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ORIGINAL RESEARCH

How to work with conceptualization in cognitive behavioral supervision

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Abstract

Case conceptualization is the ability to understand difficulties in terms of client´s history and the current context of the problem. The use of CBT strategies can be competently implemented when they are selected according to the case conceptualization, they are used professionally, and at the right time. The supervisor helps the therapist in supervision by with questions to recognize the broader background of the case conceptualization. The supervisor uses several approaches (like education, guided discovery, imagination, role playing) in which therapist can realize what didn't think about before and what is significant for understanding of the client and what need to be changed. Problems with the conceptualization might be connected with the difficulty of gaining information from the client, the lack of knowledge or practice of the supervisee or to their tendency hurry up which can product to the preliminary use the problem-solving strategies. However, the problems with the formulation can be influenced by numerous influences from the therapist surroundings as a demanding for rapid outcomes, time pressure, economic requirements and so on.

Introduction

The basic feature of the CBT is the experimental approach to solving the problems of individual clients. Based on the formulation of the client's problem, the therapist with the client make a hypothesis that a certain intervention will be effective for the specified issue and then empirically verify this assumption. There are many effective approaches in CBT that can solve most of the client's problems. This, however, does not mean that any therapist is able to use them appropriately according client's needs. The use of CBT strategies can be competently implemented when they are selected according to the case conceptualization, they are used professionally, and at the right time (Kuyken *et al.* 2009). The choice of intervention, or its preference over others, at particular time in therapy may also be related to the therapeutic relationship, which includes transference and countertransference issues. Therapist

must be aware of this impact or learn it in supervision. (Linehan & Kehreer 1993, Beck *et al.* 2004, Newman & Beck 2009).

Supervision in the cognitive behavioural therapy is one of the most important parts in the process of "making" a cognitive behavioural therapist. The goal of supervisor's efforts is not only to support the supervisee and promote therapist´s professional development, but also to help understand a particular client, context where problems developed and maintain, relationship between them and processes going on in the therapy. Supervision should start / include case conceptualisation, because on our understanding of the particular client, therapeutic relationship, therapy process, depends the choice of strategies and supervisee's capabilities to implement them, later in the therapy monitor the therapy progress and change if needed. Novice therapists often come into supervision asking for useful strategies ("What should I do next?"). But during supervision turns out they do not enough understand what is happening to the client in one's context and overall in therapy, why some interventions needed, because they have not developed link between case conceptualisation, interventions and therapeutic relationship and progress monitoring. However, during the session, they usually start more understand that they actually need to focus on a proper conceptualization first what was lacked earlier.

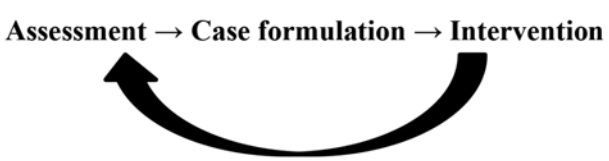
One of the clearest examples of clinical empiricism is the formulation of a case as a set of hypotheses (Beck *et al.* 1979, Kuyken *et al.* 2009), which are then tested and revised if a new information emerges that rejects some of the hypotheses. Just as the therapist maps and discusses with the client the formulation of their problems in the current functioning (cross-section case formulation), as well as their understanding how the problem is related to the client's development since childhood (case formulation). During discussion, the supervisor helps the supervisee by using questions to understand the broader context of the case conceptualization and its impact on therapy. To explore the broader context, the supervisor uses guided discovery and other methods (cognitive restructuration, experiments, imagery etc.) to reach supervisee's cognitive and behavioural shift and to create place to reflect deeply on his / her understanding of the client and if necessary, fundamentally change what is needed. This is a delicate work because it cannot substitute the therapist's personal therapy or other strategies for development (self-reflection exercises, groups therapy), but it is often necessary to link the current lack of understanding and behavioral patterns with the therapist's personal history.

What is important when supervising the case conceptualization

Case conceptualization is the ability to understand problems and symptoms in terms of client´s history and the current context of the problem. This skill is based on the theoretical approach but its development is only possible through the practice with clients, reflective process and can be deepened by systematic supervision (Armstrong & Freeston 2003). Good conceptualization comes from understanding the scientific basis of treatment approach. A competent CBT therapist has sufficient knowledge of the scientific foundations of cognitive theory of mental disorders, but is also aware of the limitations of current scientific knowledge (Clark *et al.* 1999). It is important for him to know the latest developments in CBT, both in research and application, to be able to work with schemas, behavioral experiments, imagery, traumatic experiences and emotions from childhood, mindfulness-based topics, or meta-cognitions. The therapists also look at their own work, which is similar to the scientific investigation, with healthy scepticism. Every case management consists of assessment on which we base our case conceptualisation, hypothesis about client, and our choice of intervention and later analysis of results (assessment again). Such sequence helps to guide therapy correctly. CBT conceptualisation (formulation) includes cognitive, behavioural and functional analysis – mapping present symptoms and problems in categories of antecedents, cognitions (automatic thoughts, core and conditional beliefs), emotions, behaviour, body responses, consequences, and interpersonal contexts related to current problems.

In supervision, the supervisor is interested in how therapists understand client in terms of the cross-sectional conceptualization - what problems the client has, when they appear, how they look, how often, with whom they appear and with whom not, what modulates their occurrence and severity, what short- and long-term consequences they have, and how they function in clients' lives, or to what extent they affect its functioning at work, in relationships and in lifestyle. It is also important to understand why the client came to the therapy in the current life situation. The supervisor explores how much the therapist understands the vicious circle maintenance of the client's problems and the context in which the problems occur. Another goal of supervision is to find out or help the therapist to understand how the client's life story is contributing to current problems. This includes understanding of predisposing factors, including formative factors from childhood, adolescence and adulthood, precipitating and sustaining factors of problems (Table 1).

It is important to understand that case conceptualisation is a dynamic process and constant change is normal and beneficial. We use case conceptualisation



Tab. 1. Important components of case formulation

- Predisposition factors
- Childhood experiences and their current representation (schemas, beliefs)
- Core beliefs and conditional rules
- Precipitant factors
- Automatic thoughts and vicious circle of client's problems
- Consequences
- Cognitive analysis
- Functional analysis
- Obtaining a comprehensive problem lists
  - Psychological/psychiatric disorders and symptoms
  - Medical disorders and symptoms
  - Interpersonal problems
  - Work problems
  - Finances
  - Housing
  - Legal issues
  - Leisure
  - Heath care difficulties
  - Disability pension (acquisition / retention)
- List of agreed therapy goals (goals of clients and therapist can be different and can hider therapy a lot)
- Behavioural strategies overused and underused by the client
  - Suicidal and self-harming behavioral patterns
  - Behavioural patterns interfering therapy
  - Maintaining factors
- Life quality interfering factors
- Therapeutic relationship features (problematic and helping)
- Biological factors (temperament etc)
- Other important context (like environment)

and progress monitoring to guide cognitive-behavioural therapy.

Constant testing hypotheses, assessing results (monitoring progress) and reconceptualization helps to guide therapy, deal with problematic behaviour during treatment, non-responsive clients, therapy failure – case conceptualisation guided CBT. Same concept is applicable in supervision. To enhance constant dynamic conceptualisation skill the supervisor helps to create bridge between previous sessions conceptualisation parts (what new things emerged in our understanding of the case?).

Typical problems in case conceptualizing

Problems with the case formulation may be related to the difficulty of assessing the client, the lack of knowledge or experience of the therapist or to his/her tendency hurry up which can result to the preliminary search for a problem-solving strategy. However, the problems with the case formulation can be influenced by many factors from the therapist context as a demand for quick results, time pressure, financial requirements, and also avoidance of difficult themes for the therapist like rape, death of child and so on. Also, the conceptualization is sometimes neglected when the therapist wants to have clients supervised as soon as possible to complete the training requirements and comes unprepared for the supervision. In this case, the supervision should not take place because it is suboptimal use of supervisor and therapist time. In that case, an emphatic confrontation and limit setting are appropriate strategies. A well-established agreement between the supervisor and the supervisee on how to prepare for the supervisory meeting can prevent this problem. The contract should include working methods as well as basic rules, requirements for supervision preparation, place and number of sessions agreed upon by the participants, or when and how the sessions will be evaluated. This agreement helps to create safe space for collaborative supervisory work (Table 2).

Problems related to the difficulty of obtaining information from clients

Assessment is core stone to create case conceptualisation and change it during therapy process to guide therapy appropriate. Important to remember because of factors mentioned below conceptualisation is a dynamic process which is constantly developing by information emerging. Assessing clients may be sometimes challenging. The client may dissociate part of their problems, not realize their emotions or thoughts, downplay the importance of certain events or contexts for themselves or for the therapist. A cognitive deficit, problem with speech expression, hearing, different native language, or caused by the pathological

Tab. 2. Important items of the supervision agreement

• Confidentiality
• Supervision goals
• Working methods
• Ethical aspects
• Preparing for supervision
• Timing of supervision
• Home exercise
• Supervision fee
• Original supervision contract (therapist expectation)
• Assessment and evaluation
• Supervision and supervisory process (if work longer) **progress monitoring**
• Supervision limits
• Covering supervision

process can limit the of getting appropriate information too. Clients may also be ashamed of some facts, afraid of stigmatization, or want to be seen by a therapist in a better light. These problems lead to an underdeveloped conceptualization that lacks the foundation stones necessary for sufficient understanding of the issues. The initial stage of the therapy sometimes focuses on increasing the client's motivation to undergo treatment and the conceptualization part often insufficient. In these cases, the supervision can focus on finding ways to complement the conceptualization puzzle within possible limits, discussing hypotheses about possible explanations of some observations and possibilities of testing these hypotheses.

Problems related to lack of knowledge or experience of the supervisee

Beginner therapists experience problems with conceptualization are the most often. The supervisee needs to learn the basic understanding of the client, the analysis of their problems within a given time framework, behavioral, functional and cognitive analysis, and the historical conceptualization of the case. Keeping in mind therapist development stage to create appropriate conceptualisation is very important.

Novice therapists

Unthinkable application of manualized approaches without sufficient diagnosis and contextual deep conceptualisation often misses the needs of a particular client. The manuals certainly help to use evidence-based approaches in carefully diagnosed clients, however many clients suffer from co-morbid disorders, often personality, autistic spectrum features, dissociative states and clients with the same diagnosis generally may have different case formulation, different childhood experiences, different relationship formation, and current context. Novice therapists sometimes confuse clinical diagnosis with case formulation. The supervisor needs to help to the supervisee understand that this is not the same, the diagnosis can only illuminate a part of the conceptualization, most often related to the client's symptoms, but is unable to explain the wider context of their development and maintenance. While it is the responsibility of the training institutions to educate students adequately, and the students themselves should to learn the necessary things. The supervisor often faces a situation where need help the supervisee to get oriented in theoretical concepts in order to understand a particular client. It is useful to suggest to therapist study the text about the quality conceptualization of the case (Beck 1995, Davidson 2008, Kuyken *et al.* 2009).

At the beginning of the training, it is common for the therapists to struggle with integration of the information received from the client and linking it to the case formulation. Novice therapists often have a problem negotiating data for conceptualization because they only learn the skills of conducting a diagnostic interview with a client. The client can overwhelm them with the information and the therapists cannot focus on those that are important and get lost them in the conceptualization. They can also experience problems with linking different levels of information to a meaningful model. In such cases, the role of the supervisor is to help the therapist model the conduct of the interview by playing roles, or finding meaningful questions to obtain relevant information.

Another problem may be the tendency to interpret the client's problems by disorder model without sufficient facts obtained in the interview or measurement tools, or the use of incorrect measurement tools or reliance on evaluation tools rather than the interview itself. Overwhelming use of psychometric questionnaires can be a problem for novices who are unsure whether they can put particular question and whether their judgment is sufficient for conclusion. Then they rely more on formal diagnosis according to the classification system, or findings from psychological tests, than the logical implications of a carefully conducted diagnostic interview. This may be due to university education, which often overestimates the importance of psychometric testing for therapy management. On the other hand, we have few protocols of the same disorder and one client, whose main mechanisms (primary and sec-

ondary) maintaining problems novices need to understand. Empirical protocols involve that clients want to recover, when client's goal can be just alleviating or cure the symptom. Case conceptualisation in this case helps better – client's goals is important to manage successful therapy, not only comprehensive problems list.

Novice therapists may also have a problem with which model of client conceptualization to choose. The creativity of researchers helps to reveal a number of contexts, contributes to innovation in approaches, and there are several different models for many disorders. This brings progress in research and therapy, but on the other hand, different models in similar disorders can cause confusion for the novice therapists. Offering various advanced workshops while the student is learning the basics knowledges contributes to the confusion. Being in short time in CBT, schematherapy and mindfulness-based approaches and other third wave trends creates enough stew to present the novice to the supervisor. The supervisor's role is to help the therapist organize and reflect own knowledge and decide on the model closest to him and be able to work in it. This may also be influenced by the supervisor's preference and whether it is capable of synthesizing different views into a meaningful entity that most closely matches the needs of the therapist and the client.

Start the treatment with uncollaborative patient or without contract

Some clients have difficult or severe acute problems, with deep depression, feel helpless, hopeless, experience severe psychotic symptoms, withdrawal symptoms, take high doses of benzodiazepines or so. There is difficult for them to collaborate and discuss about therapeutic aims or use workable strategies. Generally, the client is not able to collaborate in cognitive behavioral therapy. Sometimes novice therapists want to help them and start the therapy without any contract and without conceptualization.

Premature search for problem solving strategies

Many therapists, if not most at least initially, come into supervision with search of strategies. This is due to various reasons, most often trying to help the client as soon as possible from distressing symptoms or problems, lack of experience, feeling of time pressure caused by the facility in which they work, loved ones or their own impatience, sometimes the proud belief that it is clear from the partial data what is going on in the case of the client;

Therapist: My need for today's supervision is to understand what to do? Which strategies could be useful? I feel confused, because we did so much and there is a progress, but still a lot of problems are present. Maybe I couldn't see some things and it could be very important to see from another point of view in this supervision what to do. And honestly, I feel some time pressure, because my client is going abroad for several months and I feel I need to help her to do it in the best way. It's very important for my client's future to be in good condition.
Supervisor: Ok, do I understand right, that you feel concerned about your client?
Therapist: Yes, yes, I could explain a little bit more about her and it will be understandable, why I concerned. It's really about the story of her life and now she is on the turning point and I feel I could help her and this supervision is very important.
Supervisor: Dou you mind, if I ask you, what do you understand about the client and what is done before we are moving to strategies. Is it sound well for you?
Therapist: Yes, it's good idea.

The effort to help the client as quickly as possible is understandable and universal human. Understandable the anxiety of the therapist to lose confidence, if soon not will come to clear outcomes. The supervisor needs to help the therapist calm down, be self-compassionate and reflect. Using guided discovery supervisor wants him/her to realize that without a good understanding of the problems of the client the therapy will be the system of trials and errors. Finally, it will take longer than if he/she first put depend on careful formulation of the client's case. During the acquisition of blocks of mosaic of the client's story to the whole image is significantly enhanced client confidence in the therapist. He/she had never experienced such a systematic interest in his/her story, problems and symptoms before. Confidence in the therapist usually rises already at the time of a qualitatively performed problem analysis.

Supervisor: /after therapist described the history of the client/ I know that you work with a lot of clients with similar problems and usually you have a lot of strategies. What do you think is different in this case?
Therapist: I feel very confused with her.
Supervisor: Thank you for opening these feelings. Could you tell me what are your thoughts, when you feel confused?
Therapist: Let me think...
Supervisor: Shure, take your time.
Therapist: Strange, I didn't recognize, that I think a lot of negative thoughts. /Smiling/ Like my client. I think that I'm bad therapist, that good therapists are doing things like in the protocol, but I was collecting information four sessions. Good therapists know how to help people, they are not confused. I should be more prepared next time.
Supervisor: I see good reflection about your own negative thoughts. Maybe we could draw your vicious circle next to client's?
Therapist: It could be interesting. I can guess that there will be similarities. Interesting, that when we are talking now about these things, I feel released. May be these is not my confusion, but clients? She talks so often about confusion on our sessions.

The pressure of a client's family which wants to get better their family member as soon as possible, can contribute to the pressure in implementing early change. In particular, the parents of child and adolescent clients

may urge the changes because the client is either angry or poorly learning, self-harming or suffering from other symptoms. If the therapist is uncertain and dependent on consent, he is easily subjected to such pressure and out of anxiety tries to approach the therapy before he understands the client sufficiently. If the supervisor finds that this is happening, the supervisor needs to help the therapist recognize it and find a form of communication with the family that will reduce their pressure.

Therapist: I was working ten sessions with my 15-year-old client and I feel that he is not motivated enough for moving to the results, for his own goals. And I don't know what to do.
Supervisor: You told me earlier, that he is depressed, right?
Therapist: Yes, he has depression and his parents found me by the recommendation of the psychiatrist.
Supervisor: And you also told me that you did together with him conceptualization, that you feel that you have good contact and he is trusting you more and more, that you started behavioural activation and he is exercising more, that you did cognitive reconstruction. It's sounds so much good work done! But I feel, that you are somehow disappointed, do I understand right?
Therapist: Yes, I feel disappointed. He was not reading a material about depression. It was his homework.
Supervisor: Do I understand correctly, that disappointment is because he didn't make his homework reading?
Therapist: Right, maybe I was not motivating him, enough?
Supervisor: And what do you think about all these things you did very well?
Therapist: I don't feel that I did well, because there is no result?
Supervisor: What kind of result?
Therapist: …to overcome depression.
Supervisor: Do I understand right, that you feel disappointed, that you didn't help your client to overcome depression in ten sessions?
Therapist: /Pause/ It's impossible with these client.... It's very, very strange. I feel that I'm talking like my client's father. He is coming on every session and telling that it's important to reach the goal, to do exams, to overcome depression, to learn, to sport, to be normal...
Supervisor: I see you got very important insight about the father's pressure about achievements.
Therapist: Yes, I'm shocked how client's father pressure jumped on me and I also started to be so demanding! But I know that these young man needs to be accepted!
Supervisor: With this new insight what do you think about your work and client's motivation?
Therapist: We are doing well, really. He is trying his best. And I think maybe I should change my strategies with the father not with the boy.
Supervisor: I'm glad that you could see that you are doing well and you have an idea about conversation with father. Maybe we could discuss it more detailed?

Sometimes, a proud therapist comes into supervision and reports the treatment strategy without knowing what the client's problems are. An emphatic confrontation by the supervisor is appropriate. The supervisor can use the metaphor: If I want to hit the target, I have to see it first. When I punch in the fog, I can accidentally hit, but usually I miss. Guided discovery often helps the supervisor to notice that this is a hypercompensation of a therapist who was caught up with false self-confidence in which he/she feels comfortable for a while. In these cases, emphatic promotion of self – reflection and change of behaviour is one of core stones of development of the therapist.

Veronika (supervisee): I have a client, Mr. V, is depressed, but I do not think that somehow deeply, but the problem is that he does not do homework. Every time I try to plan the tasks with him as best as possible, discussing why and how the homework should be done to make sense, and I ask about possible obstacles. He always promises to do them but he doesn't. Every time he tells me at the next session, "You know, Doctor, I know I should do it, it's for my own good, but then I always postpone it, somehow I just can't force myself. How do I not know how to do this? How do I force myself to do it?!" It seems to me that he always puts his responsibility on me. I have to explain him why he can't force himself. It seems to me that he's just lazy and that's how it plays with me.
Supervisor: Um, I understand that. You try to help him, you think over how to make it easier for him to do it, explain the purpose of the task, even ask about possible obstacles to fulfilment, and he promises you all that and then he does not do the task and looks helpless. I am not surprised that dissatisfied or even angry you are (the supervisor supports the therapist - this is the basic supervision competence) and gives positive feedback to the learner's specific homework assignments, he is empathetic to problems).
Veronika: Sometimes I wonder if I should give up on his homework. I press it unnecessarily and then I'm just angry and it has no meaning (the therapist feels safe enough in the therapeutic relationship to reveal her scepticism about continuing in an important part of the therapeutic plan).
Supervisor: It is also possible… But before trying to make a decision, let's try to map what is going on with the client. What makes him unable to do these tasks? What is stopping him? Does it have any attitudes or expectations that may be related to? Doesn't he believe he can handle it? Or is something else preventing it? Let's try to hypothesize schemes that may affect his behavior that hinders this part of the therapy (the supervisor offers an alternative strategy that requires the therapist's use of conceptualization skills and the specific competence of working with schemas in case conceptualization).
Veronika: I have discussed this with him, I have offered him the hypothesis that he may be prevented by some thoughts that are always activated when he wants to do his homework, and that it activates his feelings of incompetence, which also occur in other situations. When I asked him what he thought, he just said, "I don't know, you're the expert." And he got me again! (The therapist tried to use conceptualization to understand the client's non-cooperation, but still felt blocked, there are also signs of counter-transference).
Supervisor: What do you say we would try to brainstorm together whatever comes to mind, how to change this situation?

Otherwise, I also have experience when I ask some clients who are strongly avoiding or depressed about why they are not doing their tasks, they usually tell me that they "don't know" or that "they don't have the strength" or that " there is no point anyway, "and then I feel the futility of working somewhere. The question is what to do in such a situation!? It seems to me that we could look for a way to ask the client so that he feels as guilty as possible, and at the same time feel more like an "expert" when answering, maybe we could come up with the reason. What do you think?

Veronika: You're right, I ask him why he didn't, and he has to feel like a pupil at school. I didn't get it. At the same time, he had a mother teacher who constantly pursued him with some tasks and constantly criticized. I can look at him like the mother ... I hope not (laughs). He may feel helpless when he sits down to his tasks. Actually, I wasn't discussing his feelings with his tasks. I expected him to make excuses. Nor did I discuss his thoughts with him when I give him his tasks. What is happening to him when he promises everything? Is he not afraid to tell me that there is too much? Is he not afraid to admit if he doesn't understand something? When he had such experiences with his mother…?! I hope that in brainstorming we will find some way to encourage him more. But I have to admit that when I am with him, I seriously doubt myself. Do I even have to do the therapy? I am often irritated with him, sometimes I do cognitive reconstruction for him when he does not say anything, then I comfort him when he says it is worth nothing, that he did not find anything by himself. Sometimes I "save" him, but then it bothers me that he himself did nothing and still uses it as something that wipes my eyes: "look how I am incapable". Then I'm helpless. It is clear to me that what I am doing is not helping anyone (the therapist has uncovered some of the counter-transference patterns she noticed in her reactions to the client, demonstrating the basic competence of self-awareness).

Supervisor: Very nice self-reflection! You really surprized me, how good it is. Especially when I know you're only in your second year of training. Just go on! You also asked yourself some important questions. What actually happens to a client when he promises to complete the tasks and what happens to him when he sit down for the tasks? It seems to me that a detailed mapping of his thoughts, emotions and behavior in these situations could help him to understand more. Maybe you could also be a little concerned with your self-doubt. Is it really so bad with your skills that you have to seriously doubt yourself? Maybe you could find some rational answers that you could use to reduce your self-doubt. I think you have to do it right. (The supervisor used the basic skill to build a supervisory relationship – strengthened the therapist's basic skill - self-reflection. The supervisor also encouraged the therapist to try a specific CBT skill - cognitive restructuring - to change her doubts about herself, which may interfere when working with complex clients like Mr. V).

Veronika: Do you think I should ask myself what the pros and cons show that I can handle my therapeutic work? (laughs) Actually, I usually manage it, but sometimes, as I do now, I can't do anything. Then I unnecessarily fall into self-doubt. Fortunately, only for a moment, then I overcome it. I think it's better to solve the problem than to rumble about your mistakes. But you are right, it is related to my attitudes to myself, which I should still elaborate (The therapist responds to the supervisor's support by mobilizing her basic rational response skills and applies it to herself). I wonder if I should record a session with Mr. V, too, that you would listen to how I do it with him directly? Would you have time to listen to it?

Supervisor: I would like to listen to the recording of the session with Mr. V so that I can give you more specific feedback. However, his signed informed consent is required. You must also be clear that you are willing to expose yourself to such an exposure, that we will listen to what you are saying to the client. But I like it very much. It shows your courage and directness. These are qualities that I have noticed on you before (the supervisor decided to work directly on the recording of the supervisory session, pointed out the ethical side of the matter, and appreciated the therapist for coming up with the idea).

Influence of therapist´s work place surroundings

It is important to consider and discuss context of supervisee's practice – facility, institution, rules, traditions etc. The influence of older colleagues, the influence of middle staff on the therapist working in the team can be considerable. Others' opinions of the client, often very superficial, because they know the client only from outside speeches, but are communicated by authority or team, can influence the therapist's own eyes, especially if he has little self-confidence. The task of the supervisor is to help the therapist to adopt his / her own attitude, based on the client's understanding, support his / her autonomy.

Problems related to therapeutic relationship

The therapist's relationship with the client are affected by transference and counter-transference. It is important to recognise and observe during the process when it is becoming a problem in managing therapy. In the case of transference of the therapist to the client, the distortion is caused by past experiences with people who are reminding of some of the client's characteristics or manifestations, and in the case of counter-transference the therapist responds to the transference behaviour of the client (Andersen & Przybylinski 2012). The effect of transference and counter-transference on the conceptualization of the case can sometimes disrupt the objectivity of the selection of relevant client data as well as the interpretation of their connection. Counter-transference is an unconscious reaction to the transference or projection of expectations of past relationships in the therapist-client or supervisor-supervised direction (Hartl & Hartlova 2000). It is important that the supervisor can help supervisee to reflect and process these processes for their own and benefit of the client, the supervised and supervisory process in general (Yourman & Farber 1996). Sensitively formed therapeutic alliance, listening to client feedback, re-assessing and monitoring therapy progress and quality self-reflection are the main antidotes for these misconceptions. This makes the supervisory function irreplaceable. In the process of supervision, it may be necessary to realize

and process unconscious material that manifests itself in both therapeutic and supervisory relationships (Reichelt & Skjerve 2002). The task of the supervisor is to identify unconscious processes, identify them and use them for the supervisory processes. The supervisor assists the therapist to stop over his client's cognition and emotional responses to the client and to determine whether are based on the facts he or she has experienced or they come out from the client's own attitudes, influenced by their own history, circumstances or experience with similar clients.

Similar processes, mechanisms and phenomena appear in supervision that occur among the participants in the supervised case. We are talking about a parallel process. The supervisor must be able to recognize and integrate this process, which may be manifested, for example, by helplessness, hostility, tension or coalition bonding, and integrated them into supervision. Supervision is particularly important when working with heavy clients, such as those with personality disorders, hypochondriac disorders, eating disorders, or when a therapeutic or conflicting or helpless situation occurs (Beck 2005). The therapist may not always have the capacity to understand what is happening in the situation, especially when it is overwhelmed with its own countertransference. Important to understand that those reactions can be normal process of therapeutic relationship, we need to recognise and observe, reflect on them and its consequences, without making dysfunctional decisions. Very important find a link between client's case conceptualisation, therapy process (non-responsiveness, treatment failure) and therapeutic relationship problems, then reformulate case and find another treatment plan, monitor progress, way how case conceptualisation helps to solve treatment failure. Another issue how to help supervisee understand and reflect about problems mentioned above. Schema therapy concepts about unmet core needs of the client and therapist, schemas and modes can be very helpful to understand and experience those impacts in safe way. Deeper understanding own reactions inspired by own experiences and schemas (system of cognitions, associated emotions, body responses and memories) helps to understand and manage problems mentioned later in article.

Lucie (supervisee): I have a young woman in the ward, Miss K, who makes me terribly upset. I know she shouldn't, but I can't help myself. She's terribly urgent, she keeps commanding something, I just appear in the hallway, she has a request right away, she complains about something. She does the same things to Petr (colleague Lucie). I would like to find out what I should do so that she would not upset me, because then I will not help her much. When I talk to her alone, I'm not client enough for her, I can't listen to her too much, so she makes me dial. Otherwise it does not happen to me, I have a good relationship with other clients.

Supervisor: If I understand you, you usually manage to establish a good relationship with your clients, but now you have a client in the department that is extremely urgent outside the session and it upsets you. You can't be client enough with her anymore. You're sorry, and you're afraid you won't be able to help her. In doing so, you'd like to help her if I understand it well. At the same time, you're angry with her. It is right? (The supervisor summarizes what he has heard from the therapist, giving the therapist a sense of acceptance - he listened well - and safety - understands her).

Lucie: Exactly…. The client has a borderline personality disorder and upsets everyone, most of her close ones, whom she constantly swears on the phone. On the other hand, she helps others client in the department, lends fellow clients a mobile phone to make a call, and is committed to others and can be sensitive to them. I see that too, she's not just bad. Still, I'm allergic to her. I can't do it with the borderline. I understand that they are troubled, but why do others also bother?! She was swearing this whole hallway on her phone to "Fuck" and "Pussy" that she forgot to bring her something. I don't mind the vulgar words, but the mother always tries to help her, she goes to her every day. In addition, she frightened the other clients who feared her. I just do not have the patience for the borderline clients and I am immediately mad at them. It's my fault. Petr doesn't make it that way, he has an understanding for them. But I can't. At the same time, I would like to learn it somehow, because it is clear to me that I miss the client and do not help her at all. I then think that I am a bad doctor…. (The therapist clearly feels safe enough to speak openly. She is aware of the different aspects of her relationship with the client and begins to reflect on herself)

Supervisor: You seem to think a lot about it when you realize, not only that it bothers you, but also that it engages others and can be sensitive. And I understand a lot that she's dialling you upsetting the whole department. I have the experience that most people upset this type of client. However, they tend to blame the client for everything and do not think of themselves as you. Your attitude seems much more honest. You also want to change it somehow, learn how to treat her so that she can benefit more from it. I like you thinking this way (Supervisor first reflects contradiction in relation to the client, then reinforces the safe atmosphere, empathizes with the therapist, expresses her understanding of her negative emotions, and normalizes the negative reactions. ethical attitude and encourages and rewards the therapist's tendency to seek a way to the client).

Lucie: I'm right, in some ways I see it is very nice. When he helps others. Also, I don't want to be like the others and just complain about how terrible the borderline is. I guess the most pissing on her is that I can't help her. When manic clients curse and make a mess, I am much more kind to them than to her. But there the medication helps and they calm down. However, her medication does not affect much and my attempts at psychotherapy do not accept at all. She says she has gone to at least five experienced therapists for psychotherapy and that was no good. She showed me that I was young and inexperienced… If I could make contact with her and motivate her, maybe it would be better for both. I don't know if I can help her, but at least we could try. He refuses me this way, but he urges crap - for example, he changes the list of people to whom I can give information about her several times a day (Self-opening of the therapist continues).

Supervisor: You are thinking very nice about that. It is understandable that she may anger you when she refuses your efforts for therapy and urges your time for unimportant things. I like it even more that you want to help her, even if she shows you that you are not so experienced. Can we try to think about how to motivate her? What do you think? (The supervisor strengthened again and responded empathically. He underlined one of the possible causes of the relationship problems - the therapist's depreciation of the therapist but pointed out this in contrast to the appetite for help.

Lucie: Maybe she would accept if I could just talk with her about her childhood. When I examined her, I went through it too quickly, because I didn't have enough time because she described me the current problems. Actually, I don't know much about her, except for the numerous conflicts she has with her father, boyfriend, she has had several jobs. I know almost nothing about how she grew up. But as I saw now, it certainly wasn't easy. Now I realize that I don't have much to understand from, because I know little about its development. Perhaps she would be pleased to discuss it with her (Therapist realizes she doesn't actually have a case conceptualization - which is one of her core competencies - because she doesn't know much about the child's childhood, feels so safe that).

Supervisor: I see that you have already found one way to improve the therapeutic relationship with it and to understand it more. Is it possible that she really had a difficult time in her childhood… do you think that a sensitive waking up of her childhood could help the client feel more accepted? (The supervisor encourages and confirms, using an inductive question to indicate a possible schematic problem of the client).

Lucie: Yeah, she still insists that we all pay little attention to her. The staff, me, the family ... too little attention from her friend ... she was probably right, she doesn't feel accepted ... she doesn't feel accepted anywhere, all those conflicts are about it. Well, I can't accept it either… it's hard… that's why she has to try to help others. And so, she gets so upset when someone doesn't pay enough attention (Therapist develops the hypothesis and the client's core scheme, looking for evidence for the facts she knows).

Continuation of the next supervisory session

Supervisor: Last time we discussed Miss K, who upset you as urgent. Eventually, we came to the conclusion that she might feel unaccepted. You said you'd try to talk more about her childhood with her. Do you want to talk about it today, or do you have something else to work on? (The supervisor in continuous supervision offers a continuation of the topic from the past, but gives the therapist the freedom to choose the topic).

Lucie: Today I would like to talk about a new client, but I also need to talk about my work with Miss K. I have to decide ... we're not going to make both of them… so I will continue with Miss K, it moved a little there. But today I need to discuss what strategies I should continue to apply. Maybe even try something with you, because I've never done anything with anyone who has been sexually abused in my childhood ... it would help me to play it back. Do you think we could do that? (The therapist specifies a contract)

Supervisor: Sure. I like how you tell yourself what you would like to do today. I think it makes sense. And I'm glad it moved. I also wonder where. What did you find out and how did it go to talk to her? (Supervisor appreciates and then focuses session first to clarify conceptualization and therapeutic relationship)

Lucie: I just sat down with her and offered her to talk about everything from the beginning, from childhood, and she said yes. She also said somewhat venomously that we could have discussed this a long time ago. But I passed that. Then she suddenly cried and told me that no one believed her, she was molested and then raped her older brother. When she finally said this in adulthood, her mother did not believe her and her father yelled that he was making up. She burned it at me and then cried and watched what I said. I felt she was desperate and at the same time able to start fighting immediately if I didn't tell her I believed her. So, I told her I believed her and whether she wanted to say more about it. She said not now, that she was enough to believe her, and she escaped from her room.

Supervisor: So after all, she found trust in you. That's perfect. It's good that you told her you believed her… (Supervisor confirms therapist)

Lucie: She came to me again that day if I had time for her to tell me more. I hesitated to agree to talk whenever she wanted, on the other hand, it was clear to me that she wanted to talk about such a difficult thing that I said yes. She told me how her brother had been sexually touching her regularly since the age of 8, threatening to kill her if she said so. He pushed her repeatedly into the sex with his fingers, forcing her to touch his penis and irritate him. She tried to avoid him as much as she could, but in the end, he always found her. When he was 13, he raped her. She told it to her parents in the next 10 years because she was so shy about it. But they did not accept it, her mother did not believe her, and her father started screaming that she faked it and that she always created lies. Reportedly, if it had happened, she had already said it…. When she told it to me, she was almost always crying or fuming - at her parents and brother. She also said that if she could, she would kill him or cut off his penis. That he's in jail for fraud now. I didn't know what to do about it when she was so angry and was spoken roughly. But she probably needed it. But when I hear so much hatred in her? … I feel completely helpless, even if it doesn't belong to me. When she was crying, I was afraid to get close to her so she wouldn't explode again. Rather, I just sat there listening to her. I couldn't interfere too much.

Supervisor: As I listen to you, you did a lot of work. She could tell you such a painful thing. When she remembers, she is overwhelmed by strong opposing emotions that take turns. I don't even blame you that at times it strikes you, as you thought. I also think there is not much to add to such a story, and that things typically affects the therapist emotionally ... that somebody doesn't notice how important it was to her. Do you think this can now be better be understood based on what she has experienced? (Supervisor appreciates, expresses understanding, and normalizes. Then, using an inductive question, directs the therapist to conceptualize the case)

Lucie: I still need to discuss this childhood with her so that we can remember not only traumatic things, but also to be able to lean on something good, but what she experienced is enough to make her feel unaccepted and misunderstood. I will make a "falling arrow" with her to name her scheme somehow, and then I will discuss the implications of the scheme. I think that this will

mainly concern the belief that she is unloved and hurt by others. Then, her compensatory strategies in behavior – an excessive desire for attention and anger if she doesn't get it – are understandable. I think I understand her much more after she confides in me. I think I should continue now by talking about trauma and exposing in imagination… but I am a little afraid of reacting violently so that I don't even decide it anymore… I also don't know how to anchor it to calm down. Could you help me in this? Explain to me what to do or play some of it here? (The therapist summarizes the conceptualization and considers other strategies - to share the conceptualization with the client through working with the schema, then returns to the original order, to learn more about the strategy she would like to use or play)

Supervisor: I like how you gradually conceptualize her story. If you discuss it with her, you will have a good base to work with the trauma in imagination. You're probably right that it can be very stormy with Miss K. I think it would be best to rescript the trauma in imagination. I'm sure you remember how you practiced it in training. First, it is necessary to create an atmosphere of security and acceptance with the client, to give her the possibility of control, i.e. that she can withdraw from the imagination at any time. You will explain in advance what you will do. The second step is the actual imagination of the traumatic event, by using present time in imagination. For the first time, it is usually short because it is hard to live and tries to avoid. In the third step you work out a saviour person. It may be someone she believed back then, or it could be herself as an adult, or it could be you. The saviour enters the imagination and protects it and then eventually quits. Want to play it? As a therapist, or first as a client and I will be a therapist? (The supervisor appreciates, then expresses his understanding of the therapist's concerns and structures the options for trying out the strategy she wanted)

Lucie: I think I'll try it as a therapist. I believe I can do it. I've tried it for training and I think I did it. After all, we can stop and remodel it at any time if I can't. Do you agree? (The therapist encourages herself to play roles)

It is also important to clarify in which way he has similar attitudes to the client, in which part of his own story is similar, or in which the client resembles people he has met in his life.

Hawkins and Shohet described useful technique 'Checks for identity' which they have adapted from 'Co-counselling' (see Heron 1974 as mentioned in Hawkins & Shohet,2006). The main goal is to help elicit countertransference. The supervisor leads the supervisee through five stages:

- *Stage 1:* The supervisee is invited to share the first spontaneous responses to the question: 'Who does this client remind you of?' It is important to repeat this question until the supervisee can give an answer. The person that reminds supervisee about the client could be from their past, also a well-known celebrity or even historical or mythic figure or part of themselves.
- *Stage 2:* The supervisor asks to describe all the ways in which the supervisee`s client is like this person.
- *Stage 3:* In this stage it is possible to use role-play or an empty chair. The main idea is to allow the supervisee to expresses their feelings to this person (that they discovered in stage 1). It is particularly helpful if the relationship with this person is unfinished. The supervisor encourages the supervisee to say to the person everything he wants.
- *Stage 4:* Now it is important to ask the supervisee to describe all the ways in which their client is different from this person.
- *Stage 5:* Finally the supervisee is asked to share what they want to say to their client.

During this exercise, it is possible to discover unlikely connections and unfinished thoughts and feelings, which often are getting in the way of seeing the client.

Problematic clients' behaviour during the session, here and now, is often similar in other situations in own's life and interfere treatment. Same parallel process of problematic behaviour can be spotted in supervision session and can be similar in other problems. Working with them here and now – conceptualisation in the session can help understand its function and cause.

Client stigmatization

Probably the biggest problem is stigmatization of the client. The use of tags such as "hysterics", "hypochondriacs" or "psychopaths", "nonresponsive to therapy", "personality" generally prevents a deeper understanding of the client's needs based on their history and current context, or the coping modes which the client uses in various situations. Rather, such stickers are indicative of the beliefs the therapist treats with the client. They are often influenced by recommendations given by the therapist from another specialist, by the opinion of the surroundings, but also by the therapist's prejudices about the treatment of more complex clients. Often there is hidden uncertainty about his / her own view on similar problems, competencies to help the client, helplessness or anger at the client's behavior, which is unpleasant to the therapist. If, during supervision, a therapist manages to understand the client and his / her life story, behaviour causes and function, stigmatization goes aside. On the other hand, the supervisor needs to weigh sensitively whether the therapist is competent to treat the complex client and whether it is appropriate to refer the client to more suitable therapist, Sensitive ethical reflection of the situation with the therapist are in place.

Distrust of the client

The therapist may not trust the client, suspecting him / her from misrepresenting data, rent tendencies, manipulation or other dishonesty. While it is sometimes true that a client uses indirect strategies, consciously or unconsciously, to meet their needs, but they can be reflected in good case formulation – cognitions, emotions, memories of problematic behaviour. The supervisor helps the therapist to understand whether or why the client uses these strategies or why therapist have difficulties trusting the client. It is often a misunder-

standing of the client's needs, his selective perception, excessive criticism related to the uncertainty of how to respond to the client's manifestations. Understanding the client's behavior through careful conceptualization of the case and concurrent self-reflection of the therapist can help break out of the stuck point.

Excessive client protection
The need for over-protection of the client is related to the therapist's hypercompensation, most often driven by the need to be valued for how well he cares. The excessive need to protect the client leads to blind spots in conceptualization, excusing the client's maladaptive behavior, avoiding painful topics, exposures or confrontation. The supervisor tries to help understand not only the conceptualization of the client's behavior, but also the therapist's response to the client. Another cause of therapist protecting behaviour from other end of continuum is therapist anxiety of client's reactions and uncertainty how to handle them.

Admiration to the client
From time to time the therapist comes under supervision with the treatment of a famous or very important person. He is uncertain whether he is good enough for such an individual, doubts about his intelligence and competence. They are afraid to ask their client about important areas of conceptualization, or simply assume that such a smart or proficient person has long ago solved these things. It is all the more difficult the less the therapist has confidence. The task of the supervisor is to normalize the therapist's expectations and to blind the client's specialness.

Competition with the client
The client's with certain personality features or in the valued professions often tends to discuss with the therapist, ask for details, and verify the therapist's competences, especially at the beginning of therapy. If the client has narcissistic traits, it can be painful for the therapist and easily provokes a rivalry with him. However, competing countertransference reactions leads to selective perception of the client and misinterpretations of the client's behavior. It is simply an opponent who needs to show who understands what. The task of the supervisor is to help controlled discovery to help the therapist to understand the competing counter-transference, or the therapist to empathically confront the situation.

Boring with client
A monotonous, unpleasant, unattractive, simpler, unjustifiable, little-changing or addicted client can bore the therapist. This leads to carelessness in obtaining anamnestic data, reduced interest in the client, impaired understanding of his or her life story, and subsequent flattened case formulation. It can indeed be a serious disability of the client (for example, strong stuttering, obedience, reduced intelligence, lasting changes after a serious mental disorder), which requires particular patience, but it can also be a counter-transference of a therapist who would prefer to work with interesting client's little motivation. The supervisor can help the therapist to find a point of interest on the client through a deeper understanding of the client's story and its conceptualization. It can also deal with the therapist's automatic thoughts and emotions that hinder the desire to deal more closely with the client.

Anger at the client
The therapist may be angry with the client. This can result from various reasons. E.g.:
- The client does not improve sufficiently during therapy despite the efforts of the therapist;
- The client does not do homework;
- The client tends to oppose the therapist;
- The client is still moaning;
- The client presents himself as an expert;
- The client competes with the therapist.

This behavior may occur at the beginning of therapy, as it usually complicates an objective understanding of the client's problems and the conceptualization tends to be distorted by the therapist's counter-transference tendencies. However, similar behavior even later in the course of therapy may distort the image of the case formulation through counter-transference of the therapist.

Strategies used for case conceptualization in supervision

Traditionally we use "talking" psychotherapy interventions during supervision: discussion, interview, guided discovery, Socratic questioning, thought records sheets and restructuring, chain analysis etc. The basic model: a three-systems (DPR) model of therapist skill development presented by James Bennet – Levy (2006) to enhance helpful learning and development of the therapists encouraging to use interventions from declarative system (reading, developing knowledge/skills, case studies, lectures, didactic/modelling supervision, clinical demonstrations, problem-based learning, clinical experience, written conceptualizations, feedback, refining knowledge/skills, reflective practice, Socratic supervision, self-practice/self-reflection), procedural system (practice, developing knowledge/skills, experiential training, role-play, clinical experience, self-practice/self-reflection, personal therapy, clinical demonstrations, experiential/modelling supervision, feedback, refining knowledge/skills, reflective practice, problem-based learning, practicing new strategies for new situations, self-practice/self-reflection, experiential/Socratic supervision), reflective system (reflective attitude, reflective practice, self-practice/self-reflection, personal therapy, reflective/Socratic supervision, self-supervision, reflective writing, reflective reading). To enhance learning and development of therapist in area

of case conceptualisation supervisors should use interventions from all 3 systems. Popular interventions like role play, imagery, imagery rescripting, chair work, work with certain modes or beliefs which interfering therapy, demonstration and using other experiential interventions, creating and solving disruptions during supervision, conceptualising unhelpful supervisee's behaviour during supervision, visual charts, reflective exercises etc. and subsequent reflection on it helps to understand and experience the case and therapist own conceptualisation deeper and create meaningful impact later in development therapist's self. Experiential work is hypothesis from case conceptualisation testing in session, live CBT curious exploration. Creativity using of experiential work during case conceptualisation in supervision can create more deep and constant changes in supervisee's and later have favourable impact to client's outcomes.

Problems on the side of supervisor

The functional relationship between supervisor and supervisee includes mutual respect, openness, authenticity, empathy, cooperation, but also a certain "allied relationship" - both are team, colleagues alleviating symptoms, solving problems and overall managing case (3 levels of conceptualisation: symptom, problem, case). The question is how much the supervisor should be personal, clear and open in their collaboration. Ideally, however, the supervisory relationship does not need to be formed, as it can be disrupted by the supervisor's transference or personality. Both can interfere with cooperation to conceptualize the patient.

Too much professional distance or overly empathetic attitude of a supervisor, coldness, superior behavior, excessive criticality of the supervisor can lead to the supervisee's negative feelings, hindering the development of the atmosphere of safety and creativity he needs to have the background for understanding his client (Ladany *et al.* 1996). Excessively empathetic approach or identification with the supervised may lead to a halt of the supervisory dynamics – the necessary perspective of the supervision is lost. This can be transmitted to therapy where the therapist does not address the client's understanding questions that supervision should ask. Similarly, a friendly relationship between the two sides - it can hinder perspective, objectivity and the ability to give negative feedback (Svobodová 2002). However, the ability of perspective is essential for the formulation of the case.

Professional hierarchy - if the relationship is significantly hierarchical with the manager's dominance and critical approach, free supervision is practically not possible. However, in a democratic relationship within an organization, the fact that the supervisor is a member of the management of the organization may not be a major obstacle to the supervisory process. However, it is always freer if the supervisor is outside the supervised organization.

Supervision requires, first of all, the creation of a supervisory relationship that will convey the supervised atmosphere and the value of the therapeutic relationship (Yalom & Leszcz 2007). In order to establish this relationship, it requires the professional and personal qualities of the supervisor to which the supervisor refers. If he meets a man who exalts himself, controls him pedantically, finds faults and then crushes him with criticism, the relationship is not safe enough. Moreover, the danger of power and its abuse in assisting processes is great (Guggenbühl-Craig 2007). Similarly, if a supervisor lacks behind in knowledge or experience, it can hardly be the authority from which the supervised learns. Right balance between attachment attitude (empathy, safeness, normalisation, care etc.) and assertiveness (emphatic confrontation, limits, approach, goals etc.) is key in development of competent and autonomous therapist.

Supervisor's transference to the therapist

Supervision is a complex process involving a client, therapist and supervisor, each with their own attitudes, experiences, typical patterns of thought and behavior. Moreover, each is influenced by other contextual factors. The task of supervision is to make these factors visible and help the supervisee to use them both for the therapeutic process and for their professional growth. The therapist has the advantage that the supervisor can view the counter-transference quite easily. It is much harder for supervisor to detect a counter-transference to a therapist. Self-reflection can help, either in the session or after, sometimes supervision is needed.

The supervisor can capture the counter-transference reaction mainly in his behavior, but also in his thoughts, emotional experiences and bodily symptoms. The core of counter-transference is formerly underdeveloped experience that tends to translate into current relationships. They can be recognized by working with their own kernel schemas and derived rules. They lead to behaviours that can be evasive (e.g. lack of openness, congruence) or compensatory (e.g. excessive help, competition, demonstration). Self-reflection or awareness of counter-transference in supervision helps to overcome the counter-transference response and can be critical to establishing a more realistic relationship and more objective work in both therapy and supervision. One of several ways to recognize counter-transference in supervision is to consistently become aware of one's own thoughts and attitudes that influence how we respond to the behavior of the supervisor. Another aid for the supervisor is to become aware of the modes he / she gets during supervision. Rather than controlling his own emotions, the CBT supervisor is encouraged to take note of them and consider how they appear to him and what thoughts and attitudes they are associated with.

Supervisor's transference to the client

The therapist's narrative may induce a supervisor response to the client. The supervisor can then create

superficial interpretations of the client's behavior on the basis of insufficient information, mark the client, be angry with him, create inadequate interpretations about the client's behavior, e.g. say that the client is manipulating or that he is a typical client with rent tendencies.

Personality of the supervisor

The personality traits of the supervisor can significantly interfere or helps with how the conceptualization of the client is discussed with the therapist, the extent to which it is objectively and in depth discussed, which things are emphasized and which are neglected. If the supervisor is miserable, he tends to "know everything" on the basis of insufficient information, referring to his years of experience to support his leads, to instruct the therapist. The frightened supervisor, on the other hand, prefers not to say anything, just asks, does not confirm or refute the therapist's outcomes, gives feedback or, if so, very vague, unclear. Other features of the supervisor that are inappropriate include in particular dissocial features, the need for power and control of others, excessive self-demonstration, impatience, dogmatism, the tendency of others to learn, self-centeredness, excessive competition, lack of discretion, excessive need for others to accept, omnipotent tendencies, dramatization tendencies and sensationalism.

Conclusion

Supervision consists of the systematic cooperation of the supervisor with the supervisee, which is conducted as a dialogue and other interventions in a safe, open and discovery way, creating balance between attachment and assertiveness in relationship. One of the first tasks of the supervisory work is to help conceptualise case in 3 levels – symptoms, disorders and case. The supervisor helps the therapist to interconnect individual components of the patient's symptoms, problems, behaviour and interpersonal patterns with his developmental history. Later is important to help understand case in broader context of clients and therapist's relationship, their development history, therapy progress and it's monitoring with using feedback from it to re-conceptualise the case and guide therapy, also important to promote therapist own conceptualisation and self-reflection as tool of own development. Supervision in cognitive behavioural therapy is based on the same principles as therapy: assessment, case conceptualisation, interventions, therapeutic relationship and promoting self-reflection. To discover the context, the supervisor creatively uses guided discovery and other strategies, in which the supervisee can realize and experience what one had not thought about before. As a result, supervisee's understanding of the client, case and itself deepens and, if necessary, can fundamentally change the course of therapy.

Conflict of interest statement

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

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Cognitive-behavioral therapy aims to change our thought patterns, our conscious and unconscious beliefs, our attitudes, and, ultimately, our behavior, in order to help us face difficulties and achieve our goals. Psychiatrist Aaron Beck was the first to practice cognitive behavioral therapy.Â There are many tools and techniques used in cognitive behavioral therapy, many of which can be used in both a therapy context and in everyday life. The nine techniques and tools listed below are some of the most common and effective CBT practices.Â In this worksheet, a therapist will work with their client through 4 steps. First, they identify predisposing factors, which are those external or internal and can add to the likelihood of someone developing a perceived problem (â€œThe Problemâ€). How can supervisors create such a positive SR? It starts at the first meeting, with the supervisor inviting a discussion about the goals of supervision, and overtly saying things such asÂ Itâ€™s not verboten in cognitiveâ€“ behavioral therapy, and in fact I could show you quite a bit of CBT literature that explicitly uses this term, although maybe in different ways than it was originally formulated. I am very open to hearing your views on the matter.Â At other times the supervision is guided less by circumscribed manuals and more by general CBT principles tailored toward individually based case conceptualizations (e.g., Kuyken, Padesky, & Dudley, 2009) and treatment plans (e.g., Leahy, Holland, & McGinn, 2011).Â In addition, supervisors work with their supervisees to create homework assignments... Clinical supervision of cognitive behavioral therapy (CBT) with youth ensures better patient care and fosters trainees' professional development. However, often insufficient attention is directed toward disseminating best practices in supervision of CBT with youth. This Therapeutic Advances contribution aims to communicate the core content of supervision. Additionally, the key supervisory practices associated with CBT with youth are described. Supervisory outcomes are summarized and recommendations for supervisory practices are made. Key Words: Cognitive behavioral therapy, Pediatric populations, Supervision. Core tip: There are several core tips in this therapeutic advances article. How Was Beckâ€™s Cognitive Behavior Therapy Developed ? What Are The Basic Principles Of Treatment ? What Is A Therapy Sessionlike?Â Of course, no book can substitute for supervision in cognitive behavior therapy.Â I have observed a number of participants in clinical trials, for example, who can go through the motions of working with â€œautomatic thoughts,â€ without any real understanding of the patientsâ€™ perceptions of their personal world or any sense of the principle of â€œcollaborative empiri-cism.â€Â Chapter 3. Cognitive Conceptualization. The Cognitive Model 30 Beliefs 32 Relationship of Behavior to Automatic Thoughts 36. xv.