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How to use self-reflection in cognitive behavioral supervision

Jan Prasko [1,2,3], Marija Abeltina [4], Jakub Vanek [1], Darius Dicevicius [5], Marie Ociskova [1], Ilona Krone [6], Krystof Kantor [1], Julius Burkauskas [7], Alicja Juskiene [8], Milos Slepecky [2], Lina Bagdonaviciene [9]

[1] Department of Psychiatry, University Hospital Olomouc, Faculty of Medicine, Palacky University in Olomouc, the Czech Republic, [2] Department of Psychology Sciences, Faculty of Social Science and Health Care, Constantine the Philosopher University in Nitra, the Slovak Republic, [3] Department of Psychotherapy, Institute for Postgraduate Training in Health Care, Prague, the Czech Republic, [4] University of Latvia, Latvian Association of CBT, Latvia, [5] MB Saules miesto medicine and psychotherapy centre, Lithuania, [6] Riga`s Psychiatry and Narcology centre, Latvian Association of CBT, Latvia, [7] Laboratory of Behavioral Medicine, Neuroscience Institute, Lithuanian University of Health Sciences, Lithuania, [8] Behavioral Medicine Clinic, Faculty of Nursing, Lithuanian University of Health Sciences, Behavioral Medicine Laboratory, Neuroscience Institute, Lithuanian University of Health Sciences, [9] Institute of Neuromedicine, Lithuania

Correspondence to: Prof. Dr. Jan Prasko, Ph.D., Department of Psychiatry, Faculty of Medicine and Dentistry, Palacky University Olomouc, University Hospital, I. P. Pavlova 6, 77520 Olomouc, Czech Republic
E-MAIL: praskojan@seznam.cz

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Abstract

Conscious recognition of one's own emotions, feelings, thoughts or attitudes at the time of their origin and the ability to observe and continuously realize them are among the essential skills of the therapist and supervisor. In self-reflective awareness, the mind observes and explores all experiences, including emotions and bodily reactions. Awareness of one's own experience during therapy is an important feedback system for the therapist. It helps to optimize therapeutic behaviour. The therapist predominantly learns self-reflection during the supervision process, so that their attitudes and behaviour can be better used to work with clients. The deepening of self-reflection happens continuously during training and supervision. There is an evidence that at the very beginning of the supervisory relationship, the supervisor needs to emphasize the importance of self-reflection and to set an example to the supervisee. The importance of self-reflection can be underlined already in the establishment of a supervisory contract, during which the supervisor discusses with the supervised individual the motivation and expectations of supervision, as well as a regular daily homework. In order for supervisees to learn to self-reflect well, the supervisors themselves need to perform self-reflection. The more experienced the supervisee is, the more self-reflection they use in their supervision and openly talk about their experience during supervision. We can state that self-reflection is also a tool to understand transference and countertransference in both therapy and supervision. The importance of these issues has not been emphasized in cognitive behavioural therapy as much as in other therapeutic approaches. However, evidence shows, that self-reflection differentiates "great therapists" from "average therapists" and addressing these topics in an evidence-based way is necessary to improve the quality of therapeutic care.

Introduction

The importance of reflection and self-reflection has been emphasized in cognitive-behavioural therapy from the earliest stages of its development (Beck *et al.* 1979). Beck *et al.* (1990) assume that effectively managing a therapeutic relationship and recognizing its boundaries, as well as utilizing a personal response in the treatment process, requires that cognitive therapists first become sensitive observers of their own thoughts, emotions, and beliefs. The terms reflection and self-reflection began to emerge in cognitive behavioural literature at the beginning of this millennium (Safran & Muran 2000; Bennett-Levy *et al.* 2001; Milne & Westerman 2001) when therapists linked cognitive behavioural views with learning models in adults. The reflective system guides the therapist's lifelong learning, both in training and practice, and helps them acquire and cultivate therapeutic skills.

Therapists identify the need to improve their declarative knowledge and procedural skills through their "reflective systems", and it is through the reflection of clinical experience that they learn to distinguish what skills, under what circumstances, and at what point they should apply. Awareness of one's own experience during therapy is an important feedback system for the therapist to help optimize therapeutic behaviour. Self-experience and feedback are particularly important for increasing self-reflection and interpersonal skills (Bennett-Levy *et al.* 2003).

One of the differences between cognitive behavioural therapy and some other psychotherapeutic schools is that personal therapy of the therapist is not a formal requirement in some countries (e.g. the United Kingdom, the USA, Australia, Lithuania). However, in others, it is required (e.g. Sweden, Germany, the Czech Republic, Latvia, Slovakia). Because of this, more emphasis should be placed on developing self-awareness and self-reflection. It is possible to distinguish between personal self-experience as a method of personal development or as a training tool for enhancing cognitive behavioural practice (Bennett-Levy 2005, Bennett-Levy *et al.* 2001). Personal therapy is usually a more extensive and in-depth process than the process of self-reflection in therapeutic practice but is less focused on training the self-reflection as a tool to use in a therapeutic situation. In personal therapy, we usually focus on ourselves and do not necessarily reflect the clinical consequences of the internal processes. Even though personal therapies for cognitive behavioural therapy students are carried out in several countries, there has been a lack of studies examining their results. However, the experience of teachers and supervisors suggests that CBT therapists with personal therapy are better equipped to use the therapeutic strategies they have previously used to solve their own problems, and are better able to understand how each strategy affects them including potential pitfalls. However, this anecdotal experience needs relevant examination in controlled studies.

What is self-reflection in psychotherapy

Boud *et al.* (1985) describe of self-reflection as an intellectual and affective activity that individuals have used to explore their experiences to understand and evaluate them better. Self-reflection can also be characterized as impartial, non-judgmental attention focused on the state of our heart (Goleman 1996). This kind of attention impartially perceives everything that passes through consciousness, acting as a watchful observer. (Hupková 2010). Another important term is the metacognition (Wells 1997) which denotes awareness of one's thought and attitude processes, and the term meta-mood which described *meta-emotions*, the awareness of one's emotional processes (Bishop *et al.* 2004). Jon Kabat Zinn sees mindfulness as a way of paying attention to what is happening in the present moment in a non-judgmental manner (Kabat-Zinn 1982), which is very close to self-reflection. Mindfulness as skill develops over time, and the number of practices teaches therapists and patients become more self-aware and less reactive to adverse or overly positive events or stimuli. It can potentially present a way to promote self-reflection – adaptive self-focused attention to the self and the situational context. We will use the terms self-reflection and self-awareness as synonyms in this text, because cognitive and emotional reactions usually occur concurrently (Prasko *et al.* 2012).

Self-reflection characteristics

Self-reflection in psychotherapy has been described as a cyclic process in which the therapist carefully assesses their emotional and cognitive experiences during therapy with the patient, and is aware of their behavioural responses, gains insight through internal dialogue and generalization, and changes original attitudes and beliefs regarding the therapeutic (or supervisory) situation (Kimmerling *et al.* 2000, Kolp 1984, Schon 1987). In self-reflective awareness, the mind observes and explores all experiences, including emotions and bodily reactions (Beck *et al.* 2004, Thwaites & Bennett-Levy 2007). Self-reflection is, therefore, a complex process aimed at perceiving the therapist's cognition and attitudes, motives, emotions, body reactions, and behaviour towards the patient, as well as realizing the relationship between their past experiences and current situation, personal core beliefs and conditional rules, in therapy or supervision. It is an essential process that the supervisor helps to develop in the supervisee, but at the same time needs to develop it in themselves.

A study by Jennings & Skovholt (1999) examining the personal characteristics of "masters of therapy" showed that reflectivity plays a crucial role in their therapeutic functioning. They were characterized by

a desire to learn and understand their own experience, including the ambivalent nature of experience. They used self-reflection in their personal lives to better understand themselves, others, and in therapeutic practice. They also showed an open, reflective reaction without using defences in response to negative feedback.

Self-reflection in therapy is a *continuous process*. Awareness of one's inner experiences is a fundamental skill, from which further skills, as well as knowledge and attitudes necessary for therapy and grow. These include awareness of their role as a therapist, recognition of and countertransference, emotional self-control, and the continuous development of therapeutic competencies (Greenberg 2007, Praško *et al.* 2011b). Self-reflection is a never-ending process. Humans and their experiences continually change and evolve, and so does external information and relationships – likewise, self-reflection also evolves and changes (Prasko *et al.* 2012).

Bennett-Levy (2006), in his Declarative-Procedural-Reflective model, provides a useful insight into the conceptualization of the development of therapeutic skills. This model distinguishes three information-processing systems (Bennett-Levy 2006, Kyuken *et al.* 2009):

(a) The *Declarative System* is a knowledge system based on an intellectual understanding of theoretical models and their practical implications (Anderson *et al.* 2004). When applied to self-reflection, it presents knowledge of what self-reflection is, its meaning, how it can be practised, etc. This knowledge is the basis for other systems, but alone it is just a theory that without practical experience, does not allow for quality therapeutic practice.

(b) The *procedural system* is a treasury of skills, attitudes and behaviour in action. It is a practical competence, professional art. This system is saturated via training and practical experience with clients.

(c) The *reflective system* is the most important for the ongoing development of skills (Bennett-Levy *et al.* 2009a). Its importance is increasing especially in situations where acquired declarative knowledge and procedural skills are not sufficient because the current situation is too complicated, the individual in therapy does not respond to previous approaches, or where transference and countertransference negatively affect the therapeutic process. The ability of self-reflection differentiates between average therapists and experts (Skovholt & Ronnestad 2001). This system is built mainly by supervision and the regular practice of self-reflection.

The meaning of self-reflection

The process of self-reflection is one of the crucial phases of learning and is, therefore, a fundamental element of the supervision (Kolb 1984; Bennett-Levy 2006). The development of self-reflection is particularly crucial in the light of studies that indicate that up to 60 % of clinical psychologists work with clients even when they feel uncomfortable, and their work is barely sufficient (Pope *et al.* 1987). Practising attention to one's own emotions and the ability to self-reflect can improve the ability to recognize one's discomfort and thus prevent adverse effects on clients (Vasquez 1992, Bennett-Levy *et al.* 2009b). Self-reflection is an important part of most cognitive-behavioural models of supervision (Milne & James 2002; Armstrong & Freeston 2003, James *et al.* 2007). Its importance has also been confirmed in a survey of UK cognitive-behavioral leaders who have agreed that self-reflection is a fundamental process within supervision and is associated with the process of supervision (Townend 2008). Therapists with a good understanding of their cognitive and emotional movements during client sessions can make better decisions, differentiate their needs from the client's needs, understand transference and countertransference, and consider the optimal response at a given time (Leahy 2003, Orchowski *et al.* 2010). They can handle their emotions and behaviours in a way that reflects the therapeutic situation, and their response pursues the best interests of the client. Their emotional manifestations are cultivated (Praško *et al.* 2011a). Self-reflection is particularly essential when working with complex patients. Hoffart *et al.* (2006) investigated to what extent the emotional reactions of therapists to the manifestations of agoraphobic patients are influenced by the personality disorder of the patient and their problems with interpersonal behaviour, and how much it affects the outcome of treatment and the response of therapists. The significance of personality disorder was related to the uncertainty of therapists. The more uncertain the therapist was, the worse the treatment outcome was.

The supervisor accompanies the therapist and helps him to focus and to explore issues that produce difficulties in therapy. The therapist learns both the patient's understanding and the automatic reflection on what is happening inside them, clarifying their emotional atonements, motivation to intervene, transference and countertransference steps. They also need to consider to what extent the therapeutic steps they are taking are beneficial for the client or their own needs (Prasko *et al.* 2010). In cognitive-behavioural therapy, self-experiential work and self-reflection seem to enhance empathy (Bennett-Levy *et al.* 2003).

Practising self-reflection in therapy and personal life is particularly crucial for the therapists in the beginning of their career, as it is a skill that helps to develop critical thinking, self-awareness, self-compassion and ethical decision-making. The ability of self-reflection also enhances the understanding of other people's internal states, stimulates altruism, and increases atonement to subtle manifestations of what others want or need (Rogers 1967; Goleman 1996).

From a transcultural perspective, the therapist's self-reflection is an essential component in the process of building a relationship, sharing power, and encouraging the client's opinion. For culturally sensitive prac-

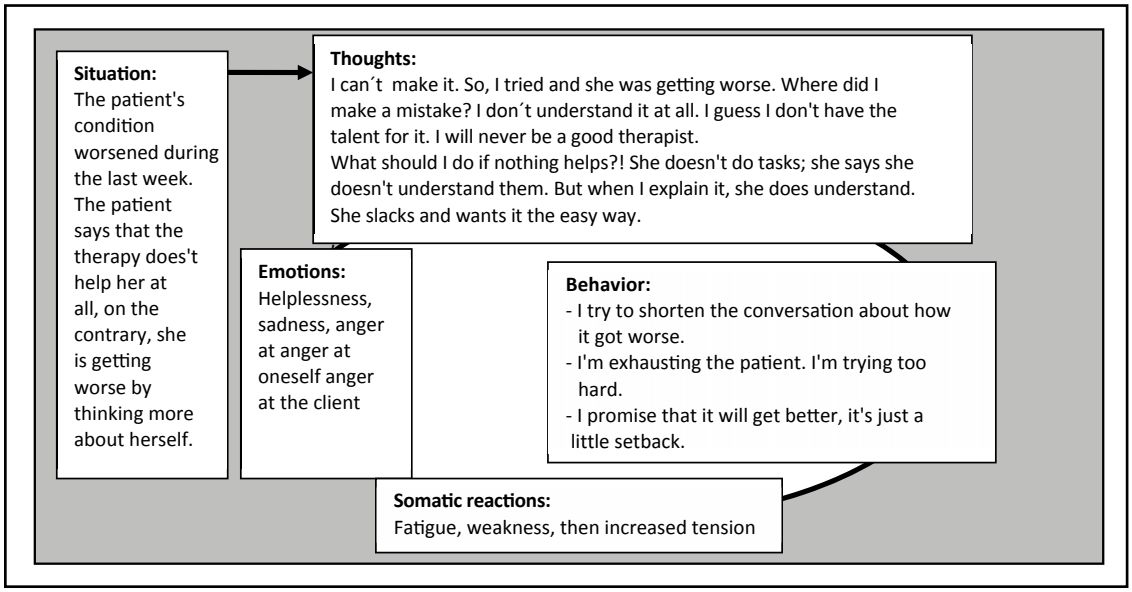

Fig. 1. Vicious circle of the reaction to the patient during a therapeutic session.

tice, it is essential to realize how the cultural, ethnic, or racial identity of the client, therapist, and supervisor influences the therapeutic and supervisory relationship (Ramirez 1999).

The ability of self-reflection seems to improve both the procedural experience in the therapeutic process and the clinician's ability to use their own emotions, body reactions, and cognition to understand the therapeutic relationship better (Safran & Muran 2000, Bennett-Lewy 2003). This continuous self-reflection is similar to the non-judgmental inquisitive focus during full awareness techniques (Brown & Ryan 2003). Self-reflection in therapy or supervision requires (Hoffart *et al.* 2002, Aubuchon and Malatesta 2003, Bennett-Levy 2006, Kaslow *et al.* 2008, Prasko *et al.* 2012, Vyskocilova & Prasko. 2013):

- the ability to capture, observe, and think about what the therapist experienced in the therapeutic process;
- understanding of one's own emotions, thoughts and attitudes;
- the ability to be authentic in the relationship with another person;
- the willingness to admit own mistakes and blind spots;
- the ability to accept criticism and self-criticism with a constructive perspective and to learn from it;
- adeeper understanding of one's role in the therapy (or supervision) of a particular patient (supervisee) and the ability to understand transference and counter-transference, including the specific responses associated with them;
- the ability to recognize, use and evaluate their own therapeutic or supervisory skills and their application to a particular patient or supervised patient;
- a desire to further understand their role in the therapy or supervision of a person and their willingness to be supervised;
- the therapeutic use of one's thinking, emotional, physical and imaginative experiences in interaction with the patient or supervised.

Self-reflection in the supervisee

It is unlikely that supervision without self-reflection will help the supervisee to develop new therapeutic skills that can be flexibly, efficiently, and sensitively applied in therapy. Psychotherapy without self-reflection and awareness of the therapeutic situation is likely to be less sensitive and more likely to "get stuck" or lead to interpersonal rupture.

Development of self-reflection in supervision

Self-reflection is one of the essential competencies of the therapist and the supervisor. It needs to be learned and continuously practised. Otherwise, its quality may be decrease. Padesky (1996) states that supervisors use the emotional reactions of therapists, their patterns, and developmental history to understand the dilemmas faced by the therapist performing the therapy. However, they are not processed as in personal therapy. The general ability of self-reflection increases during the actual therapeutic training and the ability of self-reflection during therapy increases during supervision (Machado *et al.* 1999, Milne 2008). Self-reflection can be practised by the therapist using classical cognitive-behavioural therapy techniques or new ones learned during supervision (Laireiter & Willutzki 2003). A vicious circle can be used to practice their reactions to the patient (Praško *et al.* 2011a) (Figure 1).

Another possibility is to record automatic thoughts regularly after the session when the therapist has time to consider what happened and what they really

Tab. 1. Automatic thoughts record – a therapeutic situation

Situations	Automatic thoughts: I believe it 0-100 %	Emotions: Intensity 0-10	Facts for:	Fact against:	Alternative thoughts: I believe it 0-100 %	Emotions: Intensity 0-10	Action: What now What in the future
The patient repeatedly complains about her mother, at whom she has to "shout" to get her to comply.	She would never understand that if she didn´t scream at her mother, her mother would want to accommodate her. 70% She claims to be a victim everywhere, but she is actually the aggressor. 75%	Helplessness 8 Anger 7	She repeatedly complains about her mother's behaviour. She criticizes her mother every day or shouts at her. Even in other situations, she doesn´t consider what she is doing, and repeatedly blames other people.	She has said on several occassions that she understands that her mother is responding to her behaviour. However, she isn´t able to react differently yet. She mentions her unruly, aggressive behaviour, and she is ashamed of it.	She understands that screaming, doesn´t get her anywhere. So far, doesn´t behave as she would like, but lately, she has been doing better. 90 %	Helplessness 3 Anger 1	I could commend her for what she is already doing. I could express empathy about how she feels. I can include role-playing dialogues with the mother in the therapy sessions.
Falling Arrow - Search for a a core belief and a conditional rule about myself							
Automatic thought: She never understands that if she screams at her mother, her mother will not want to oblige to her.							
What does this mean about me?				I can´t work with her!			
What is so bad for me?				I am an incompetent therapist!			
Core belief:				I am incompetent!			
What do I do not to look incompetent?				I have to do everything correctly, and everyone must be happy with me!			

wanted, why they reacted in some way emotionally and why they behaved in a certain way. The therapists can also complete the falling arrow technique in order to gain a deeper understanding of the attitudes of their thoughts, emotions and behaviour (Praško *et al.* 2011a).

It is possible to make notes about one`s cognitions and emotions during a therapeutic session or while watching an audio or video recording of a session with a patient (Braum & Gray 1992). Initially, a recording presents a concern to supervisees because they are uncertain about their skills, they may fear a negative assessment from others, or even themselves when they see the recording (Hawkins & Shohet 2000). Supervision aims to support the supervisee in gaining an insight into themselves, which may initially cause anxiety. During supervision, however, supervisees usually habitually forget about the camera after several recordings. If supervision is safe, encouraging, and respecting, the recording does not cause problems (Praško *et al.* 2011b).

Self-reflection and supervision

The therapist learns self-reflection significantly during the supervision process, so that their attitudes and behaviour can be better used to work with clients. The deepening of self-reflection takes place continuously during training and supervision. Therapists who often use self-reflection at work gradually improve in this ability. Self-reflection is an essential component growing the supervisors' clinical skills (Sutton *et al.* 2007). Therefore, supervisors need to strengthen this ability with their supervisees. Unfortunately, supervisors often automatically their attention, on the technical components of therapy that they try to evaluate and forget about the importance of the supervisees' self-reflection. However, it seems clear that if we do not pay enough attention to the supervisee's self-reflection in supervision, the client may remain misunderstood and the therapy might eventually fail (Bernard & Goodyear 2004). All supervisors can benefit from a greater focus on self-reflection (Orchowski *et al.* 2010). Specific questions can help to enhance self-reflection in supervision (Table 2).

The feelings of uncertainty and dissonance that disturb the clinical picture are influenced by the personality of the supervisor and supervisee as well as the supervisory environment. The process of supervision involves learning self-reflection during the supervisor's and supervisee's dialogue as they work together to understand the supervisee's emotional response in a particular therapeutic situation or in a particular therapeutic relationship based on how the supervised individual understands the situation (Overholser 1991, Beck *et al.* 2008). Self-reflection is significantly

Tab. 2. Typical questions helping self-reflection

Questions focused on therapist situations:
• What in particular caused you to feel internal discomfort, uncertainty, or hesitation in therapy with this patient?
• Do you also think about this patient after the session is over? What are you thinking specifically about? Does it ever force you to think of the session repeatedly? Which situations do you ponder about?
• Do you feel any discomfort before meeting this patient? What does it relate to?
Questions focused on ideas (cognitions):
• What do you think of this patient?
• What would you say about the patient in this situation?
• What would you say about yourself in this situation?
• What do you worry about with this patient in therapy? What are you most worried about?
Questions focused on the emotional experience of the therapist:
• What emotions appear when you are with this patient?
• Does your emotion change in therapy with this patient?
• If you remember this patient outside of the therapy session, what emotions will appear?
• Speaking of this patient now, what emotions do you feel?
Questions focused on the physical experience of the therapist:
• Have there been any bodily reactions in this session?
• Speaking of thies therapeutic situation, what do you experience physically?
• If you remember this patient outside the session, do you feel any somatic sensation?
Questions focused on the therapist`s behaviour:
• How did you react in this situation? What do you think about your reaction?
• What did you tell him/her at the moment?
• What strategy did you choose in this situation? Can you describe how it went?
Questions about patient`s behaviour:
• How does this patient typically behave in a therapeutic session? What is your attitude to this behaviour?
• What did you say, how did you feel, what happened to the patient when you applied this strategy?
• What happened with the patient after this strategy was completed?
Questions focused on the therapist's attitudes:
• When it happened, what did you think about yourself? What does this mean about you in more depth? What schema is this associated with?
• What do you think of yourself as a therapist with this patient? What are your attitudes to this? What does it say about you?
Questions about patient transference:
• What have you noticed about the patient's behaviour towards you? Can it present a transference reaction reaction? What does it evoke in you? How do you respond to this?
Countertransference issues:
• What do you think of this patient?
• How do you typically respond to him/her? What do you think about your reaction?
• Are there any reactions to the patient that make you embarrassed, guilty, or shy?
• What do you like about this patient? What do you dislike about him/her? What annoys you?
• Does he/she remind you of someone? Any situation in your life?
Strategy Choice Questions:
• What reason did you have for choosing this strategy?
• Do you think the choice of this strategy was right/wrong? Why?
• What do you think about yourself when considering choosing this strategy for this patient?
Questions to assess patient status:
• What do you think when you see how this patient is changing in therapy?

enhanced by creative experiential techniques such as imagery, chair, or toy work (Prasko *et al.* 2019a, Prasko *et al.* 2019b), mindfulness attitude and practices to increase self-awareness and contextual, schema therapy's schema and modes awareness exercises.

Self-reflection can result in both a new understanding of the situation and a new response that can be used in therapy. In a quantitative study of more than 100 mental health professionals in five stages of their professional growth, Skovholt & Ronnestad (1992) found that the introduction of continuous professional reflection training may be central to gradual professional maturation. Also, practitioners who have built reflective attitudes into their clinical practice can create a supportive and open professional environment and often interview their colleagues about their practice. In contrast, individuals who do not use self-reflection often exhibit insufficient and fragmented professional development (Skovholt & Ronnestad 1992).

So far, little attention has been paid what strategies can be used to increase the reflective attitudes of supervisees. Even before the start of supervision, the super-

visor should reflect on his / her attitudes towards the supervisee and make clear how they perceive the new relationship, what emotions and attitudes they have. This process of self-reflection also includes attention to the cultural background of all participants – supervisor, client and therapist. If useful for the therapy, the supervisor can also be a model for the therapist to reflect on his own more deep-rooted attitudes.

Therapist: (looks very tense) I want to talk today about my 19 years old client Dace. I am so concerned about her! There are so many things I want to put together. I need to talk about her!
Supervisor: O.k., I see that something is bothering you. How do you feel now?
Therapist: I am so anxious! So, concerned… maybe even scared!
Supervisor: Thank you for your disclosure. It seems to be important because as I know, you are usually very calm, even when working with demanding clients. Is there something special about this client?
Therapist: I don't know. I am surprised by my reactions. I have been working with young people for many years, but this is a strange case. My reactions are so strong.
Supervisor: Would you mind, if I´d ask you what do you think about Dace, when you feel so scared?
Therapist: I think I should help her immediately, maybe I should offer more sessions or even take her home! She is such a pure girl! She experienced so much violence in her age; it´s so unfair! I´m scared something terrible could happen between the sessions. Her relatives are so uncooperative! She has depression, PTSD, and suicidal thoughts! However, they still don´t believe her! I´m a little angry too!
Supervisor: Thank you for your broad reflection. Do you think about this client outside of the sessions?
Therapist: Oh, yes, a lot! I´m tired of thinking all the time about new strategies about how to help. I couldn´t find a new one. Maybe you could help me with this?
Supervisor: The question about strategies is good, and I can see that you think very often about this young lady. You told me that this is unusual for you. What makes this client so unique for you?
Therapist: Her life story. Nobody helped her. I want to be different. I want her to live a good life!
Supervisor: Thank you for your answer. What do you think about this reaction?
Therapist: When I hear myself, it sounds like I'm so overinvolved.
Supervisor: I think this is a valuable insight. Do you think it is somehow connected to the conceptualisation of this client?
Therapist: I didn´t think about it in such a perspective. However, it could come along with her life... (pause) Oh, I just had an idea! I took her older sister's place! She left abroad half a year ago, and she was supporting Dace so much and somehow, I took on sister's place!
Supervisor: Great reflection of the therapeutic process. How do you feel now?
Therapist: Relieved. Somehow, I'm again feeling more like myself.

It is evident that at the very beginning of the supervisory relationship, the supervisor has the responsibility to emphasize the importance of self-reflection and to set an example to the supervisee. The importance of self-reflection can be underlined in the establishment of a supervisory contract, during which supervisor discusses with the supervised individual the motivation and expectations of the supervision, as well as a regular daily homework (Bernard & Goodyear 2004). Watkins (1995) emphasizes that the more experienced a supervisee is, the more self-reflection they use in their supervision and openly talk about their experience during supervision.

Similarly, Dunne (1994) argues that in order for supervisees to learn to self-reflect well, the supervisors themselves need to perform self-reflection. Being a role model is essential for teaching supervisees (Bernard & Goodyear 2004). Thus, supervisors who fail in self-reflection, especially in multicultural orientation, also cannot provide supervisees with an understanding of how cultural, racial, and ethnic identity affects the therapeutic and supervisory relationship (Ramirez 1999). According to current transcultural counselling theory, individuals with different cultural backgrounds may perceive expressions of trust and empowerment differently (Cook & Helms 1988). People from some cultural groups may prefer direct supervisory practices, while those from other cultural backgrounds may prefer a more free and individualistic approach (Gardner 1980). Also, supervisors must be aware that cultural foundations may be associated with different vulnerabilities and different ways of self-opening. Supervisors also need to consider their own cultural identity and its influence on what they pay attention to (Serok & Urda 1987).

Self-reflection is essential in forming a supervisory relationship (Hoffart *et al.* 2002, Gilbert & Leahy 2007, Hardy *et al.* 2007). The supervisor's task is to find a balance between supporting the supervisee's experience and making the necessary changes in their therapeutic understanding so that (Armstrong & Freeston 2003, Waltz *et al.* 1993):

- a quality supervisory relationship has been established and maintained in which the therapist feels support, acceptance and appreciation;
- solutions to the client's problems have been sought;
- the therapist's strengths and competencies have been continuously encouraged and built;
- there has been natural learning of new skills;
- the individual style of the therapist, his originality and creativity were promoted;
- bad habits were corrected;
- unconscious tendencies, transference and countertransference, have been identified and acknowledged;
- self-reflection and healthy self-esteem have been built and strengthened;
- free space for creativity but also for expressing misunderstanding and disagreement are provided;
- risks have been identified in difficult therapeutic situations;

Tab. 3. Examples of frequently used scaling questions

• When the goal you want to reach is at ten, and the opposite is zero, where are you now on this scale?
• Where would your clients say you are now on the scale?
• How do you manage to be at that point?
• How is it that the point is not lower than it is?
• Where would you like to be on the scale at the end of this supervision
• How will a point higher on the scale look to you?
• What will be different when you are a point higher?
• What will you be doing differently?
• What will others (clients, colleagues) see you doing differently at one point higher on the scale?
• How can you reach a point higher?
• What would your clients say about how you could reach one point higher?
• Who or what can help you to get there?

Tab. 4. Examples of the question to self-reflection in chairwork with three chairs

• How are you doing?
• What is making you happy or satisfied?
• How are you managing to achieve that?
• What would you like to be different?
• What is working for you at this time?
• What could be the next sign of progress?
• What could be your (small) next step?

- attention has been paid to ethical dilemmas, borders, distribution of power and responsibility;
- the risk of harming the client or therapist has been monitored and eliminated;
- the risk of burnout has been reduced;
- the ability to care for themselves has been modelled, including the rejection of excessive expectations and demands.

Scaling questions for self - reflection

The scaling questions are widely used in CBT and also in supervision. It is a useful way of inviting supervisees to observe, evaluate, and predict the therapy`s process. Usually, a scale from 0 to 10 is used. Bannink (2015) mentioned that scaling question is a form of operant conditioning, in which the increasingly accurate approximations of desired response are reinforced. Bannik (2015) also gives examples of a frequently used set of scaling questions (Table 3).

Another creative way to increase self-reflection is the *chairwork* (exercise" Sit on Three Chairs, Bannink 2015, p.106). It is also similar to the scaling question, but in this case, the supervisor uses space. Such kind of reflection also could be useful in the therapy session to understand how the client sees his/her progress in the therapy.

During a supervision session, the supervisees are invited to take turns in sitting on three chairs (placed in a row) and talk about themselves. On the first chair, supervisees reflect on their life two years ago, on the second about their life now and on the third chair represent their life in two years. Instead of two years, it is possible to choose another time frame, such as before/during/after supervision, before/during/after therapy, or six months etc. There some question which could help to reflect (Bannink 2015) (Table 4).

Interventions enhancing self-reflection

To increase self-reflection, we are using traditional techniques mentioned above: discussion, questions, imagery, automatic thoughts lists, and vicious circle etc. More experiential and emotionally charged interventions can increase self-reflection with respect to the awareness and the response to it. Increased self-awareness does not automatically mean changing behaviour (response) functionally. Experiential learning techniques tend to leave a more profound impact not on only self-reflection but also on motivation and change in the desired way. Self-reflection can be significantly enhanced by those creative techniques such as imagery or working with chairs or plush figures, toys (Prasko *et al.* 2019a, Prasko *et al.* 2019b), board games, mindfulness attitude and mindfulness-based practices, schema therapy's schema and modes awareness exercises, mode conceptualisation cards, drama, metaphors, therapeutic tales and fables, body interventions, exposure, working in front of the mirror, reflective journal. Variety of techniques can be used for this purpose and therapist or supervisors can get very creative, but in the end, we should put more emphasis on results of discussion, reflection and summarisation of the intervention, also useful to do it as a home assignment (Table 5).

The supervisor as a model of self-reflection

The self-reflection of the supervisor acts as a model for the supervisee. It does not lead to dependence but teaches them how to look deeper into themselves, how to understand themselves more in their interac-

Tab. 5. Examples of techniques for enhancing self-reflection

Intervention (exercise)	Short description	Reflectivity features
Mindfulness-based exercises (meditations)	Body scan meditation Open mindfulness meditation Three-step pause Loving-kindness meditation	Increases body, emotions, thoughts, and impulses awareness, decreases reactivity, strengthens the observer attitude..
Mode awareness games (Schema therapy)	To act playfully/game all modes (child modes, coping modes, critic or parent modes, healthy adult mode) – be, feel, think as that mode	Increase mode awareness: body feelings, emotions, thoughts, etc., also increase the realization that modes can be changed voluntarily.
Chairwork	The four dialogues are: giving voice, telling the story, internal dialogues, and relationships and encounters. The chair work provides a framework and a language for not only listening to patients and therapists but also for creating dialogical interventions (Kellogg, 2019). We sit on the chairs representing our parts or modes, participants of interpersonal situations.	Principles: • The multiplicity of self – people are seen as containing different parts, modes, voices, or selves. • Healing and transformative for people to give voice to different parts of the psyche. • Healing and transformative to enact or re-enact scenes from the past, the present, or the future. • The goal of Chairwork is strengthening of what has been variously called the Ego, the Healthy Adult Mode, or the Inner Leader.
Role-play with toys, plush figures, board games	Playing with plush figures or toys, giving voice to express needs, emotions, tell the story, act in a new functional way of response to the situation.	The games focus on experiential exploring and learning while overcoming defences.
Situation drama rescription	Remembering is difficult situation and acting it out, how it was, explore more relevant context (memories from past, thoughts, attitudes, emotions, body feelings etc.), act new more functional version (for example stop the Critic or the Aggressor).	Emotional bridge and link with past experiences, increasing self-awareness and situation awareness, understanding modes and schemas involved, and emotional corrective experience.

tions with other people, especially clients (Prasko & Vyskocilova 2010).

The term "supervisor" is sometimes associated with the notion of superiority, someone who is "bigger" therapist, someone who is better, has power, control, knowledge, and competencies that go beyond the supervisee (Pope *et al.* 1987, Prasko *et al.* 2012b). This leads to fear of the supervisor as an authority who seeks out errors, draws attention to deficiencies, and embarrasses the therapist. Alternatively, they can be seen as someone who knows everything and answers all questions and can solve all problems. If the supervisor acts in this way, they miss the ethical principles that are important to supervision. The supervisor is not "above" the supervisee, but they work together to find the best solution for the client. Self-reflection also protects the supervisee from the inducing of supervisors´ ideas. The supervisor enhances the courage to self-reflect and the ability to ventilate it in the supervisee.

The role of the supervisor in the self-reflection of the supervisee

Since the beginning of the supervisory process, some supervisors encourage supervisees to engage in self-reflection and identify their attitudes and beliefs about themselves. For example, a supervisee at the beginning of their career may start to think about how they communicate with others, why they chose the role of a psychotherapist, and why they chose a particular supervisor (if applicable). Haarhoff & Kazantzis (2007) cite examples of cases of supervision in which the recognition of therapist's attitudes and schemes was a crucial point because they interfered with therapy. The supervisor's role in building the supervisee's reflection and self-reflection capacity is threefold:

(1) to assist the supervisee in conceptualizing the patient's story, by increasing awareness of the impact of their own experience on the patient's perspective, helping them to realise which parts of the story they emphasize, and which parts of the story they perceive less or are blinded to;
(2) be aware of the influence of one's thoughts, emotions, bodily reactions, and behaviour resulting from more deep-rooted attitudes to the course of the supervisory process and the supervisory relationship;
(3) be aware of one's thoughts, emotions, bodily reactions outside the supervisory relationship, and develop self-reflection outside the supervisory meeting (e.g. in clinical meetings, peer supervision or self-supervision).

To achieve this, each supervisory session requires the creation of a secure atmosphere, acceptance, and

appreciation (despite supervision also including an assessment and corrective component), modelling openness to new ways of thinking and experiencing, appropriate stimulation, controlled discovery, cognitive restructuring, using imagery (Prasko *et al.* 2019a).

The role of the supervisee

Although the relationship in supervision is often considered primarily to be the responsibility of the supervisor as a more experienced therapist, the supervision process cannot effectively take place without adequate supervisee input. This may not be easy because supervisees often feel vulnerable and fear a negative assessment by their supervisor (Bennett-Levy & Beedie 2007). They are tense, uncertain about their therapeutic role, anxious. They may be worried about the supervisor's view of their work, the fear of criticism, whether they are worse or better than other supervisees, and so on. They often secure themselves by bringing numerous materials, looking at the paper and not at the supervisor, not paying attention to supervision process.

Nevertheless, they are generally highly motivated to do the best they can (Hawkins & Shohet 2000). They long for the supervisor's approval. However, even if the attitude of the supervisor is in some way different from the attitude of the supervisee, discussion with other people who have not only different opinions but also different feelings evoked by the same incident is often stimulating for self-knowledge. The thereutic process involves a range of skills, both technical and interpersonal, many of which are essential to the "therapist as a person" (Thwaites & Bennett-Levy 2007). A supervisee may feel that if they are making mistakes or getting negative feedback, it means that they are incapable or in some way a worse human. Supervisors need to normalize their emotional responses and create a non-judgmental environment to overcome any concerns about discussing their emotional responses to patients or ways of working (Bennett-Levy & Beedie 2007).

There are many questionnaires that supervisees can complete, which can facilitate this process. These include, for example, the Dysfunctional Attitude Scale (Weissman & Beck 1978) or Young Schema Questionnaire (Young 2005). They may be tasked with thinking about the role of the supervisor and the supervisee and themselves as a cognitive-behavioural therapist. For example, the Therapists' Schema Questionnaire (Leahy 2003) can help supervisees think about their beliefs as a therapist. Some patterns that are more common in cognitive-behavioural therapy students, such as "demanding standards", "excessive self-sacrifice" and "special superior person" (Haarhoff 2006) have an impact on both the treatment and the supervision processes. For example, if the supervisee believes they have to "heal all their patients," they tend to avoid the more complicated patients or chooses to only communicate about the "good parts" of the therapy process, or even cuts unsuccessful parts from video recordings shown in supervision.

Supervision models and self-reflection

Several supervision models provide a framework for enhancing self-reflection in the management of supervision. The relationship approaches Safran & Segal (1996), the Newcastle Cake Stand Model (Armstrong & Freeston 2006), the evidence-based supervision model (Milne 2008), and the six-step model (Bennett-Levy & Beedie 2007) which deserves particular attention. The six-stage model includes six phases of the supervisory process:

- Phase 1: Focus attention on the problem
- Phase 2: Reconstruction and observation of experience
- Phase 3: Clarify the experience
- Phase 4: Conceptualization and synthesis of new information
- Phase 5: Practicing procedural skills
- Phase 6: Testing a new strategy

In the following example, we will illustrate the usefulness of the six-step model for improving the self-reflective processes of the supervised

Stage 1: Focus attention on the problem. The supervisee described an unclear problem with patient Anna suffering from PTSD. Anna did not improve during treatment. During supervision, the conceptualization proved to be adequate, but the supervisee delayed discussing the traumatic event with the patient. The supervisee knew that they should start working on the traumatic event, but she was afraid to start talking about it because she was afraid it would be painful for Anna and herself, and it would cause stress that they could not handle. The supervisor, through controlled interviewing and discovery, revealed that the supervisee understood the PTSD (declarative knowledge) model and was able to apply it to Anna. However, the problem was that every time she decided that they could talk about a traumatic event together, she was afraid and postponed the conversation to the next session. The patient who read the PTSD materials that she received from the therapist at the start of treatment had already spoken about it. The supervisee told her that she was not ready to do so and postponed the trauma work again.

Phase 2: Reconstruction and observation of experience. The supervisor asked the supervisee to return in imagery to the last session when Anna asked if they would work with the traumatic event, as she read in the booklet the therapist had given her at the beginning of the therapy. To make the situation more vivid, the supervisor asked the therapist to describe as much as possible the office environment, the furniture, the patient's clothes, and to remember how the patient looked and what the patient said. In her imagination, she sensed that the patient was asking if they should talk about the assault she had experienced, and at the same time, she sensed that the patient was talking cautiously and with fear. The therapist realized she got angry and quickly said that the patient was not ready for it yet. When

the patient said "all right", she experienced relief. Both of them quickly began to talk about the patient's situation at work and were satisfied.

Phase 3: Clarification of experience. The supervisor led the supervisee to become aware of her emotions during this brief situation and to present her bodily reactions. She said she was trembling, worried, and afraid. She thought that if she began to talk about the trauma, the patient would experience severe anxiety, pain, helplessness, and she would not know how to get her out of the trauma. She felt helpless herself as she imagined the patient suffering... She would blame herself for putting her in that state and not knowing what to do next. When the supervisor asked her what it would mean about herself, she said she would be inhuman and incapable.

Phase 4: Conceptualization and synthesis of new information. During the guided discovery, the supervisee realized that the schema that she was incapable and unhappy was the schema that had come up within her personal therapy, and it was triggered during the therapeutic work. She is doing well in her personal life now, but she has excessive demands on herself when working with patients, worried that she is not a good therapist. She knows what to do, but she does not dare to do so, because she is afraid that it will fail. The supervisor normalized the supervisee's experience. She remarked that she also experienced this trouble early in her career, as it is a common issue for novice therapists.

Under the influence of her schema, the therapist feared the patient would suffer, and she would not know what to do about it. Correspondingly, she was convinced that, above all, she had to protect the patient, be careful and to encourage her, and the notion of exposures frightened her because she felt she might hurt the patient. The supervisor asked what kind of traumatic memories Anna has. They discussed it, and she soon realised that what she avoided in therapy was experienced repeatedly by the patient every day, and the patient was trying to avoid it as well. However, reminiscence of trauma appears and thwarts her effort. The fact that the processing of the trauma is avoided leads to the maintenance of the failure. The therapist, however, is not responsible for her reminiscences, nightmares, and flashbacks, they arise "on their own", but if she encouraged the patient to describe the trauma, she would be responsible for the activation of the trauma.

Stage 5: Practicing procedural skills. The supervisor asked the supervisee if they could rehearse together how she would work with the trauma. The therapist role-played herself, the supervisor played – Anna. She played the situation nicely, sensitively and empathically. According to the patient's story, the supervisor described to her how she was ambushed and beaten two years ago in a park. The therapist reacted very sensitively and then rewrote the situation in the imagery, saying that a friend of Anna entered the situation, chased the invaders away and hugged Anna. After playing the roles, the supervisee felt very comfortable, expressing her conviction that she would try it at the next session with Anna. She believed she would not postpone it, and that she and the patient could handle the strategy well.

Phase 6: Testing a new strategy. In the next therapy session, the therapist started working with patient Anna on her trauma and managed to resolve the trauma. The patient was relieved and, recorded a cell phone rescript. It was a breakthrough in treatment, followed by transcriptions of nightmares in therapy and beginning to solve problems at school. The patient began to improve significantly, reminiscences and nightmares gradually disappeared.

The therapist has started to consider the role of her own core beliefs, which lead to excessive standards and avoidance of strategies that evoke strong emotions in patients.

Problems with self-reflection

If the therapist is not able to recognize their feelings, thoughts or the influence of their attitudes in the therapeutic process, then they are vulnerable to their influence and cannot control their behaviour to the detriment of both the patient and themselves (Praško *et al.* 2010). Therapists who often get caught up in their emotions are unable to escape them. They usually do not realize their feelings or cognitive reactions, or they do so only afterwards (Praško *et al.* 2010). They are succumbing to their moods, often responding in countertransference, or feeling helpless in a therapeutic situation (Young *et al.* 2003).

Some people have problems with self-reflection. They do not like thinking about themselves. They have troubles to record what they are thinking and have difficulty capturing what happens in them at emotional level. This is often the result of mental avoidance. Deeper self-reflection could reveal thoughts and feelings that one would not prefer to be said out loud. For example, they might find that they are angry with others, feel helpless, sad, or anxious. These people are told by their cognitive and emotional schema that they should not have such thoughts and feelings or must repudiate them because they mean weakness or unacceptability to others (Praško *et al.* 2009). This also applies to therapists in training. However, blocks in self-reflection hinder understanding of countertransference phenomena and may limit the ability to form a quality therapeutic relationship because the therapist is unaware of their share in it (Prasko *et al.* 2010)

Role-playing with toys

Cuddly animals, puppets, or dolls may be used to play the therapist and the patient. It is also good to have a baby chair in which dolls representing the therapist and patient can sit. Toys boost both understanding and creativity. Many of the things that are out of focus in an ordinary conversation suddenly come under the spotlight. The supervisor asks the therapist to replay the situation from the therapy session with toys. A supervisor can select individual characters, usually the therapist and the patient, but also the patient's family members, their boss, co-workers, or choose the toys representing the modes and play the dialogue of the modes within the therapist or the patient. They then discuss it is looking for the optimal response and then play the scenario with the toys so they can review it again.

Therapist: I feel that something strange is going on in the therapy. I have a client Petra, she is 19 years old, and she has severe OCD. We had been working pretty well, but now we have got stuck suddenly.
Somehow, I have the feeling that it could be connected to her situation at home. She lives in a big family, and I am lost in their communication and how it affects my client. She has a very controlling mother, uninvolved father, her grandmother coming to her house every day to take care of the great-grandmother. Her sister and husband, two dogs and three cats also live in the client's family. I feel overwhelmed with all everyday information, and I want to make some clear picture.
Supervisor: It is sound tough for you to organize a lot of small pieces of this information about the client's family. Maybe we could be creative today and use toys we have in this room for reconstructing situation you have with the client?
Therapist: Sounds good, let´s try that. I am ready for everything, to make clear what is going on.
Supervisor: I have a house for dolls, and I would like to ask you to put all the family members and Petra there. You can use all the figures you see on the shelf. Here are animals also.
Therapist: (smiling) I like these small dolls. Ok, I will have a look (the therapist goes to the shelves and takes figures). Ok, I found all the characters.
Supervisor: Great, try to put them in the doll's house.
Therapist: Ok, my client Petra has her bedroom on the second floor, and one cat usually sleeps with her. Sister (she is pregnant) lives in the room behind. They share the door to each other's room through the bathroom. Two other cats live with the sister. They are fighting with Petra cat. I will put them in a fight pose. The sister loves to come to Petra to talk (puts sister's doll in the room). Her parents sleep separately: mother in the last room on the second floor. She is a dog lover. Father sleeps in the TV room on the first floor. The great grandmother has the other room on the first floor. She is paralysed. Mother is continuously concerned, and checks if her daughter is making rituals or not (shows how mother's doll running all the time in Petra's room). Father hates grandmother (mother's mother) who is coming to take care of great-grandmother. They quarrel every day. She is usually throwing things in the kitchen (throwing doll things around). Petra is trying to listen to music in her room not to hear father and grandmother shouting to each other.
Supervisor: Well done. Do you want to put any other detail?
Therapist: Yes, there is a TV all the time switched on in every room all the time because the mother loves to clean and listen to TV. They have four of them – so she can go everywhere in the house and hear her favourite show. I will put red balls on TV.
Supervisor: Outstanding and now - what do you see, when you are looking at this installation? If you want, you could step back.
Therapist: I see absolutely no boundaries in the house! I feel sick of all this mess! It is no surprise that my client has OCD and that last week she had worsened symptoms - father had an episode of over-drinking for three days in addition to everyday mess.
Supervisor: Perfect, I could hear an excellent reflection from you, and I absolutely agree, I see no limits as well.

Correction options

Continued discussion of the therapy with colleagues or supervisor is of great value (even for experienced therapists) and is considered necessary for empirically investigated therapeutic approaches (Gunderson & Links 2008). Such interviews increase the therapist's ability to see the patient's transference clearly and to understand their countertransference anger or disappointment (Gabbard & Wilkinson 1994, Marginson *et al.* 2000) quickly. Supervision can support the therapist, show them a different view of the situation and its solution, especially helping them to understand difficult situations. In supervision, it is easier to separate the therapist's unmet needs from the patient's problems and see where the therapist solves their problems rather than the patient's. Proper supervision is also a role model for the therapist, how to behave in therapy, how to remain open to other possibilities and other perspectives, how to be tolerant, non-judgmental, understanding, sensitive and yet firm (Gunderson & Links 2008).

Self-reflection of supervisor

The supervisor makes the process of self-reflection easier for the supervisee. However, the supervisor also has to use their self-reflection ability to realize thoughts and feelings that the supervisee, or the patient and a therapeutic process evokes in them and avoid engaging in useless interpersonal processes such as collusion with the supervisee (Milne 2008).

Understanding and managing one's countertransference reactions is one of the primary 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. Therefore, adequate self-reflection and supervision of one's work are necessary prerequisites for the adequate development of the supervisor's competences even if they have years of experience as a supervisor (Figure 2).

We can notice the countertransference reaction mainly in our behaviour, but also our thoughts, emotional experiences and bodily symptoms. Cognitive-behavioural therapy includes the expression of emotions during therapy, as the therapist is also a model for the patient to behave naturally with sophistication and maturity. The same is valid for supervision. The supervisor, in many ways, becomes a role model for the therapist, especially if the supervisee is in training and is only beginning to develop his or her therapeutic style. Just as a therapist encourages a patient to notice their physical reactions, it is essential for them to notice their own, as they can alert them to unconscious processes in the therapeutic relation-

ship. The supervisor needs to do the same. Physical reactions often reveal to us emotional motives that we are not aware of, or that we divert attention from automatically, because, for some reason, they are difficult to bear. Any change in the physical and emotional experience or behaviour of the therapist towards the patient and the supervisor to the supervisee indicates the presence of automatic thoughts. Changing the tone of voice, feelings of insecurity, urgency, commands, a reluctance to supervise, prolonging or shortening a meeting, can be typical manifestations of countertransference reactions. Cognitive errors can occur in automatic thoughts. "This patient is a hypochondriac" (labelling), "Seeks secondary goals "(thought reading), "... will never improve" (predicting the future), "Does nothing at all" (black-and-white thinking), "Does it on purpose" (personalization), "should try harder" (excessive use of MUST), "keeps making the same mistakes" (excessive generalization).

Self-reflection is also one of the means that, among other things, protects the supervisee from uncritical acceptance of the supervisor's views. Therefore, the courage to self-reflect and the ability to ventilate it is enhanced by a good supervisor during supervision

Correction options

The supervisor needs to regularly examine their thoughts and behaviour towards the supervisee, which may be based on their dysfunctional attitudes (Linehan & Kehrer 1993, Williams *et al.* 1997). The supervisor should ask themselves before each new supervision if there is any other unusual relationship with the supervisee. Unless they ask themselves to self-reflect, or see the difficulty, and are not aware, likely, they will probably be unable to avoid countertransference. At that moment, they must go to personal supervision, or to colleagues who could advise them to try to map automatic thoughts about the relationship with the supervisee.

If the supervisor pays attention to their possible countertransference reactions, they can recognize and manage them. This reduces the risk of negative consequences for supervision (Young *et al.* 2003). During the supervision process, more robust emotional responses to the supervisee, both positive and negative, and the flow of their own inner speech need to be monitored. They then need to compare these reactions with similar reactions in the past and try to find out what attitudes towards themselves and other people are. A supervisor monitoring their own positive and negative feelings needs to be particularly aware of the following reactions:

- concerns or excessive enjoyment of the upcoming session;
- excessive anger/hatred or, conversely, feelings of attachment to the supervisee;
- the desire to end prematurely or extend the session;

The first step in dealing with countertransference is the supervisor's realization that their feelings for the supervised individual are strikingly pronounced, either positively or negatively. It is advisable to take some time, preferably outside the supervisory environment, to ask some questions patiently:

- How do I respond emotionally to a supervisor?
- Isn't that a bit exaggerated?
- Why don't I like this person or I like them too much?
- What things do I want or not want to discuss with this supervisee? What causes my feelings of discomfort?

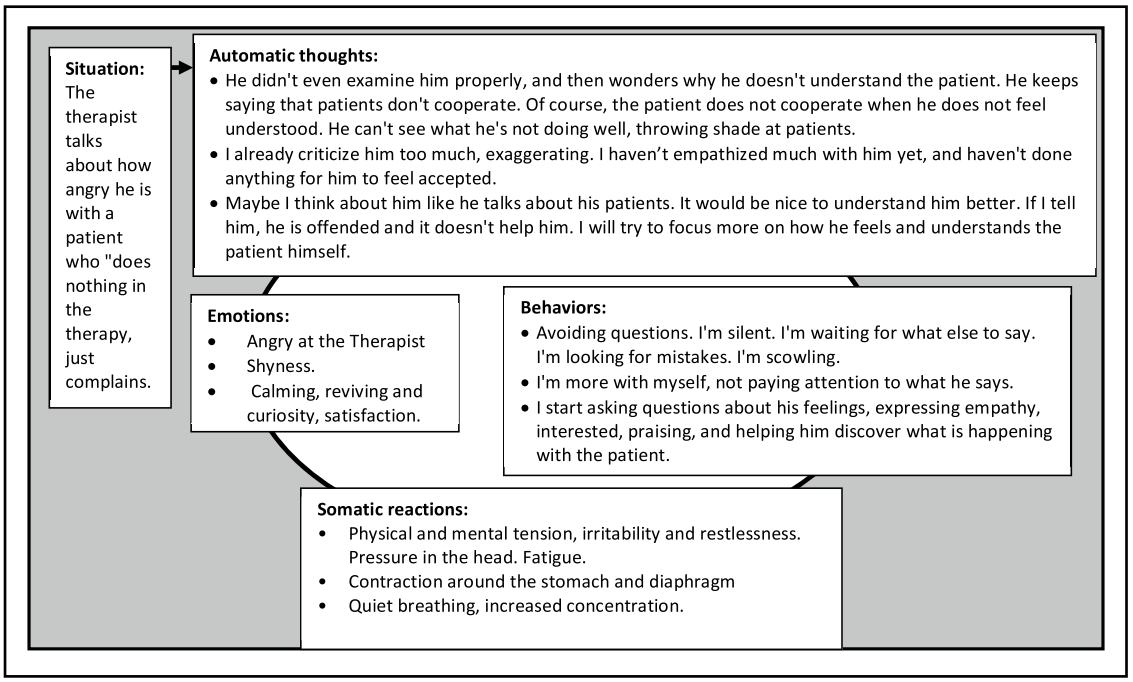

Fig. 2. Vicious circle of supervisor reaction on the supervisee

- Are there any signs of a supervisor's problem I missed? What does it say about me that I overlooked them?

The next step may be to seek a consultation with one´s supervisor, who can dig deeper and help identify sources of strong countertransference reactions. In order to detect countertransference, the supervisor may examine the life problems of their experience. Have they experienced rejection or abandonment in their life? Then they can investigate how similar feelings appear to them in contact with the supervisee. Do they always have to be "right"? Then it is essential to realize whether they will not “beat” them repeatedly in discussions with the supervisee, as this would lead to a loss of supervisee´s self-confidence. Are they unafraid of losing or being criticized because they consider success or loss to be related to their value as a human being?

Recording of supervisory sessions or monitoring of colleague supervision may be necessary for the development of self-reflection (Linehan *et al.* 1994, Swales & Heard 2009). Feedback while watching a recording can show very clearly how self-reflection is used. For example, supervisors can avoid critical self-reflection by continuing to ask the supervisee further questions or using general or theoretical answers to the questions. This is sometimes referred to as "playing games". For example, supervisors avoid showing their vulnerability or attempt to reduce their level of anxiety and uncertainty by avoiding discussion of sensitive topics (Kadushin 1976). Supervisors avoid self-reflection, especially when they are hypersensitive or insensitive to criticism, or are afraid to show their vulnerability, doubt their supervisory skills, and are afraid to admit that they do not know something or are uncertain in some way (Powers 1994, Bennett-Levy & Beedie 2007). A sign that the supervisor avoids critical reflection may be emphasizing theory instead of discussing personal or professional experiences (Hahn 2001). To strengthen self-reflection in the supervisor, similar approaches can be used as in self-reflection training in therapists: records of vicious circles, automatic thoughts, and elaboration of cognitive schema associated with countertransference.

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 that supervision can continue successfully. It is useful to confront every fear of making a supervisory mistake and trying to understand what preceded these concerns. Supervisory responses can have a variety of sources, including culturally-determined attitudes and values, looking at one's professional role, a unique life experience, including training, or triggered by the supervisee's behaviour (Kimmerling *et al.* 2000).

The only way to recognize counter-transference in supervision is to consistently realize our thoughts and attitudes that affect how we respond to the behaviour of the supervisee. Rather than controlling their own emotions, the cognitive behavioral supervisor is encouraged to notice them and consider how they appear in the supervision and what thoughts and attitudes they are tied to.

Conclusion

Self-reflection, transference, and countertransference are terms that are relatively new in cognitive behavioral therapy. For cognitive behavioral therapy, their conceptualization need to be in line with its tradition of experimental science.

Based on the current literature, we can conclude that improving self-reflection can increase the quality of therapeutic care, concerning both the therapy itself as well as the supervision. We propose that the critical characteristics for developing self-reflection in cognitive behavioral supervision might be:

- the supervisor and supervisee need to share a standard model of work and awareness of the importance of self-reflection in that model;
- various techniques are used to enhance self-reflection (role-playing, imagination, or video);
- safe, accepting and appreciative atmosphere needs to be created by the supervisor, which helps to increase the self-awareness and self-expression of the supervisee;
- the supervisor maintains a balance between accepting the supervisee´s thoughts, emotions and feelings and promoting clinically functional alternatives.

Conflict of interest statement

The authors declare no confict of interest.

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