perspective, we must be able to ask ourselves: How would I feel myself in the position of this supervisee?”

The way a supervisor treats idea related to supervision may lead to the need for cognitive restructuring in order to reduce negative or overly positive emotions so supervision can continue. It is useful to confront every fear of making a supervisory mistake and try to understand what preceded these concerns (Table 7). Supervisor responses can have a variety of sources, including culturally determined attitudes and values, looking at one's own professional role, a unique life experience, including training, or triggered by the supervisee's behavior (Kimmerling *et al.* 2000).

Key skills and methods working with relational exchanges in therapy and supervision relationship

As the therapeutic and supervisory relationship are integral and essential parts of therapy and supervisions, first we have to acknowledge their importance by tackling this part of the therapy explicitly setting making functional relational exchanges/responses as one of the goals in working process. Work on case conceptualisation and exploring clients/therapist/supervisors cognitive, historic, affective, physiologic, behavioural etc. context of the interpersonal patterns is good start to increase awareness, self-reflection, prognose possible relational responses and their impact on therapy process, construct more functional relational responses and patterns, which meet client’s needs. We can do by traditional CBT conceptualisation forms, use in figure 1 presented chart of relational elements within the therapeutic relationship (Wills 2015). In training or group supervision format is useful to practice case supervision with emphasis on relational exchanges and therapeutic/supervisory relationship in example below:

Another part of work takes place in therapy/supervision session, here and now. The best way to share impressions about how people come across in the sessions is by using immediacy (Inskipp 1996), also termed you/me talk (Egan 2013), distinguishes between relationship immediacy – the ability to reflect on what is happening in the present moment with the client and the therapist. Egan (2013) offers useful steps in delivering immediate statement: 1) say how client affects you, 2) explore your contribution to what is going on, 3) describe the client’s behaviour and offer „reasonable hunches“ about what is happening, 4) invite the client to consider what is happening. Other way using immediacy is emphatic confrontation from Schema therapy approach, asking feedback often.

Meta-communication was initially developed in interpersonal therapy and has been applied to CBT by Safran (Katzow & Safran 2007). In simple words meta-communication means the facility to communicate about communication. It was defined by Safran in the context of dealing with ruptures in the therapeutic rela-

tionship, recognising them as liked to cognitive – interpersonal styles of both client and therapist. It is useful when therapist notices feeling „stuck" in the clients cognitive-interpersonal cycle and can break free from unhelpful aspects of what is going on between therapist and the client. Doing this kind of work therapist uses awareness, self-reflection, mindful communication, collaboration, empathy, validation, negotiating, emphatic confrontation, getting feedback and immediacy to solve problems threatening therapeutic relationship. The client may feel hurt but can continue collaboration on therapy goals. Third wave CBT therapies have various very useful concepts and recourses to do „working through" interpersonal patterns: ACT psychological flexibility concept, mindfulness-based approaches, schema therapy basic emotional needs, modes and schemas concepts and tools to work with them, compasion therapy and mindful self-compasion, dialectical behavior therapy.

Getting constant feedback and reviewing sessions from the relational exchange perspective helps to monitor therapeutic relationship, therapy progress (many problems occur in interpersonal situations) and do important self-reflective work, make plans and train/experience to respond in similar situations contextually (for example flash cards, schema flash cards, if-then plans, role play, chair work) (Table 8).

To start such complex work supervision is essential and helpful in developing sufficient therapist skills in creating and maintaining functional relationships.

Conslusion

An important portion part of supervision is the emphasis on the therapeutic relationship between the therapist and the client, because the therapeutic relationship is the foundation upon which the therapy works. The basis of the supervisory relationship is a clear contract, empathy, positive empowerment, and emphasis on the characteristics of the relationship. The relational exchange and therapeutic relationship work are important, as the supervisor can help to realize, strengthen or block the supervisory effort. The supervisor's task is to help the therapist understand the conceptualization of the client problems, find therapeutic strategies and help with establishing good therapeutic relation with the client. The therapist therefore needs to regularly examine his / her thoughts and behavior towards the client, which may be based on his / her own dysfunctional attitudes. Complications in founding a therapeutic relationship can replicate the client's difficulty in other relationships and/or the countertransference problems of the therapist. The way to recognize countertransference in supervision is to consistently be aware of our own thoughts, emotions and attitudes that affect how we respond to the behavior of the supervisee. Rather than suppressing his/her own emotions, the CBT supervisor is encouraged to take note of them and consider how they appear to him and what thoughts, emotions and attitudes they are associated with. Supervisor´s guided discovery and Socratic dialogue help supervisee to find beneficial reaction to the client in case of countertransference.

The foundation of supervision is relation between the supervisor and the supervisee. Throughout supervision, the therapist should feel safe, understood, accepted, reinforced and at the same time to be supported to further differentiate the situation. The delineation between supervision and therapy is that in supervision, emotional problems are only worked with in the field of the therapeutic work, while psychotherapy discusses the whole life of the person. In order to be able to recognise the countertransference of supervised therapists, the supervisor must understand him/her own countertransference. Suitable self-reflection and supervision of supervision are elementary fundamentals for satisfactory growth of the supervisor's abilities.

Conflict of interest statement

The authors declare that the article was done in the nonappearance of any commercial or economic relationships that could be understood as a potential conflict of interest.

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