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EXPERT OPINION

Managing Transference and Countertransference in Cognitive Behavioral Supervision: Theoretical Framework and Clinical Application

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Abstract: Dysfunctional patterns, beliefs, and assumptions that affect a patient's perception of other people often affect their perceptions and behaviours towards the therapist. This tendency has been traditionally called transference for its psychoanalytical roots and presents an important factor to monitor and process. In supervision, it is important to put the patient's transference in the context of the conceptualization of the case. Countertransference occurs when the therapist responds complementary to the patient's transference based on their own dysfunctional beliefs or assumptions. Transference and countertransference provide useful insights into the inner world of the patient, therapist, and supervisor. Guided discovery is one of the most common approaches used by a supervisor and a supervisee to map all types and directions of transference and countertransference. Other options to map transference and countertransference are imagery and role-playing techniques.

Keywords: supervision, cognitive behavioral therapy, therapeutic relationship, supervisory relationship, transference, countertransference

Introduction

Comparing current and past experiences is automatic and mostly unconscious.[1] Thus, transference and countertransference reactions present valuable sources of information about the individual's inner world, either a patient, a therapist or a supervisor[2,3,4,56]. Examining the supervisee's countertransference is a crucial but delicate part of the supervision process.[5] However, transference and countertransference alone do not yet provide sufficient insight into the inner world of the patient, therapist, and supervisor. However, their careful identification and elaboration can be a useful source of clinical information and help remove barriers to treatment.

Sigmund Freud introduced the history of the early development of countertransference in 1909, as described by Stefana (2015).[6] In the original psychoanalytic construction, transference was understood as one of the numerous forms of resistance and difficulty forming a required trusting relationship between therapist and patient.[7] The concept of transference has gradually become an essential tool of analysis, through which it has undergone profound changes in definition and clinical use. The transference was recognised as a central element of the psychoanalytic process.[9] Now classical psychoanalysis recognizes transference as an essential component of the therapeutic relationship.[10] The basic tasks of supervision consist of clarifying the mutual expectations of the supervisee and the supervisor, creating a credible supervisory relationship as a basis for countertransference analysis, and examining "parallel processes" between the supervisor and the supervisee.[11] Examining the supervisee's countertransference is a necessary but delicate part of the

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supervision process.[5] From the psychoanalytic perspective, the therapeutic relationship is the sum of the real relationship between two people, the working alliance, transference and countertransference,[12,13] Levy and Scala 2012).[7,70] Watkins (2011)[14] and Gelso (2017)[13] explored a tripartite model of the therapeutic relationship. This model postulates that a therapeutic relationship contains a working alliance, a real relationship, and transference and countertransference formation. Although the model seems theoretically and empirically feasible, further research is needed to improve the model further. In transference, the patients project to the therapist's thoughts and feelings, originating from their experiences with important individuals they met earlier, especially in childhood and their mother and father (Gutheil and Gabbard 1998).[10,71]

Some psychotherapists believe that the difference between psychodynamic psychotherapy and cognitive behavioural therapy (CBT) lies mainly in the emphasis or lack of attention on transference.[15] This is one of the most common misconceptions about CBT.[15–18] However, CBT usually does not analyse the therapeutic relationship when solving uncomplicated problems and disorders (Beck 1995).[2,19,17]

When the patient trusts the therapist and actively engages in the therapy, the therapist acts as a supporting expert who accompanies the patient in the individual steps of the therapy and encourages them in their independent implementation.[20] The patient does not depend on the therapist but only seeks a colleague to discuss the steps performed on their own. The relationship is straightforward. In more complex cases, including patients with personality disorders, the therapeutic relationship becomes an important therapeutic focus (Beck 1995;[17] Zanarini 2009;[2,72] McCracken and Gutiérrez-Martínez 2011).[73]

When we look at the history of CBT perspectives of transference and countertransference, we can recognise it from the beginning of cognitive therapy. Beck mentions transference as a "schematic response" in his publications as early as the 1970s.[21] Although transference and countertransference were described early in CBT, they were not of clinical interest in initial, especially short-term therapies, unless they provided an example for the guided discovery of core beliefs or conditional rules triggered in the therapeutic relationship.[2,22,23] In cognitive-analytical therapy (CAT), transference and countertransference are conceptualized as the organization of an individual's experiences and behaviours throughout patterns composed of self-confirming sequences, including cognitive, emotional, and interpersonal processes based on previous experience.[24] Individuals play roles and seek or provoke reciprocal reactions from others. CBT therapists have also pointed out how a patient relates to a therapist may reflect on their past emotional bonding difficulties, previous relationship patterns, and learned maladaptive emotion processing. Previously learned cognitive and emotional processes can lead to blocks in therapy.[25]

Nevertheless, specific difficulties in dealing with the disruption of the therapeutic relationship due to transference or countertransference have rarely been discussed.[26] A deeper interest in theoretical and clinical views on transference and countertransference appeared at the turn of the millennium. From a socio-cognitive approach, it is important to recognise the therapeutic relationship as a co-construction so that what the patient brings and what the therapist brings are important for the way the relationship pattern is formed.[27] According to their model, transference supposes that internal representations of important persons are in memory and could be activated by related signals in any context. Once the transference is activated, the individual looks at the other person through the glasses of the earlier representations of important persons. Leahy (2007)[28] portrays a therapeutic relationship as an interactive game in which the therapist and the patient follow their previously learned rules and use them to expect the other to behave and adapt their behaviour accordingly. Previously developed relationship patterns and expressions of emotions significantly impact building and developing a therapeutic relationship. Eg, s therapist with unrealistic standards may unintentionally authorise a negative belief in a patient's relationships. Understanding transference and countertransference allows the therapist to overcome the pitfalls of the therapeutic relationship and the blocks in therapy. It also helps the therapist better understand how the patient's interpersonal world is reflected in the current relationship in therapy.[28] Leahy (2007) states that the transference relationship consists of intrapersonal and interpersonal processes between the patient and the therapist. These processes include personal schemas about the self, others, and the world entering a therapeutic relationship. These patterns that make up the transference relationship can be recognised through guided questioning and Socratic dialogues and corrected by working with thoughts and schemas. To recognise countertransference, the therapist needs to apply the same procedures to themselves and train in self-reflection in a therapeutic situation.[29] In his monograph, Newman (2013)[23]

also emphasises the importance of CBT therapists using CBT methods and strategies for themselves and using CBT methods considerably in coping with barriers in a therapeutic relationship, despite the patient's self-understanding and understanding. Cartwright (2011)[30] inspects the transference and countertransference from various perspectives, including attachment, the socio-cognitive perspective, the perspective of cognitive analytical therapy, and schema therapy. According to the author, countertransference reactions of therapists can offer insight into the experience of patients, especially their ways of relating to others and how others reciprocally react to them. Therefore, therapists can profit from understanding countertransference through reflective practice and supervision.

Hayes et al (2018)[31] dealt with the definition and empirical research evaluating the relationship of countertransference to the effectiveness of psychotherapy. The authors presented three meta-analyses. The first showed that countertransference responses are inversely related to psychotherapy results, and the second supported the view that approaches to countertransference management can significantly reduce countertransference responses. Finally, a third meta-analysis showed that successful countertransference management is associated with better therapy outcomes.

Stefana et al (2020)[32] conducted a systematic review of quantitative research on the relationship between the personality pathology of the patient and the cognitive, emotional, and behavioural responses of the psychotherapists in individual psychotherapy. Significant relationships between therapist responses and specific personality traits or disorders have been found. In general, eccentric and odd patients evoke feelings of detachment and disconnection in the therapist; patients with emotional dysregulation cause anxiety and feelings of incompetence, and anxious and withdrawn patients cause sympathy and concern. Relatively small studies sample and methodological discrepancies across studies limit the clear conclusions and propose the necessity for further research. This review suggests that patients who share similar personality disorders or symptoms tend to elicit similar cognitive, emotional, and behavioral responses in therapists.

A therapeutic relationship identifies the patient's automatic thoughts, dysfunctional assumptions, and core beliefs, especially when dysfunctional beliefs about the therapist's relationship trigger during a session (Beck 1995;[17] Spinhoven et al 2007;[74] Rivera and Darke 2012).[75] If the transference relates to the patient's relationship problems or lack of self-acceptance or presents an obstacle in the therapy, it is necessary to help the patient discover and gradually process it (Linehan and Kehrer 1993;[76] Williams 1997;[77] Spinhoven et al 2007).[78]

From a humanistic perspective, Rogers (1965)[33] distinguish transference attitudes and a transference relationship between a client towards a therapist. In typical cases, clients' attitudes toward their therapists are mild and of reality, rather than a transference in the psychoanalytical interpretation of transferring infantile attitudes to a present relationship where they are inappropriate. For example, the client may feel annoyed in early interviews that he does not receive the guidance he expected or leaves therapy with gratitude to the therapist for providing him with the opportunity to work things out for himself. Even though transference attitudes exist in many clients in non-directive therapy, these do not develop into a transference neurosis or a transference relationship that becomes central for psychoanalytical treatment. This is a consequence of a client-centred therapist's different handling of clients' transference attitudes than the psychoanalytical interpretation of transference. The client-centred therapist handles these attitudes just as he would handle similar attitudes directed toward others or any other client's attitude – "he endeavours to understand and accept.[33]

In an existentialistic psychotherapeutic perspective, interpreting a client's reaction as transference (with the implication that s/he was driven to respond as s/he did by echoes of the past within their unconscious) is perceived as a devaluation of a client's capacity to choose or as reducing a client's responsibility. The existential definition of transference places more emphasis on the client's capacity to choose,[34] which means that earlier dynamics and displaced feelings cannot completely explain a client's motivation as they are also "motivated by more contemporary reasons why s/he is choosing to act in that manner to a real person in that room at that minute" (ref).

This paper describes case studies to provide more understanding and practical ideas about transference and countertransference in CBT supervision. The main focus is on approaches and techniques that effectively use transference in supervision. Illustrative supervision cases accompany the theoretical framework.

Patient Transference to the Therapist in Cbt Supervision

Transference within the therapy can be understood as reactions to the patient's emotional, cognitive, and physical experiences, which can be seen in the responses to the therapist, but which are more related to the patient's attitudes

than to the therapist's behaviour.[2,35,36] These reactions are related to what the patient consciously and unconsciously expects from the therapist, and these expectations reflect their experience with important people in their life,[26,36] (Levy and Scala 2012).[70] Transference occurs when a patient's previous experience with other people and with a therapist overlap.[37] The patient's transference reactions allow the therapist to recognize their likely behaviour toward important people in their life.[28,38] The patient may respond to the therapist's personality traits, appearance, style, or behaviour which may remind them of a significant person in the past. Dysfunctional patterns, beliefs, and assumptions that affect patients' perceptions of other people often affect their therapist's perception and behaviour.[2] This is particularly significant when treating patients whose relationships have been painful, complicated or if they have been abandoned in childhood.[39]

Transference can also be abused in favour of the therapist at the patient's expense, and this crossing of boundaries can occur unconsciously or consciously.[40,41] The patient is usually unaware of it during psychotherapy if it is not interpreted or revealed to them during the work with the therapist. In treatment, transference can be beneficial, mainly if slightly positive, as it increases the patient's assurance in the therapist and the likelihood of a cure,[35,42,43] (Singer and Conway 2011;[79] Nordgren et al 2013).[80] Conversely, excessively positive and negative transference can block or slow down the therapeutic process, especially if it is not recognized and processed[36] (Prasko et al in review process).

Manifestations of Patient's Transference to the Therapist

Various signals manifest transference, eg, sudden change of expression, posture, looking away, quick transition to a new topic, admiring glances, avoiding important issues, stalling, pauses in the middle of the speech, clenched fists, knocking of feet, not wanting to say the automatic thoughts, etc.[2,22] When asked by the therapist what is going on in their head or what they are experiencing, the patient may say: "It does not matter!" Mapping these reactions provides insight into the patient's past and present relationships outside of therapy.

The development of strong transference is triggered by an unreadable therapist who behaves neutrally, says nothing about themselves and presents presenting without emotional involvement. The patient can freely transfer to the therapist the feelings they have learned with important people (Breuer and Freud 1895).[44,81] A self-disclosure, warm and empathetic atmosphere, leadership for cooperation and an emphasis on patient autonomy can limit the potential for transference.[2,37]

The therapist should pay attention to any negative or positive reactions but not intentionally provoke them. The patient's automatic thoughts and feelings about the therapist and their activity can provide a valuable opportunity to test automatic thoughts.[17,45] Idealized transference usually develops at the beginning of the therapy, while negative transference usually occurs later. A therapist's tendency to devaluate is one of the biggest challenges when managing resistance in patients who provoke aggressive or helpless reactions in therapists. When these situations occur, the therapist has a dual role, and they must tolerate the transference sufficiently to not react in a countertransference manner. In addition, from this vulnerable position, the therapist needs to help the patient understand the significance and consequences of the therapist's devaluation.[46]

The patient forms the therapeutic relationship through many attitudes and expectations, which are shaped by:

(a) relationship with the therapist as a representative of authority, a system depending on personal experience with authorities, experience with previous therapists,
(b) the patient's relationship to themselves (how much they trust themselves, their ability to manage, to have value, to control their experience and to respond to stress, and how much they label themselves);
(c) relationship to the therapist according to their actual behaviour (how the therapist behaves and how they act on him);
(d) concerns over therapy results and how therapy suits them;
(e) relation to the therapist in the context of societal attitudes, including myths about therapy and therapists;
(f) relationship with the therapist according to their reputation (what patient heard about a therapist before);
(g) the relationship to the whole system and the environment where the therapy occurs.

All of the above aspects may change dynamically during therapy[39] (Adshead 2003;[82] Hayes et al 2013).[83] The transference relationship can work in conjunction with therapy to help achieve its goals, limit, disrupt, or block the entire therapy process[36,42] (Høglend et al 2011).[7,84]

If a strong transference develops, it is an important task for the therapist to behave authentically and at the same time with an understanding of the patient's behaviour (Table 1). One of the most important tasks is to avoid complementary behaviour, such as not reacting to the patient's aggression by counter-aggression, not providing relief from the patient's excessive loyalty, etc. This complementary behaviour is usually dictated by countertransference.[2,47]

Supervision of the Patient's Transference to the Therapist

Automatic thoughts and feelings associated with therapist-patient interactions can provide valuable opportunities for testing and modifying dysfunctional automatic thoughts.[17,45] A rapid leaving of the emotions expressed to the therapist or therapy and insufficient attention to this opportunity to understand the patient further are among therapeutic leadership mistakes.[22] Tactics and timing are important when examining transference responses. Focusing on transference allows the patient and therapist to realize the difference between reality and fantasy in a therapy session[2,40] directly. However, in short therapy, the therapist's analyses of transference with the patient may be confusing.

In supervision, it is important to put the patient's transference responses in context with the conceptualization of the case. Supervision helps the therapist realize that the patient's transference response is taking place and understand how the type of transference relates to the patient's previous experiences. Transference work allows the identification and modification of core schemes and conditional beliefs (Beck 1995,[17] Nordgren et al 2013),[80] early maladaptive schemes[45] and modes.[48] An explicit discussion of the patient's relationship with the supervising therapist is compelling if it is accurate and the facts from the therapy are analysed.

The Use of Psychoeducation When Working with the Transference of the Patient to the Therapist

The supervisor's education about transference and countertransference can increase the therapist's awareness of what is happening to the patient during the therapeutic sessions. The supervisor asks the supervisee what types of transference or countertransference they know and then whether what is happening in the patient's session is described.

Supervisors can discuss typical questions that help the therapist understand the transference reactions (Box 1).

Use of Guided Discovery to Map Patient Transference to Therapists

Guided discovery is one of the most common approaches that a supervisor and a supervisee use to map the transference of a patient to a therapist. Based on the description of what is happening in the therapy, the supervisor determines whether the therapist is aware of the patient's transference. If not, the supervisor asks if there may be any connection between the patient's behaviour towards the therapist and their behaviour towards important people in life. Another supervisor's question is whether the therapist perceives from the patient's conceptualization why a particular patient treats the therapist in a certain way and how their core schemes and conditional beliefs influence behaviour in a therapeutic session.[2]

Box 1 Typical Questions That Help the Therapist to Map the Patient's Transference

- What's on your mind? What do you mean in this situation? What do you think of me in this situation? Do similar thoughts occur to a loved one? In whom and in which situations? Do you know these thoughts from any past situations?
- What emotions do you experience now in conversation with me? Is there anyone in your life with whom you have experienced similar emotions? Is there any person you currently experience similar emotions with? What would you need most in this situation? Have there been similar needs in the past? What did you do to fill them?
- When we talked about how you experienced your relationship with your loved ones as a child, did something similar happen to you when you met me?
- Is there something similar that you expect from me and what you expect from your loved ones, colleagues or superiors?
- Sometimes during our meetings, you do this … Is it something that is repeated in other situations or with other people?
- I wonder if there is something you would like to tell me when … (describe the behaviour)?

Table 1 Types of Patients Transference and Possible Responses of the Therapist

Type of Transference	Examples of Typical Thoughts	Emotional Reactions	Examples of Typical Behaviour	Possible Therapeutic Reactions
Admiring-dependent	The therapist is fantastic. She's the only person who really understands me, and I will never get out of this without her help.	Enthusiasm and admiration repeatedly change. There is a fear of abandonment.	Frequent complaints and expressions of independence. Giving gifts, praise therapist, flattery, They need a lot of praise, rewards and support. They often require advice, explanation, and care.	Asking about needs and plans, but not advising but encouraging free choice. Empower the patient to create their own homework. Empathic confrontation of dependent behaviour, mapping its origin, discussing the advantages and disadvantages of dependent attitudes, and discussing the free goals of behaviour in the imagination.
Admiring - Independent	The therapist is an excellent professional, just like me. He will certainly enjoy working with an intelligent patient. I am glad I found such a specialist, even though I know most things he tells me. In the end, it's all up to me.	Euphory, pride, arousal	He/she likes to compete and compare himself in sessions with a therapist. He/she enjoys expressing opposite attitudes and discusses philosophy, fashion, culture, and politics with the therapist. Invites therapist to a "good lunch". Frequently changes the theme of the session, competes, emphasizes his/her originality and independence	Empathic confrontation of competitive and demonstrative tendencies, empathy with the vulnerable feelings beneath them. Normalization of hypercompensation, mapping of their roots, and then a discussion of the positive and negative consequences of the behaviour. Mapping similarities with behavior outside therapy. Want homework assignments; discuss obstacles.
Moderate positive	The therapist is nice to me, and she wishes the best for me and understands me. She is a good professional.	Hope	Adherence to the therapy, be open, active, make home experiments and exercises	Empower the patient, continue therapy without changes in the approach
Aggressive	I have to show that I am strong; otherwise, he will do what he wants with me. I will not let me chop wood! Either I win or he. How dare he! I have to defend myself!	Fear, anger	He speaks with an angry voice, angrily faces, blames, reproaches, threatens	Validate anger. Let her ventilate within limits. Ask what triggered her. Provide empathic feedback on the anxiety or helplessness that is behind it. Let the patient know that the therapist understands his feelings. Let him express his anger with the help of negative questioning and assertive consent. Then discuss the unmet needs and attitudes behind it, including mapping the causes of these attitudes.

Erotic	It would be great if she wanted me. She must be a great partner. I feel like making love to her, and she is so charming and yet intelligent. She will save me.	Intense desire to be with a therapist, difficulty concentrating on working in a session for feelings of infatuation and desire.	He is flirting with a therapist, wearing expressive clothes, emphasizing interesting things about himself, long sighs, loving sights to the therapist, interest in her partnership, and preferences.	If the intensity is mild, there is no need to address it if it does not affect the course of therapy. In this case, it usually subsides. However, if this transmission blocks therapy, it is necessary to address this topic in a session, go through the associated cognitions, realize their influence on behaviour, and then discuss resources in unmet needs in the past. The therapist needs to express sensitively but firmly that he is willing to cooperate therapeutically but is not interested in a close personal relationship.
Shy	The therapist can criticize me, hurt me, and make fun of me. He rejects me and leaves me when he finds out who I am.	Shame, fear, helplessness	He/she cannot look the therapist in the eye. He/she has trouble entrusting a therapist with painful events. He/she carefully does his/her homework for fear of criticism. He/she often talks about not deserving attention; he/she is incompetent. He often apologizes, he explains.	Easily terminates therapy prematurely. It needs a therapist's accepting and unobtrusive attitude and empathy for fear and mistrust. Encouragement and step-by-step action are needed. A relationship is important to normalize and empathetically confront. Praise gently and truthfully every attempt at openness and courage.
Suspicious	The therapist is doing this to me on purpose. He wants to hurt and abuse me. He's against me, and I have to watch it. He has hidden motives; he does not play fair.	Fear, anxiety, anger	It retracts and closes. He does not talk about himself at all or only very superficially. It can be indirectly aggressive, not doing homework. He often falls out of therapy.	Provide empathic feedback, discuss the situation openly, help examine where sensitivity comes from, and go through relationships where it also occurs — map out reasonable attitudes, their pros and cons, and their impact on behaviour — experiment with confidence.

(*Continued*)

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Table 1 (Continued).

Type of Transference	Examples of Typical Thoughts	Emotional Reactions	Examples of Typical Behaviour	Possible Therapeutic Reactions
Competitive	I know that; I have heard it many times. I have tried what he's telling me, and it was useless. He's no better than me. I know many things better than she does, and he underestimates and teaches me. However, I know a lot better than she does.	Frustration, tension, anger, pride, envy	She competes with a therapist. He discusses fiercely the need to "be right." He does other things than are agreed. It is difficult to reach compromises.	Provide empathic feedback on manifestations of competitiveness and confrontation. Express understanding and normalize. Map their origin and occurrence in the past and present. Discuss the advantages and disadvantages in specific situations and the impact on cooperation with therapy.
Contemptuous	He cannot do it. He is weak and stupid. How could he help me who does not?	Pride, contempt, impatience, anger	The patient despises psychotherapy and a therapist who throws away what the therapist is doing. He refuses to do his homework, leave a session or stop attending therapy.	Provide empathic feedback on specific behaviours. Explore thoughts and attitudes. You find their origins, Find out how they work in different situations, the behavior they lead to, the pros and cons for life and relationships and what they mean for therapy.
Jealous	Why he/she prefers another patient it's unfair. He/she gave her/him ten minutes more than me! Why am I worse for him/her? He/she prefers.	Tension, anger, helplessness	Withdrawal or regret. Occasionally there are outbursts of rage. I am measuring session time (others and himself/herself) and monitoring the expression of the therapist's favour towards others and comparing oneself.	I am asking about thoughts related to helplessness and anxiety. Express understanding and use guided discovery to map the consequences. Elicite angry thoughts, emotions and behaviors. Help identify the origins, maintenance factors, and affection to behaviours, emotions, and relationships in various life situations.
Possessive	They are paid to help me. They must always be available to me because they must help me. I do not care that they have a family, and they should have chosen another profession.	Feelings of pride and smell alternate with anger and anxiety depending on the therapist's behaviour.	The patient is urgent, controlling, and often domineering. He calls very often, and they are skipping a session. However, he gets angry when the therapist is unavailable to him, and he often blames reproaches.	Explore emotions, thoughts and attitudes. Find out the primary emotions and cognitions before anger—express understanding for them while giving empathetic but firm feedback on behaviour. Find the origins of attitudes and injuries in the past (the need to control protects against the fear of abandonment). Map similar behaviour outside of therapy and identify its advantages and disadvantages.

Box 2 Case Vignette - Using Imagination in Supervision to Mentalize the Patient's Feelings

Supervisor: You described that the patient repeatedly does not do homework for the session. She apologizes for not having time, and you respond by repeatedly explaining that she cannot expect a change in her experience without homework. How does she react to that?

Therapist: She says she wants to do homework, but she does not have time. She is anxious, and she looks guilty. When she comes to the session, over and over again, she promises to start doing homework. And she did it only rarely.

Supervisor: You say she is anxious, looks guilty, and then eagerly promises to start doing homework. Do you think we can try to see what is she going through?

Therapist: I guess so. I have also experienced many times that I have not completed a task.

Supervisor: So, we can try … to be in her shoes in the imagery and imagine what's going on … What do you say?

Therapist: I will try. What should I do?

Supervisor: Close your eyes. Imagine that you come to therapy and do not have homework and experience anxiety and guilt. Then you promise to start doing homework. If possible, imagine it in the present tense and tell me what's happening inside you and what you are doing …

Therapist: (closes the eyes). I come to the session, and I am ashamed that I do not have homework. The therapist will be angry. I feel guilty, and I blame myself for not doing it. But I cannot do it … I have a lot to do, two small children, my husband and I are arguing, I have no energy to think about any tasks … he will be angry at me … I am not surprised at all … next time I have to manage it ….

Supervisor: Now the therapist tells you that without homework, you cannot expect something to change … what's going on with you …

Therapist: I feel miserable … helpless … bad … incompetent … I promise I will try … I want to try … not to get kicked out of therapy …

Supervisor: Does it remind you of a previous situation, from childhood, adolescence or adulthood? …

Therapist: Yeah, like when my mom shouted at me … I also felt bad, helpless, guilty … I also promised to be nice …

Supervisor: Let us try to go back … What was it like for you to get in her shoes?

Therapist: Well, now I see it all. Her mother criticized her terribly, and she was afraid of her and tried to be nice, but she could not do what her mother wanted her to do. Maybe she is experiencing the same thing as me. I should probably discuss this with her … and give her less difficult tasks that consider her situation at home … or prepare her a lot in a session and encourage her to do so …

Using Imagery to Map Patient Transference to Therapists

Imagery will allow the therapist to return to a specific situation in therapy during the supervision session (Box 2). One possibility is to imagine how the patient looked or behaved in a certain situation, and this can help the therapist reveal what could happen to the patient. Another possibility is to ask the therapist to imagine that they are a patient and what is happening in a particular situation. The connection of the imagery with the patient's story increases the therapist's understanding of why the transference occurs.

Use of Role-Playing to Map Patient Transference to a Therapist

Role-playing, where the therapist and the supervisor play a significant situation in the therapy, often reveals counter-transference reactions. In the beginning, the supervisor may ask the supervisee to describe a specific situation from the therapy session in which they did not feel well. Then they play this situation together – the therapist plays themself, and the supervisor plays the patient. The supervisor then requests a role change and plays what the therapist said or did while the therapist is in the patient's role (Box 3).

Therapist's Countertransference to Patient in Cbt Supervision

The supervisor-supervisee relationship (supervisory relationship) is based on similar laws as a therapeutic relationship,[19,49,50] (Henry et al 1993).[85] The supervisory relationship largely reflects the therapist-patient relationship. Still, more emphasis is placed on equality between the two and the independence and autonomy of the supervisee from the beginning of the supervision process[51] (Prasko et al in review process). Countertransference occurs when the therapist responds in a complementary manner to the patient's transference.[52] Countertransference cannot be avoided despite procedures in the treatment and frequent emphasis on therapeutic techniques. Transference and countertransference are important sources of information about the inner world of the patient and the therapist. The therapist needs to recognize, understand, label, and express emotions to understand countertransference.[22] Self-reflection is one of the basic competencies of a psychotherapist.[2,43] The therapist should not underestimate their reactions to the patient but rather formulate them honestly and deal with them.

Box 3 Case Vignette - Example of Using Role-Playing During Supervision

Supervisor: So, I understood your patient "shuts down" and answers that she is not able to explain when you ask her about her thoughts and emotions, especially in the situations when you recognize that she criticizes herself.
Therapist: Yeah, and I feel extremely helpless in these situations – as if there are no possibilities for intervening with this criticism.
Supervisor: What do you think about trying to play it out? If I pretend I am here, and you are in your own role?
Therapist: OK. So, Kate, when you go down the street and feel that other people look at you, can you describe more about what are your automatic thoughts at these moments?
Supervisor (in the role of the patient): I cannot explain, and I cannot tell it. I do not know (looks away).
Therapist: I see it is hard to talk about it. You do not have to tell it perfectly. Just try to describe.
Supervisor (at the role of the patient): Looks away, do not talk.
Therapist: Kate, let us try to talk about something else.
Supervisor: Thank you for this great showing how it looks like! I could feel how difficult it is for you to be with this, and it seems like this part of her almost totally controls both of you. Let us try to change the roles!
Therapist: OK. So, I am Kate now.
Supervisor (therapist's role): Kate, when you go down the street and feel that other people look at you, can you describe more about what are your automatic thoughts at these moments?
Therapist (in the role of the patient): I cannot explain, and I cannot tell it. I do not know (looks away).
Supervisor: Kate, I understand how hard it is to talk about it. Still, please, look at me!
Therapist: Looks at the supervisor
Supervisor: Great, thank you, it is so nice that you can see me and I can see you. I really feel how hard it is; it seems you feel like you are just forced to escape from me as if you are afraid. Can it be like that?
Therapist: Yes … it is like … I know you will not criticize me, but it feels like you will. You will think I am crazy, totally ill, and do not deserve to be in this world.
Supervisor: Sound so hard and painful. These words: do not deserve to be in this world – do they remind something from your past?
Therapist: My grandmother. She told me often that I was spoiled like my mom and did not deserve to be in this house.
Supervisor: I see … These were such horrible words … And it is something you expect from me somehow, and from other people … Like she continues to control you and me …
Sound great; that you for this roleplay! What does it look like for you now?
Therapist: Thank you, I got it! It was so important that you asked me as a Kate to look at you directly, without the possibility of avoiding the contact. You did not let grandmother control the space, and it will help me do it, also.

Manifestations of the Therapist's Countertransference to the Patient

Countertransference is characterized by the thoughts, feelings, emotions and attitudes that the patient evoked in the therapist. The classical concept defined countertransference as the therapist's uncontrolled response to the patient, arising from the therapist's response to the patient's transference or from one's unresolved conflicts. Countertransference has been seen as an obstacle to treatment that needs to be eliminated.[3] However, countertransference is present in every therapeutic relationship. In addition, the therapist's reactions to the patient can be a valuable source of information about what reactions the patient can elicit in the people around them. The therapist needs to distinguish their counter-transference from the patient's transference related to unresolved conflicts (Box 4). This can usually be distinguished by a therapist who has gone through a process of self-knowledge and minimized their own "blind spots".[36]

If the reactions to the patient are intensive, and the therapist does not understand them, it is often a transference to the patient. However, in the literature, countertransference and transference to the patient are not differentiated because they may look similar. Only the internal sources are different. Therapeutic responses to the patient may stem from many sources, including cultural values, the therapist's view of their professional role and unique learning history, and interactions with the patient's problematic behaviour.[3,52] During countertransference, the therapist may be subject to various automatic thoughts with typical cognitive errors: "This patient is hysterical." (Labelling); "He only wants secondary profits." (Mind-reading); "He'll never get better." (Negative forecasts); "It's not improving at all." (All or nothing thinking); "It's my fault that the patient is no better." (All or nothing); "He should do his homework." "I have to try harder." "It won't get better." (Excessive generalization). According to Hadley (1980),[86] the therapist's hostile "countertransference" to the patient can be expressed in various ways:

Box 4 Case Vignette - Patient Admires the Therapist Who Developed Countertransference

A patient who developed panic disorder admires the therapist. She tells him that he is the best therapist she has ever met. He understands her best. She slanders two therapists she used to visit and describes their unprofessional behaviour. In the therapy, he provides her advice. The therapist notices that the patient is an attractive woman. The therapist feels very good about the relationship with the patient, who adores him because she praises him. Panic attacks respond to standard CBT approaches, and the patient manages them with controlled breath and cognitive restructuring. Then she reports on a problematic situation in the marriage, where she feels that her husband does not understand her. When the therapist discusses the situation with her, after a short while, the therapist informs her that her husband does not deserve her, does not appreciate her dedication and is surprised that she still stays with him—the therapist in supervision reports on the patient as an exceptional woman who quickly overcame a panic disorder. The panic attacks occurred because the husband did not support her, and they promptly disappeared with the therapist's support. Thus therapist ask in supervision whether their patient should divorce. The supervisor asks the therapist about the feelings the woman evokes in him, what he likes about her and what he does not like, and what happens to him when he expects this patient to come to the session. These questions surprise the therapist. He hoped the supervisor to support his view that the patient should divorce and not ask how they experienced it. However, during further guided discovery, he realizes that he formed views on marriage problems and therefore on the patient's husband, without a thorough analysis of the problem, that the patient likes him and is erotically attracted to him, and that he tends to observe her figure, look at her in a special way even though he thinks that she is a patient and he can not cross boundaries.

1. Lack of respect for the patient's suffering
2. An obstacle to the establishment of a working alliance
3. Failure to allow the patient to experience a choice between options
4. Aggressive attacks on patient defences
5. Feelings of disappointment over the patient and their progress
6. Slandering the patient in front of other therapists.

Betan et al (2005)[53] studied a national random sample of 181 psychiatrists and clinical psychologists in the United States. Each completed a battery of tools on a randomly selected patient in their care, including Axis II symptom measurements and a Countertransference Questionnaire, designed to assess physicians' cognitive, affective, and behavioural responses when interacting with a particular patient. Factor analysis of the countertransference questionnaire yielded eight clinically and conceptually coherent factors that were independent of clinicians' theoretical orientation: (1) overwhelmed/disorganized; (2) helpless/inadequate; (3) positive; (4) special/excessive; (5) sexualized; (6) disconnected; (7) parental/protective; and (8) critical/abusive.

Eight factors were associated predictably with personality disorder patients. Countertransference patterns have been systematically associated with patients' personality difficulties across therapeutic approaches. Therapists may use diagnostic and therapeutic responses to the patient, regardless of therapeutic orientation.[53] Robert Leahy (2003)[39] described typical countertransference problems, which include: feelings of guilt or fear due to a patient's anger; lack of strength in collecting fees or enforcing rules; excessive session extension; Catastrophization of the patient's hospitalization options; inhibition in obtaining a sexual history; uncertainty when the patient is sexually attractive, inability to set boundaries for sexually provocative or hostile patients, etc.

Some patient problems, such as feelings of abandonment, addiction, tendency to devalue oneself or others, great difficulty, sexual interest, abuse, feelings of victimization or betrayal, or trends to exploit others, can arouse these problems in the therapist's feelings and vulnerabilities.[39]

The individual schemes of the therapist significantly affect the countertransference. In addition, some patients activate certain schemes more often than others.Leahy (2003)[39] describes common problematic therapists' schemes:

Unrealistic Standards

Therapists with anankastic or perfectionist traits repeatedly perceive patients as irresponsible, self-reliant, and lazy. A therapist with unrealistic standards believes that emphasizing "rationality" and insisting on discovering the consequences can help patients. Therapists-perfectionists may try to compensate for their underlying incompetence by requiring perfect performance from themselves and the patient. The therapist might feel that therapy is simply an

opportunity to show that they are more intelligent or perfect than the patient. A typical sequence of automatic thinking might be, "My patient isn't getting better." "I'm not doing my job well enough." "Turns out I can't do it." "I failed." "I must not fail."

Abandonment

A therapist with an abandonment scheme will fear that the patient will leave the therapy if confronted with something painful, emotionally strong or adverse. They then interpret the premature termination of therapy by the patient as a personal failure. Therapists' abandonment can manifest themselves in various ways that reflect countertransference: on the one hand, through excessive care about the patient or, on the other hand, by avoiding a meaningful therapeutic relationship so that they do not become too attached themselves and then experience disappointment. Excessive care takes the form of trying to protect the patient from any problem, taking over responsibility for the patient, and solving problems. Therapists who avoid attachment often focus on superficial techniques rather than more meaningful personal matters. This type of therapist avoids difficult topics, exposure to traumatic events, working with mourning, or using exposure techniques. They often say that the patient is not yet ready for more emotionally demanding situations in therapy. They usually accept late patient arrivals, missed meetings or a lack of interest in therapy and accept them as mistakes. They consider the patient's resistance to be their failure.

Speciality, Superiority

The narcissistic therapist sees therapy as an opportunity to show their special talents. Therapy can begin by raising great hopes, telling the patient that they have finally found the "right therapist." Emphasizing themselves as special, perfect therapists can lead to the patient falling by the wayside. The therapist's goal is to show that they are the best. This type of therapist feels entitled to the patient's admiration. They may encourage the patient to break the boundaries, or the therapist may break the boundaries themselves in some cases. When the patient does not improve quickly, the narcissistic therapist gradually becomes bored, angry, or punishing. They can label a patient as "borderline, histrionic, paranoid, hypochondriac … " Rather than empathizing with the patient's understandable frustration of lack of progress. The therapist may accuse them of lacking a desire to improve. The first step to changing the narcissistic perspective is asking: "What would my life look like if I were in this patient's skin?". The narcissistic therapist needs personal therapy.

The Need for Approval and Consent

Approval-seeking therapists express empathy all the time. They want the patient to feel good despite what happens and never be angry with the therapist. Many patients appreciate the commitment and empathy of such a therapist. This therapist does not ask about substance abuse, anger, resentment, sexual dysfunction or self-harm, finding these topics too stressful. They fear the patient's negative reaction. Patients may miss sessions, be late, and do no homework, but a therapist with a high need for approval does not want to cause a "conflict" and tries to excuse the patient's maladaptive behaviour. Eg, the therapist found it difficult to decide on hospitalization for a suicidal patient because they feared the patient would be angry with them. The patient's anger is difficult to tolerate. Therefore, the therapist's behaviour has to be adapted at any cost. They see the patient's disapproval as a sign of the therapist's failure. "If a patient gets angry at me, it means I've failed."

Avoidance of Personal Problems

In some cases, focusing on the patient's issues may allow the therapist to avoid their emotional issues or enable the therapist to pass on their conflicts to the patient.[39] Some people are attracted to the profession of therapists because it gives them a sense of competence, superiority and obvious effectiveness (Box 5). This illusion of competence can allow the therapist to unknowingly pursue goals other than the patient's, such as satisfying the need for power or control or separating, intellectualizing, and isolating oneself from one's problems.

Box 5 Case Vignette - Countertransference Induced by Therapist´s Own Negative Experience

The supervising therapist says she wants to help determine appropriate strategies for a patient who has post-traumatic stress disorder after rape three years ago. The patient does not want to remember the traumatic situation in therapy because it is unpleasant. She wants to draw a thick line behind the past. She also thinks that she has so many flashbacks from which she tries to distract attention, as it seems unnecessary to remember that. The therapist agrees. According to her, the patient is not yet sufficiently prepared to work with trauma. They go to therapy "only a year" and build safety together because the patient is very fragile. The patient has already been hospitalized twice at a psychiatric clinic this year because she attempted suicide. This is proof to the therapist that work on trauma should not begin yet. However, she needs help because she suffers from daily flashbacks and nightmares several times a week when she returns to a situation where several men raped her. During the discussion in supervision, it turns out that the therapist has never treated a trauma of rape with any patient in the past. If a patient mentioned rape, the therapist tended to divert attention from this topic and emphasize the patient's other problems. The case of rape was very unpleasant for the therapist because the therapist herself experienced a situation when a drunk man harassed her.

Supervision of the Therapist's Countertransference to the Patient

The first step in managing countertransference is to realize that the therapist feeling toward the patient is significant, either positively or negatively. During therapy, the therapist must try to help the patient and, at the same time, monitor their reactions to the patient.[2] Recognizing countertransference helps the therapist identify how they are likely to respond to the patient's behaviour.[39] The supervisor encourages a therapist to use cognitive behavioural strategies, awareness of their physical feelings and subtle mood swings as stimuli that point to automatic thoughts. They also need to focus on their feelings and thoughts or behaviours. Any changes in the therapist's typical behaviour can signal the emotional response and be related to automatic thoughts. These include commanding, excessive pressing, indecisiveness, altered tone of voice, excessive thinking about the patient outside the meeting, mood swings when realizing that the patient will come to the session, avoiding answering e-mail, or problems ending the session and treatment in general.

They must pay special attention to recognizing emotional reactions to the patient, both positive and negative (Box 6). It is an opportunity to ask themselves how much the patient is processing corresponds to their own previous experience or pre-existing opinions.

Box 6 Examples of Typical Countertransference Problems

- Problems with maintaining time or space limits of sessions, repeated exceeding of time, skipping sessions, meeting outside therapy, etc.
- Giving advice and recommendations to patients in situations where they should develop something independently.
- I am performing exercises, tasks and summaries instead of the patient.
- Anger at patients who call or request a time outside of scheduled sessions.
- It relieves the patient's problems.
- Lack of assurance, validation and standardization.
- Disrespect the patient's strong emotions, such as anxiety, fear, shame, helplessness, disgust
- Failure to respect the patient's defences.
- He is pushing the patient to reveal too painfully before he is ready.
- Repeated postponement of effective procedures due to fears of losing the patient's favour or excessive fear of the therapist enduring the patient's frustration.
- Performing in front of the patient, giving yourself role models that serve the therapist more than the patient.
- Avoid homework assignments for fear that the patient will reject them and the therapist will "lose authority".
- Excessively investigating patients as if they were too fragile, eg avoiding discussion of sensitive issues, discussing the patient's dysfunctional behaviour.
- Displaced or hypercompensated feelings of guilt, anger or fear are associated with the patient.

Feelings of failure or inferiority when working with the patient.

- Feelings of tension, desire or threat in a sexually attractive patient.
- Problems with setting boundaries in sexually provocative or hostile patient behaviour.
- Problems with confrontation and setting boundaries in aggressive, abusive or useless dysfunctional patient behaviour.
- Feelings of danger, stiffness or embarrassment when the patient talks about intimate problems.
- Gossiping patients in front of other health professionals.
- Indifference or restraint to the emotional needs of patients.
- Lack of proper self-disclosure

The Use of Education When Working with the Therapist's Countertransference to the Patient

Education about countertransference is one of the topics in psychotherapeutic training. However, it may be important to supervise novices to educate them about countertransference or refer them to the literature about it (Table 2). The problem for beginners in therapy is that they frequently think that every countertransference is negative and is therefore ashamed to talk about it or immediately displace signals about its presence.[54,55] The supervisor should inform that countertransference is a natural part of the therapy (Table 2). Recognizing it, mapping it and correcting it for the patient's benefit is one of the basic competencies of an experienced psychotherapist.[53] The supervisor could tell the therapist about the basic types of countertransference and ask them if it happened to them with a patient and their cognition, emotional reactions, and behaviour (Prasko et al 2020).[87] The supervisor then focuses on the specific supervised patient, and the therapist is asked to consider whether any countertransference with the patient is being experienced.[2]

The therapist's transference reactions can inform us what is happening in the patient's therapy process. At the critical points in developing transference and countertransference and their interactions, therapeutic recognition and dealing with countertransference problems become crucial to treatment.[4]

Use of Guided Discovery to Map a Therapist's Countertransference to a Patient

Psychotherapy and supervision intend to understand both sides and include this understanding in joint action. Self-reflection is advised in therapy and supervision.[2] An important goal of supervision is to increase the therapist's self-reflection to use it automatically during therapy. Self-reflection is enhanced by updating (in the imagination, role-playing) a specific situation with the patient.[56,57] To increase the ability to see problematic conditions directly in the session, the supervisee is sometimes given the homework to record the situation with the patient where they feel dissatisfied with the patient, themselves or both of them. A therapist who is unaware of or suppresses any of their feelings cannot understand what is happening between them and the patient.

Through guided discovery, imagination, or role-playing, the supervisor can help the supervisee recognize what is happening in the therapist-patient relationship, both from the therapist's and the patient's point of view. The most common approach to discovering the context is guided inductive questioning, during which the supervisee can realize what may not have been considered previously.[57] The patient's understanding may deepen and change significantly.

Cognitive Restructuring to Help with the Therapist's Countertransference to a Patient

Supervision allows the therapist to delve deeper into the patient's thoughts, emotions and reactions and seek and process countertransference reactions that potentially block therapy. Eg, the therapist may feel frustrated, angry, anxious or threatened by the patient's demands, or maybe convinced that the patient is lazy or stupid, is not doing homework on purpose, is undergoing therapy due to secondary gains, or that therapy is impossible (Box 7). Alternatively, the therapist talks about the patient in superlatives, admires them, feels sorry about them excessively, and identifies with their maladaptive attitudes. When questioning therapists' automatic thoughts, the supervisor helps them and identifies with their patient-centred strings and then tests those thoughts.[2]

To examine countertransference, the therapist needs to be aware of their core patterns towards themselves, other types of beliefs, and problems with important people in their life that they have had or have currently and who are involved in creating or maintaining these patterns. Personal therapy is suitable for processing difficult problems, and it is important to understand what schemes are triggered when working with the patient or what important people in their own life can be evoked in supervision. The supervisor can use guided discoveries, role-playing or imagination to make the therapist aware.

Inductive questions focused on countertransference are listed in the following table (Box 8).

The way therapists respond to a patient's situation may require cognitive restructuring, which can help reduce negative emotions with the patient or change their behaviour toward the patient to maintain an appropriate focus on therapeutic goals and objectives.[22] The supervisor helps the therapist face concerns that their emotions signify therapy failure. Instead, the supervisor teaches them to focus on what precedes the emotional state in the patient's behaviour and how it relates to the therapeutic setting.

Box 7 Case Vignette - Countertransference with the Complaining Patient

Therapist: This patient does not want to improve. She's been in therapy for a long time, and she still wants to complain and complain that I feel sorry for her. She avoids working on herself, and I look incompetent. And she's totally hysterical and overwhelming. I really cannot work with her. If only she were not so irrational.

Supervisor: I understand. It's hard for you to work with her. You say that she just complains and avoids working on herself. You say you look incompetent …. I noticed you said that in an angry tone as if the patient evoked strong emotions in you. Are you saying they have been going for a long time … according to everything you say, therapy does not work very well … ? I wonder if something went wrong … ?

Therapist: Yeah, something went wrong … she's not nearly as depressed as she was at the beginning … If only she did not overwhelm me with complaining about everyone, especially her children and husband … as if she wanted me to agree with everything … but she complains in front of them anyway … I understand that they avoid her …

Supervisor: As I understand it, depression has been alleviated. It's a success, and it must have been hard for you and her …. I know that she complains a lot, and it annoys you … you feel incomplete … and the fact that at that moment, you feel incompetent … is it a situation with someone else … in your life?

Therapist: Mhm … you are right, she's acting like my mother … she's still complaining and crying, and does not let me say what I want … like she cannot hear me … I'd rather avoid her if I could … I'd like to help her, just feeling helpless and incapable in front of her intensity ….

Supervisor: That's a nice insight … is the situation different for you than the situation with your mother … ?

Therapist: Definitely … I have a close relationship with my mother, and I like her, and it gets on my nerves, but I can tell her clearly what bothers me …, sometimes I get mad at her … I cannot tell my patient … she's more fragile than my mother and I'd hurt her. Plus, it would be unprofessional.

Supervisor: Is there anything you can think of that you could do differently with that patient now that you realize that you are reacting to her similarly to your mother?

Therapist: Hmm … I do not know … but I could give her feedback that she's complaining a lot … but before that, I have to praise her that she's improved a lot and has managed to overcome depression and that it is admirable how she dealt with it. I could also ask her how I react to her complaining about her children and whether any other behaviour could bring better consequences.

Box 8 Supervisor's Questions for Countertransference

- How do you feel in the presence of this patient? What emotions will awaken in you? What automatic thoughts appear? What feelings appear in your body? Is there anything else that is unusual or interferes with your experience?
- Is your experience with this patient different from what you normally experience with other patients?
- Is your behaviour toward this patient different from your typical behaviour outside of the session or during a session with other patients?
- Have you had any similar feelings, bodily reactions or thoughts in the past? Who was it with? When was it? Has a similar experience ever occurred with your loved ones?
- In what situations in and out of therapy do you have these thoughts, bodily feelings and behavioural reactions?
- What is the latest situation with the patient? What exactly do you remember? What does this mean for you? What else can you think of? Have you ever experienced a similar situation?
- What do you want to tell this patient, what has not been said yet, and what would be difficult to tell him? Which topic are you avoiding with this patient?
- What do you like and dislike about this patient? What do you find sympathetic and sympathetic?
- Are you uncertain about asking about some parts of their medical history or problems? Which areas are affected? How do you understand your hesitation regarding how you know the patient and how you know yourself?
- If you do not feel well with this patient, in what situations does this occur? What's wrong with you? What do you need the most? Does it remind you of a situation in your life?
- Is there something you perceive to be important to other patients that you do not place so much emphasis on that patient?
- Do you often think of this patient outside the session? What are you thinking about? How do you think you are thinking about this patient?

Cognitive restructuring, one of the common strategies when working with patients, is also used in supervision. However, guiding a therapist through cognitive restructuring can sometimes be difficult because it can make the supervisee feel like the supervisor is treating them as a patient. However, in situations where the therapist is blinded by a one-sided view of the problem or overestimates the difficulties experienced in the case with the patient, or obvious cognitive errors are apparent, cognitive restructuring is appropriate. However, the supervisor must directly jump to what they, as a therapist, would do. As the most common form of cognitive restructuring in supervision, Socratic dialogue is

Table 2 Examples of the Countertransference and Possible Strategies for a Change

Type of Countertransference	Examples of Typical Thoughts	Emotional Reactions	Examples of Typical Behaviour	Possible Therapeutic Reactions
Moderate positive	I like him/her. He/she is a nice person. She works well with him/her. He/she handles the homework well.	Interest, relaxation	Cooperation, interest, appreciation, support, empathy	Continue to maintain a therapeutic relationship and therapy in a similar manner
Overprotective	He/she cannot make his/her own decisions. I have to help and advise him/her. It will be my fault if something happens to him/her.	Anxiety, fear, and lack of security.	Protection, reassurance and building patient control. Providing advice, providing helpers. It does not allow the patient to make independent decisions and doubts his/her abilities.	Clarify one's own attitudes, context, background, influence on patient behaviour, advantages and disadvantages. Supervision can help and stop treatment directives and over-provision. Let the patient plan things independently. Otherwise, the patient should change therapists.
Admiring	That person is very intelligent, exceptional, talented, interesting, beautiful, original, etc.)	Looking up, pride, fascination, admiration,	The therapist does not make sufficient evaluations and does not perform systematic psychotherapy, and any non-compliance is downplayed. The therapist does not require homework from the patient, and he/she talks about the excellent qualities of the patient.	Clarify your behavior and attitudes, their impact on behavior and advantages and disadvantages. Supervision and personal therapy are recommended. Start behaving like other patients. If behaviour fails to change, opening a problem with the patient or changing therapists may help.
Apprehensive (anxious)	He can hurt me, make fun of me, humiliate me, or show me that I am worthless, stupid, etc.	Shame, anxiety, fear.	Silent speech, passivity, fear of saying something, leaving the management of the session to the patient, and uncertain behaviour.	Work on the therapist's own self-confidence—suitable personal psychotherapy. Supervision required. If this does not work, the patient should change therapists.
Aggressive (invasive)	He/she is a psychopath, hysterical, and ignorant. He/she just wants benefits, and he/she has secondary profits. He/she does not deserve my care.	Anger, irritability	Moralizing, reprimanding, reproaching, and minimizing patient needs. There is no time for the patient.	Recognize our own aggressive attitudes and behaviors. Stop denying or rationalizing them. Clarify their background, influence on behaviour and advantages and disadvantages of therapy. Otherwise, the patient should change therapists. Supervision and personal therapy are always needed.
Competitive	I will not let him/her think he is better than me. What if he/she handles it better than I do? I have done more in my life than he/she has!	Tension and regret alternate with pride	He competes with the patient in his/her views. He/she convinces or argues about his/her truth—lack of support and empathy.	Work on self-esteem and self-confidence. Supervision and personal therapy are needed to process one's own attitudes, origins and consequences. If necessary, transfer the patient to another therapist.

Distrustful	What does he/she have against me? What does he/she want from me? Does he/she have any hidden intentions?	Nervousness, tension, anger	Withdrawal. Only "formal cooperation with the patient. Lurking for hidden motives. Attempts to cancel therapy.	Work on self-confidence, self-confidence and self-acceptance. Supervision and personal therapy are needed to understand and develop attitudes, origins and effects. If necessary, have the patient change therapist.
Erotic	He/she is attractive, and it would be fine with him/her. They imagine how I am with him/her.	Desire, enchantment, "trance", or depersonalization during a session	Excessive protective behaviour, flirting, fleeting touch. Frequent talking about sex, in the worst-case sex with the patient.	Stop streamlining lascivious behaviour. Stop him completely. Allow countertransference. Find supervision and personal therapy. Understand your own motives, context, background, influence on behaviour, and advantages and disadvantages of therapies. Otherwise, the patient should change therapists. Even after the change, the therapist should not have sex with the patient.
Arrogant, contemptuous	He is weak, stupid, hysterical, crazy, etc.). I am bored. I wish they did not bother me.	Contempt, anger, boredom, vanity	Providing simple advice. Trivialization of the patient's problems and attitudes. Humiliation, ridicule. Lack of time for the patient, improper listening, interrupting the patient before he speaks	The need to work on relationships in one's own personal therapy., Attend psychotherapeutic training, possibly new, if the experience from the previous ones is not enough to process one's own attitudes, origin, and consequences. If necessary, transfer the patient to another therapist.

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based on the assumption that individuals will change their beliefs more quickly and competently when they find mistakes in their thinking through guided discovery.[58] It is much more effective than criticism. Cognitive restructuring can be especially helpful when the therapist feels hopeless or unaware of the transference. When using cognitive restructuring in supervision, it is advisable to normalize the process.[43] An uncertain supervisor can try humorously: "Let us try something you do regularly with patients and take a look at the pros and cons. Can we try?" Cognitive restructuring can help, especially when the therapist feels in a hopeless situation or when they are not aware of the transference (Table 3).

Supervision also helps the therapist deal with negative feelings about the patient or themself in a therapeutic situation, understand the broader context of therapy, overcome therapeutic blocks, and encourage more self-care.

Using Imagination to Map a Therapist's Countertransference to a Patient

Imagination is a means of supervision that allows the return to a specific situation in therapy during a supervision session and the imagining of another solution. It is possible to imagine how the patient looked or behaved in a certain situation and remind the therapist about their emotions. It is possible to imagine the patient's reaction, including remembering the emotional state and physical symptoms in therapy.[2] With the help of imagery rescripting, it is possible to return to a previous situation with similar emotions in the past, rescript this situation with a better end and return with emotions from the rescribed situation to the situation with the patient and solve it another way (Box 9).

Use of Role-Playing to Map a Therapist's Countertransference to a Patient

Role-playing can be a good method to map a therapist's countertransference to a patient, as it presents in the therapy session. The supervisor usually asks the therapist to describe a particular therapy situation where the therapist feels powerful positive or

Box 9 Case Vignette - Stay a While with the Feelings to Understand Countertransference

Therapist: I think I do too much for this client. I even wrote the text he could say to his boss between the sessions as he asked me in the e-mail what to say – it was really too much. I feel ashamed, and I did not have to do it …

Supervisor: So, maybe we can put aside self-blame now and just try to explore what happened with you. Would you agree to try to do some imaginary exercise?

Therapist: OK

Supervisor: So, close your eyes … Imagine you are now at your computer and reading your e-mails … You recognize a letter from him. What do you feel and think?

Therapist: I feel surprised, maybe a bit disappointed. Maybe angry. He sometimes writes to me too often.

Supervisor: Great, you recognize your anger and disappointment. So, you open the mail and see his letter about the situation with the boss and his question about what to do. What do you feel now?

Therapist: Honestly, some anger again …

Supervisor: If we could stay with your anger … What are your needs that they express?

Therapist: I need my own space. It is my time, and I can let my job be my job, not my private life …

Supervisor: Sound very reasonable. Let us remind about it later. Can we continue? You read it once more and start thinking about answering him. What happens with you now?

Therapist: I feel needed and an important person to him.

Supervisor: OK, well, I can imagine … Can we stay a while with this feeling? Where do you feel it in your body?

Therapist: In my stomach. Some anxious feeling, like butterflies there … Now it turns into sadness.

Supervisor: Stay with this sadness … Swipe out this scene; just stay with the sadness and this sense in the stomach … If you try to go back into your memory, as far as you can remember, even from your childhood, which memories arise?

Therapist: I remember longing for my father. He left mom when I was 5. And he promised to come, and I remember he did not … I remember feeling not needed, as if I was bad, and he did not come to me as if I was bad. It was so sad.

Supervisor: Sound really sad for you as a little girl … Imagine now yourself as an adult entering there. What would you say to this little girl?

Therapist: You are nice and good and just wonderful. Your father had his own problems with women and alcohol, and it was not your fault. Let us go and enjoy your life. There are many nice people around and such great things to do!

Supervisor: Sounds great! How does a little girl feel now?

Therapist: Calm and happy. Letting her enjoy her life. I can allow myself to do this, also. I will respect my need for boundaries with this patient. It was extremely important to recognize it. Thank you!

Supervisor: Thank you for being so open! I believe you deserve to enjoy your life. He can wait until the next session.

Table 3 An Example of Cognitive Restructuring of a Situation Where the Therapist is Angry with the Patient

Situation	Thoughts	Emotions	Arguments for	Arguments Against	Constructive Reaction
The patient criticizes the therapist for not understanding him very well because she has never experienced such problems. She is also a woman, so she cannot understand men.	He is selfish and still wants me to praise him. He wants me to understand him, but he does not understand the hurting wife, and he controls and humiliates her. And he still wants me to understand him, and he provokes me.	Anger 70%	He describes himself criticizing his wife for trifles. He is upset that his wife does not understand him. He expressed no understanding for his wife.	He says he loves his wife. He does a lot for her and often makes sacrifices for her. I could not appreciate that enough. He has repeatedly said that he understands his wife, and now he is also trying to understand her feelings. He just cannot do it in anger. My husband also controls me, and he is contemptuous, and I cannot stand it. He has a right to understand him. He does not provoke me, he is clueless about changing the situation, and he is angry that he is not doing well.	***Impact of discussion***: My anger passed and almost disappeared. I realized that I was fighting for his wife, and I was on her side because it reminded me of my marital situation. ***Action***: I commend him for improving his relationship with his wife and realizing his needs. I will understand how he feels misunderstood by a woman. I will try to discuss what he could do in marriage so that his wife could better understand his needs.
My schema that has been activated: I am not loving. Others want to meet their needs and do not care about mine. It has to do with a dad who did not have time for me, turned me down when I wanted to be with him, and often criticized my mother. ***Discussion with the scheme***: I am lovable. Many people love me and respect me. My husband loves me, but I do not talk about my needs. The patient also respects me, and he is just impatient. I have many friends who love me. My reaction to the patient was subconscious. Now that I realize how it relates to me, I can focus more on his needs.					

negative emotions. Supervisor then asks the therapist to play with the patient, and the supervisor plays the described behaviour of the therapist. The supervisor asks how the therapist, in the role of the patient, felt what they experienced and what they realized. This is followed by a change of roles, where the therapist plays themself, and the supervisor plays the role of the patient. This allows the therapist to experience the therapeutic situation from both sides and return the therapist to the part of the role play where they perceived that the therapist was experiencing the strongest emotions. The supervisor asks the therapist if they remember a situation where similar emotions were experienced, with whom it happened, and what they felt towards the person. The supervisor asks how the therapist would like to deal with this past situation to feel good or help them feel good (this is also possible in the imagery – imagery rescripting). Then they play a new reformulated situation again. The supervisor asks about the feelings after playing the rescripted situation. With these emotions, the therapist then returns to the situation with the patient and tries to replay it in a new way.

Use of Problem-Solving to Process the Therapist's Countertransference to the Patient

What to do with the patient's transference to the therapist or the therapist's countertransference to the patient is a regular part of the supervision of the therapeutic relationship. First, it is necessary to define the problem they got into with the

patient in a therapeutic relationship and then establish the therapist's goal. The goal should be, if possible, specifically descriptive, realistic and manageable in the foreseeable future. The supervisee could use the following brainstormed strategies to ensure that transference or countertransference does not block therapeutic work. Evaluating individual strategies according to whether they are appropriate is work that the supervisor should do. They then discuss the final plan created together. In subsequent sessions, they evaluate how the plan was feasible and worked.

Use of Homework to Process the Therapist's Countertransference to the Patient

Homework may include reading what types of transference and countertransference exist and writing examples of patients with whom the supervisee identifies the transference and countertransference. These may be cases they became aware of in the past and became mindful of transference and countertransference during supervision.

Keeping a record of automatic thoughts that occurred to the supervisee during therapy and finding a more adaptive response may also be a homework assignment. Paying attention to these countertransference reactions at home provides the therapist with the opportunity to recognize and manage them. This reduces the risk of complementary behaviour.[45]

Therapist's Transference to Supervisor

The supervision relationship is based on analogous principles to the therapeutic relationship, emphasizing independence, responsibility, and self-sufficiency.[59] The source of every development is the spirit of safety, acceptance and appreciation.[60,61] As in the therapeutic relationship, transference and countertransference also arise in the supervisory relationship. During the therapeutic maturation of the supervisee, the intensity of supervision increases.[54] The onset of supervision is usually associated with a certain dependence on the supervisor, but the supervisor can reduce this by self-opening and thus create a cooperating alliance of two partners.[48,62]

Manifestations of the Therapist's Transference to the Supervisor

Manifestations of the therapist's transference to the supervisor are similar to those described for the patient's transference to the therapist. The transference relationship between the supervisor and the supervisee in CBT supervision is not encouraged.[43] Nevertheless, we can expect a similar development in the supervision process as in all other relationships. Defence mechanisms, resistance, transference, and countertransference emerge and tend to evolve, and they must be reflected in the supervisory relationship as the therapist learns to deal with them.[36,63]

Supervision of the Therapist's Transference to the Supervisor

Many methods help develop an awareness of the therapist's transference to the supervisor. The therapist's transference relationship with the supervisor can be tested in the here and now experience in a supervisory relationship. The supervisor must first ask themselves if they see the therapist's transference as a natural and productive phenomenon (eg, a submissive relationship with the novice supervisor) or if there are potential negative effects of the transference (becomes dependent on the supervisor, relies on the supervisor asking the responsibility for the patient to the supervisor).[48] The supervisor also needs to consider whether the therapist's transference interferes with the cooperation in supervision, whether it blocks it or harms how the therapist performs the therapy.[41] Adaptive correction of the transference relationship, when the therapist tests dysfunctional expectations from the supervisor in the reality of the supervisory relationship, usually changes the view of oneself, increases self-acceptance and changes the relationship with other people, especially authorities and loved ones (increased trust and cooperation) (Sareen and Skakum 2005).[88] Interpersonal maladaptive thoughts, such as "others reject incompetent people" and core beliefs about the self, for example, "I am incompetent", can be corrected when working with the transference of a supervisee,[39] Rabinovich and Kacen 2009)[89]

Use of Education to Map the Therapist's Transference to the Supervisor

First of all, the therapist must realize that transference is a natural phenomenon in supervision and does not need to be feared; on the contrary, it can help understand the therapy itself and supervision and provide a deeper understanding of one's personality.[4] The supervisor advises the therapist on the literature about transference and countertransference. Then

they ask the therapist about experiencing some moments in supervision that reminds them of other life situations - for example, when the supervisee reacted in the last supervisory session with a sudden mood change.

Use of Guided Discovery to Map the Transference of a Therapist to a Supervisor

Guided discovery is one of the most common approaches by supervisors and supervisees to map transference and countertransference both in therapy and in supervision sessions.[56,59] Guided discovery helps shape and modulate the supervisory relationship by creating an atmosphere of security, acceptance, understanding and appreciation.[57,64,65]

Supervisor Countertransference to the Therapist

Unconscious countertransference reactions in supervision can lead to serious doubts about the supervisor, limit supervisees' self-confidence and discourage them from working with patients, or, conversely, exacerbate their intractable problems in dealing with patients.[4,50] Analogously, as a therapist may have significant power over the patient, the supervisor may have uncontrolled power over the supervisee (Box 10). Therefore, the supervisor must recognize and process their countertransference responses during supervision.[9]

Manifestations of Countertransference of the Supervisor to the Therapist

The supervisor may notice the countertransference reaction primarily in their behaviour towards the supervisee and in emotions, thoughts, and physical symptoms. Often the bodily responses experienced by the supervisor point to emotional motives that they may not be fully aware of at the moment or distract from them because they are uncomfortable for some reason.[50,66] Muscle tension, stomach contraction, shortness of breath, headache, and change in tone of voice may indicate changes in emotions and thoughts concerning the supervisee. Other manifestations, such as feelings of unsafety, urgency, too many instructions, reluctance to supervise, prolonging sessions or, conversely, shortening, may also be typical manifestations of countertransference reactions.[50,67] Countertransference is either a reaction to the behaviour of the supervised therapist or can be influenced by the supervisor's core beliefs and conditional rules. In this context. Leahy (2003)[39] described the following schemes:

Unreasonable Standards

Some supervisors need everything to be perfect and look into the therapist for mistakes, not to see what they are doing. Supervisors with anankastic features see supervisees as ill-prepared, unreliable, untrained, irresponsible, or lazy. They also think that showing their anxiety, admitting mistakes, and expressing their own emotions can be threatening or devastating.[4] They emphasize "logical", "constructive", or "rational" thinking, detailed analysis, and protocol tracking

Box 10 Examples of Countertransference Reactions in Supervision

Cognitive:

Countertransference of the supervisor to the therapist:

- Therapist stigmatization (has a personality disorder, is rigid, narcissistic, stupid, immature, obsessive, too slacker, retuned, etc.)
- Marking the therapist's behaviour (he is noisy, lacks empathy, manipulates, shows off, exaggerates, does not understand …)

Supervisor self-reflection:

- Evaluation of one's own performance and skills in performing supervision, self-assessment of coping well or non-coping well.
- Evaluation of acceptance or recognition from the supervisee (acknowledges me, admires me, he does not care, does not appreciate my efforts, …)

Emotional experiences (joy, satisfaction, pride, alienation, superiority, helplessness, insecurity, regret, sadness, anger, fear, shame)

Physical reactions (fatigue, muscle tension, palpitations, stomach constriction, headache, nausea, stool, etc.)

Behaviour:

- ***Criticism*** (excessive criticism or self-criticism, fault finding, moralizing, conducting, humiliation, contemptuous behaviour, showing superiority, offensive confrontation)
- ***Hypercompensation*** (giving recommendations and advice, diligence in offering solutions, excessive protection, extreme care, control, asthenitization of the supervisee, etc.)
- ***Avoidance and safety*** (avoiding confrontation, detection, postponing controversial topics, postponing supervision sessions, creating a safe distance, cold distance, sending to another supervisor, passivity, undercutting, self-destruction, etc.)

accuracy. They tend to have difficulty showing understanding, kindness, warmth and empathy for the supervisee. They often refer to theory, evidence-based approaches, and studies, speak little about themselves and have problems expressing personal perspective or self-reflection. In supervision, they try to find mistakes by the supervisee, have catastrophic comments, and use moralistic remarks. The perfectionist supervisor often unknowingly tries to compensate for their unsafety by controlling and demanding perfect presentation from themselves or the supervisee.

In some cases, the sequence of automatic thoughts may look like this: "How can she make such mistakes!", "What the hell do they teach her in that training?" "She's not preparing for supervision at all!"

Abandonment

A supervisor who does not sufficiently work with their abandonment scheme in their personal therapy may still be concerned that they may discourage the supervisee. They are afraid that the supervisee will criticize them, saying that the supervision does not help them. They are so scared to indicate that it is necessary to look for a different strategy when working with the patient because they fear that the supervisee will not like them and leave them. Premature termination of supervision is considered a personal refusal of the supervisor. Under the influence of their abandonment scheme, the supervisor can behave in various ways that reflect this scheme: for example, they can over-care for the supervisee, explain too much, and apologize, but on the other hand, they can avoid making a meaningful contract. Extreme care can protect the supervisee from any difficulties, giving advice, putting off negative feedback, or a preferential solution to the supervisee's problems that they have in common with the supervisor. Such a supervisor avoids more difficult topics and anxiety-provoking interventions. They often react painfully to the supervisee's different views, omitting supervision sessions or lacking interest in supervision. The supervisee's disagreement is often perceived as a personal rejection.

The Need for Exceptionality

A supervisor with narcissistic personality traits sees supervision as a chance to show exceptional talent. They are convinced that they understand everything and have to teach the supervisee, and they often do not realize they are showing off. Supervision of a complex case may begin with grandiose remarks that it is clear how to treat such a patient because the supervisor had many similar patients and cured them all beautifully, even though most therapists had failed before. They can also tell the supervisee that they have finally found a "true supervisor" who will help them solve everything. The supervisor is very happy to advise and knows the solution to all problems. In such cases, the supervisee feels pressured to cooperate with and admire the supervisor, encouraging them to make surprising interventions. Changing the narcissistic perspective is difficult because it tends always to see mistakes in others.

Excessive Need for Acceptance

A "likeable" supervisor is usually friendly and empathetic. The supervisor is constantly trying to please, and they believe that the supervisee should feel good no matter what happens. Supervisees generally appreciate the warmth and empathy of such a supervisor because they never express negative emotions and do not confront shortcomings. This type of supervisor usually avoids questions about the supervisee's negative emotions, and as these topics upset the supervisor, they become unacceptable The supervisee may be late, not doing homework, or skipping scheduled sessions, but the supervisor with an excessive need for acceptance does not want to "provoke a conflict" and tolerates it all. If the therapist fails in the therapy, the supervisor tends to accuse them of their inability to lead the therapist well enough in supervision. Their attitude tells them that "if a therapist fails, it is my failure."

As the supervisor recognizes their emotional responses to the supervisee, they may consider how the therapist can partially respond to patients. They can talk about a parallel process, where the patient evokes similar reactions in the therapist, and the therapist may induce this in the supervisor.

Supervisor's Transference to the Patient

The therapist's narrative may trigger a supervisor transference to the patient. The supervisor can then create artificial explanations of the patient's behaviour based on inadequate information, label the patient, be angry with them, or create inadequate interpretations about the patient's behaviour, eg, say that the patient is manipulated or that they are a typical patient with social welfare tendencies.

Box 11 Questions for Self-Reflection About Countertransference

- What do I like or dislike about this therapist? What do I see as its strengths and weaknesses?
- What are my emotional reactions to the supervisee?
- What am I worried about in supervision? What can upset me during supervision with this therapist?
- What are my body feelings during supervision?
- What am I saying about this therapist?
- Reminds me of someone?
- Am I putting too much pressure on this therapist? Am I not too strict with them?
- Does what I expect to correspond to his level of development in training?
- Am I able to give him negative feedback and alert him to mistakes directly, or do I often apologize in advance?
- Am I not being too important to this therapist? Am I not showing how I understand everything and how good I am?
- What do I want or do I not want to talk to the supervisee about?
- Are there any signs of a supervisee's difficulties that I have ignored? What does that say about me?
- Do I negate the therapist's problem with the patient? Do I give general advice and recommendations instead of leading him to discover a procedure for a particular patient?
- How am I confident when they supervise this therapist? Am I afraid of how he will see me and what he will tell me?
- Am I happening to be competing with this therapist for who is right?
- Are not I bored too much with this supervisee? How do I understand that?
- Do not I feel too energized, unfocused, frustrated or blocked during supervision?
- Do I have memory dropouts related to the details of the supervisee's case?
- Does not this supervisor talk negatively about his client?
- Does not it occur to me that I can work more than a supervisee during supervision?
- Am I not supporting a client against a supervisee?

Possibilities of Working with the Supervisor's Countertransference to the Therapist

Awareness of One's Own Countertransference to the Therapist

The first stage of countertransference is when the supervisor realizes that their feelings toward the supervisee are positive or negative.[56,67,68] It is advisable to take some time outside the supervision setting to answer a few questions patiently (Box 11).

Recognizing countertransference in supervision requires the supervisor to be constantly aware of their thoughts and attitudes, which influence how they respond to the supervisee's behaviour.[67,68] It is advisable to write down a self-reflective awareness. Rather than suppressing one's own emotions, the CBT supervisor is led to pay attention to them and consider how they appear in the supervision and what thoughts and attitudes they are tied to.

Another phase may be looking for discussion with another supervisor to help investigate in-depth and potentially resolve the cause of strong countertransference. To evaluate countertransference, the supervisor may inspect the life difficulties they experience. Have they experienced abandonment or rejection during life? Then the supervisor might examine to what extent similar feelings appear in interaction with the therapist. Does it occur that they permanently have to be "right"? Then it is necessary to realize whether he repeatedly "defeats" the supervisee in their debates since this would decrease their self-confidence. Are they too anxious about failing or being criticized in their life because they think that failures or successes are related to their value as a person?

Cognitive Restructuring of the Supervisor

The supervisor's work with thoughts related to supervision may result in cognitive restructuring to reduce negative or excessively positive feelings. It is valuable to challenge any fear of making a supervision mistake and recognize what preceded these worries (Table 4). The supervisor's responses may come from numerous sources, including cultural values and attitudes, their professional role and individual life experiences, including training, or may be activated by contact with the supervisee and their behaviour.[3]

Another way how to make a cognitive reconstruction is also by asking to identify triggers and then:[69]

- What type of client has regularly "gotten to you" in your career?

Table 4 Four-Column Record of Supervisor's Dysfunctional Thoughts

Situation	Emotions	Automatic Thoughts	Rational Reaction
Alena flips through the patient's documentation, shuffles the papers, reads the notes at times, then says that she can not find the right notes, flips through again, and starts looking at the documentation again when I ask her questions.	Annoyance Anger	She is not ready for supervision We are wasting time here I have repeatedly told her that she should prepare properly for supervision. I can not help being angry with her. I am failing as a supervisor	She is just getting started, and she is worried she will make a mistake. I told her to prepare, but I did not explain how. She prepared honestly according to what she brought, but maybe her anxiety prevented her from making important points?. I have excessive demands on myself, and I need to calm down. Even though she is a tremorist, she repeatedly told me she came to me for supervision, glad that it helped her. I will try to praise her, calm her down, and slow her down, and I will do the same for myself, and we both learn.

- How do these people put your abilities to the test?
- Have you ever cooperated with a client due to a countertransference attraction or an overidentification of their problems?
- What do you anticipate from all of your clients, even if they appear unwilling or unable to perform at times?
- What exactly is the source of your and your client's disagreement?
- How does this conflict ring true in your life? What does it make you think of?
- How do you want things to go?
- What can you do to bolster your resolve?
- Are you willing to make any specific changes?
- What have you done time after time that has not worked?
- What are three alternatives you may use?

Supervisor's Supervision

Like a therapist, a supervisor may encounter problems supervising the supervisee that they do not fully understand or cannot solve.[4] It is time to find their supervisor and discuss the supervision they do. Supervision of beginning supervisors is one of the obligatory components of supervisor training.

Conclusions

Transference and countertransference are important to monitor in therapy and supervision, and if they block therapy or lead to other problems, they need to be understood and processed. Transference mapping aims to improve the patient's interpersonal functioning and remove blocks in therapy. Transference work in CBT seems to be especially important for patients with long-term problematic interpersonal relationships. Countertransference can block or push therapy beyond the benefit of a therapeutic relationship, but mapping it can be a valuable tool for understanding how people around the patient can respond to them.

The only method of identifying countertransference throughout supervision is constant alertness of the supervisor's opinions and attitudes that impact their response to the supervisee's behaviour. Rather than control their own emotions, the CBT supervisor is guided to notice them and consider their procedure in their supervision and which thoughts and attitudes they are related to.

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