Neuroendocrinology Letters Volume 44 No. 1 2023
ISSN: 0172-780X; ISSN-L: 0172-780X; Electronic/Online ISSN: 2354-4716
Web of Knowledge / Web of Science: Neuroendocrinol Lett
Pub Med / Medline: Neuro Endocrinol Lett

REVIEW ARTICLE

Ethical reflection in cognitive behavioral therapy and supervision: Theory and practice.

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Submitted: 2022-07-31 Accepted: 2022-10-02 Published online: 2023-10-02

Key words: **cognitive behavioral therapy; ethics; supervision**

Neuroendocrinol Lett 2023; **44**(1):11–25 **PMID:** 36931223 NEL440123R03

Abstract

Ethical reflection is a process that comes from the deeper attitudes and values of the therapist and supervisor. The capability to recognize one's perspectives and ethical dimensions and how they affect own practice is one of the crucial tasks of a responsible therapist. Attitudes and values of an individual or a group may significantly influence the therapeutic process and a choice of strategies and behaviour towards the patient, often working at an unconscious, unreflected levels. Ethics is closely connected with psychotherapeutic treatment. Basic principles, such as expediency, honesty, integrity, justice, and respect, apply to all people equally, including psychologists, psychiatrists, psychotherapists, and supervisors. The goal of supervision is to cultivate the therapeutic process in the client's best interest. The supervisor-supervisee relationship is then grounded on principles similar to those in the therapeutic relationship.

INTRODUCTION

Beauchamp formulated four main principles of bioethics (1994): (1) autonomy, (2) utility, (3) non-maleficence, and (4) justice. Concern for basic ethical issues, such as the relationship between the individual and society, personal autonomy, and freedom of moral choice, seems to be automatically included in every activity that focuses on human relations, including psychotherapy.

In psychotherapy, the patient gradually learns to look at how and why their experiences shape their relationships with others. Increased self-awareness help to develop their autonomy and provide changes in the understanding of themselves, their place in the world, and their relationships (Holmes & Adshed 2009). Some changes are desired and predictable, while others can only

be anticipated with a certain probability. At the beginning of treatment, a patient would sometimes not opt for later changes (Prasko 1990). Consequences for the patient and their surroundings can be unpredictable, whether changing roles and behaviour in relationships over time or losing some relationships. The therapist cannot usually predict these consequences, especially if they do not sufficiently conceptualize their case with a deeper understanding of the client's maladaptive attitudes and core beliefs (Shafranske & Falender 2008). However, therapists aim to guide the patient, so their choices are autonomous, not induced by the therapist's decision-making. The basic characteristic is that psychotherapy is not a simple, straightforward treatment but rather a dialogue leading to independent development (Gabbard 2009). The therapist should be able to ask questions and remain appropriately neutral to allow the individual to decide what they need.

Even though ethical principles have been inadvertently applied in the theory and practice of psychotherapy, explicit attention to ethical issues in psychotherapy emerged relatively late, in the 1990s (Holmes & Adshed 2009). However, ethical processes in psychotherapy should be conscious, focused, and thoughtful. In everyday practice, psychotherapists and organizations must discuss conscious conflicts between therapy options, patients' wishes, their own and the patient's ideas, and realistic possibilities. It is necessary to maintain mandatory confidentiality, respect the need for informed consent and the therapeutic contract and keep therapy within agreed and ethical limits. Naturally, these limits can be determined by ethical codes. However, it is important to develop ethical thinking by focusing on supervision. It is desirable for the therapist to understand the nature and need for boundaries, especially those related to confidentiality and discretion, and to specify and practice attitudes and behaviours that prevent patients' economic, emotional, or sexual abuse (Gabbard 2009).

Ethical reflection is a process that results from the deeper attitudes and values of the therapist and supervisor. Individual or group attitudes and values may significantly influence therapy and a choice of strategies and behaviour towards the patient and often operate on an unconscious, unreflected level. The therapist's basic attitudes towards people and themselves are not usually analyzed during the treatment of a particular patient unless supervision is conducted on this topic. A typical example of such an attitude is labelling

Being aware of one's attitudes and ethical dimensions and how they affect one's practice is one of the important tasks of a responsible therapist. Early experiences lead to moral attitudes applied to own and other people's behaviour. We can talk about "moral schemas" that automatically associate certain behaviour by categorizing it as "right" or "wrong" in terms of morality. For example, the attitude of "stealing is bad" automatically leads to evaluating every thief as "bad" unless a noble explanation is found for him, such as robbing another thief to hand over the proceeds to a person in need. Most people agree that "helping others" is an attitude that reflects an important ethical value. However, there are different motives for the decision to help others, such as the need for power, the need for the gratitude of others, compensation for one's inferiority complex, and the need to deal with unresolved problems. These motives usually mix, and they are unperceived by their bearer. Understanding one's motives in therapy are one of the therapist's own psychotherapy goals and a frequent goal of supervision interventions.

Psychotherapeutic organizations are developing codes of ethics and rules of procedure for ethics committees to strengthen ethical practice. Basic principles such as expediency, honesty, integrity, justice, and respect apply to all people equally, including psychologists, psychiatrists, psychotherapists, and supervisors. Creating codes of ethics partially reflects the realization that psychotherapy is a therapeutic tool that changes human thoughts, attitudes, and emotions and can help and harm. However, the most important integration of ethics occurs when a supervisee learns a real integration of ethics and laws into the practice with a particular patient. This method strengthens supervisees' internalization of ethical principles more than any lecture (Koocher *et al.* 2008).

The importance of the ethical perspective in psychotherapy stems from the very content of the field. Therapists have to implement an ethical approach to work within the most fragile areas of human experiences, such as pain, hope, self-esteem, love, and disappointment. Because the therapist's work is relatively unchecked, their conscience is crucial for the therapy. Ethical issues and responsibility for one's behaviour compel the therapist even with insufficient theoretical or practical experience (Holmes & Adshed 2009). However, an ethical view is included even in common, routine practice. An ethical level can be discerned in every intervention, interpretation, attitude, and even question or non-verbal expression (Holmes & Adshed 2009).

Kamila is a therapist in her 30s and has not had a relationship with someone of a similar age. She has only had relationships with older married men in her life. Currently, she is interested in her superior, the head psychologist. Her father cheated on her mother several times, which was considered normal in the family. It was always blamed on the woman. Kamila has a patient with agoraphobia in therapy. Interviews with the patient and the composition of the conceptualization revealed that she had been dependent on her husband for fifteen years. The patient would like to become more independent from her husband; for example, she would like to be able to arrange things on her own, go to a friend without asking her husband for permission to do so, fall asleep easily in the evening when her husband is late at work or with friends. The therapist learned much from colleagues, particularly about treatment strategies, yet her

unresolved personal issues repeatedly entered her therapy. The demonstration shows that even though the therapist knows the strategy and the general essence of agoraphobia, she avoids the essentials and tries to offer the patient what she might do in her place. The conceptualization does not fully capture the essence of her patient, mainly because the therapist considers this a partnership problem and not a problem of basic self-evaluation.

Patient: You know, I would like to be more independent – go shopping, go to the office, stay home alone, enjoy time with friends more, etc.
Therapist: Yeah, you planned that very nicely. I like it. Nevertheless, maybe you should also consider being with your husband.
Patient: What do you mean? We have been married for fifteen years, and we have two children.
Therapist: Well, you said he has been annoying you lately and has even been on more business trips.
Patient: Yes, but I am just bothered to be home alone.
Therapist: Well, it does not raise your concerns about how he started going on business trips. I know how it is with those men who start spending time away from home.
Patient: But Petr would never cheat on me. He has me, the children, and he is successful at work.
Therapist: I am not saying anything; I would guess your agoraphobia may be related to your need to have him more at home. You do not know how to tell him.
Patient: (sadly) Well, I do not know. I cannot believe it.

From the above example, it is clear that the therapist projected her experiences with her relationships onto the patient's relationship with her husband. Her maladaptive attitudes and beliefs that men are unfaithful to women when they go on business trips were activated. She also mistakenly hypothesized that the patient needed her husband to handle everyday things. This demonstration shows that this specific therapy process does not maintain the ethical principle of caring for patients' well-being and protecting them from harm. Such situations can be and often are dealt with during supervision.

Ethics and the therapeutic relationship

In addition to being the main tool of psychotherapy, the therapeutic relationship is also the most common source of negative effects. This emphasizes the need to cultivate one's personality (Mrazek 1983). Ethical reflection is a process that stems from the therapist's deeper attitudes and values. Attitudes and values of an individual or a group significantly influence the therapeutic process, the choice of strategies and behaviour towards the patient and often operate at unconscious, unreflected levels (Prasko 1990). Being aware of one's attitudes and ethical dimensions and how they affect practice is one of the important skills of a responsible therapist. The main ethical issues concerning the therapist himself fall into two categories:
(1) Inappropriate personality traits of the therapist;
(2) Shortcomings in therapist's skills and training.

The therapist might have inappropriate personality traits. Hadley & Strupp (1976) named:
(1) Clinical decisions are based on their needs, although perhaps theoretically rationalized
(2) Excessive need to change people
(3) Cold or obsessive features
(4) Exaggerated unconscious hostility (often masked by diagnosing the patient with a more serious diagnosis)
(5) Seduction or, conversely, lack of interest or warmth
(6) Negligence, pessimism, absence of truthfulness
(7) Greed, narcissism, lack of self-examination/ reflection

Even if the therapists do not directly contribute to the negative effect of psychotherapy, they should be able to say when the treatment or other variable creates a negative impact. The therapist should also be able and willing to take appropriate countermeasures. Deficiencies or problems in the therapist's personality can lead to inadequate recognition of transference manifestations, early detection of unconscious conflicts without providing concomitant support, or both. Self-reflection is one of the basic competencies of a psychotherapist (Prasko *et al.* 2012a). The therapist should not underestimate their reactions to the patient but rather formulate them honestly and deal with them. According to Hadley & Strupp (1976), the therapist's hostile "countertransference" to the patient can be expressed in various ways:
(1) Lack of respect for the patient's suffering;
(2) 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.

The therapist's personality is the main tool of psychotherapy. Therefore, the relationship to oneself, self-education, personal and professional growth and self-concept belong to psychotherapy ethics (Rican 1983). According to Eis (Eis 1987), being able to take responsibility for oneself requires:
(a) That the therapist does not "stagnate, stiffen" in their personality potential
(b) To reflect on everything that happens because the therapist has the motives for each act in the psychotherapeutic relationship
(c) Undergoing supervision
(d) Education to understand the broader context.

The standard in psychotherapy education should follow a triad: self-experiential training, theoretical study and supervised practice. Training and supervision are the

main defence against bringing personal issues into therapy. Further emphasis is placed on psychotherapist's broader and deeper education (Mrazek 1983). A comprehensive education creates a base for the relative independence of the psychotherapist from the randomness of the local cultural, geographical and historical situation. Knowledge of different social strata and age groups is as important as knowledge of techniques and theory (Rican 1983).

ETHICS IN COGNITIVE BEHAVIORAL THERAPY

A good therapeutic relationship includes trust in the therapist's competence and morals on the patient's part and understanding and acceptance of the patient on the therapist's part. The patient's internal and external activity should gradually become more and more autonomous. Changes occur during psychotherapy. The patient consciously strives for some of them, some are only assumed, and some are not even consciously wanted, but they result from their growth process.

For example, relationships may change when patient begins to assert themselves openly and confidently. On the other hand, their former behaviour might have been more pleasant and acceptable to the surroundings. They may also lose some of the relationships they cared about due to the changes they have gone through (Vyskocilova & Prasko 2013a). Without empathy and understanding of the whole context, the therapist's ethical decision-making in guiding the patient is challenging because they must examine the implications for both the patient and others (Harris 2011).

The development of reflection is particularly important, considering studies that show that 60 % of clinical psychologists work when they feel uncomfortable and ineffective (Pope *et al.* 1986). Training clinicians to focus on their emotions and self-reflection is likely to improve their ability to recognize their discomfort and thus prevent a negative impact on their patients' well-being (Vasquez 1992). There are three main aspects of conscious self-reflection: (a) self-awareness; (b) self-assessment as a process and the outcome of that process; (c) observable behaviour or external manifestation of the "me" (Hupková 2010). As a vigilant observer, this kind of attention impartially accepts everything that passes through consciousness. Self-reflection is not attention carried away by the emotions that control the action but rather attention that maintains a neutral "observer" attitude that can keep self-reflection even in a whirlwind of turbulent feelings (Hoffart *et al.* 2006). The term metacognition denotes awareness of one's thought and attitude processes, and meta-mood implies understanding one's emotional processes (Wells 1997).

Self-reflection training is especially important for beginner therapists because it is a skill that also helps to develop critical thinking and ethical decision-making (Gardner 1980, Prasko *et al.* 2021b). Here is an example of discovering an ethical perspective during supervision

Radek: I do not think there is anything I can do with that patient. She has a personality disorder; she has already broken up her family. She had a child when she was very young. Anyone who got stuck over her and was kind to her paid for it in the end.
Supervisor: I understand; you do not feel like she can be helped in any way. It sounds like where she comes from; she destroys everything... is there any way to understand why she is doing so? What happened to her life?
Radek: Well, she did not have a very good childhood, but she did not have many friends or family caring for her. That is not a reason to destroy her surroundings. Even in the ward, she immediately conflicts with fellow patients and nurses, and I think she is full of anger.
Supervisor: You may be right when she behaves like that ..... I am just thinking, and I wonder what happened to her that makes her so aggressive?
Radek: Um, I do not know exactly ... it is just that her mother and father were very critical of her, but I do not know more specifically... I focused mainly on what is happening here and now… I did not collect much history on the patient's childhood ..... which is a pity ... Well, now I do not understand why she is like that .. .. for some reason, I did not do a proper conceptualization... it annoys me now ...
Supervisor: Sometimes, we get angry or unsympathetic to a patient, which can stop us from fully understanding them. Nevertheless, Radek, I have to say that I like your honesty and that you can admit it.
Radek: You are right, and I am ashamed. I have already formed an opinion of her according to parents and according to what she said about her husband, a prejudice that she's actually bad ... and I also felt angry with her, so I didn't examine the childhood or the causes of her behaviour... I just thought that if my wife did to me what she did to her husband, I don't know ... I would either leave her or I would leave the relationship. So I got mad at her.
Supervisor: You seem to have projected a bit of yourself into her story ... sometimes it happens to us ... do you think it has any effect on how you understand it?
Radek: I am saying I completely misunderstood her. I guess it's a transference ... I didn't realize it at all .... I'll try to discuss her childhood properly with her and look at her without prejudice, without reflecting on my own marriage...
Supervisor: This is a perfect observation. Well done! I keep my fingers crossed for you - you have been able to admit it and stopped rationalizing your attitude.

It can help increase self-reflection if the therapist does not suppress their emotions but accept them (Greenberg 2007). Suppose the therapist cannot capture the emotions of their surroundings or supervisor signals. It is better to ask questions: I know such feelings in a situation where similar feelings occur in my colleagues, how they experience them, how they evaluate them, and how they deal with them. Anxiety, sadness, helplessness, and anger can be a great compass for thera-

pists to better understand themselves (Kimmerling *et al.* 2000).

Self-reflection can open us to others, especially when expressing it (Shafranske & Falender 2008). It allows us to show what we hear in response to others, allowing for a path to open sharing. In self-reflection, one usually takes care of oneself, but it almost always involves interaction. If we can embrace it, others perceive it as respectful towards them. Therapists who regularly practice self-reflection gradually improve their self-reflection ability.

Self-reflection is an important component of the growth of a supervisor's clinical skills (Sutton *et al.* 2007). Therefore, supervisors must enhance the self-reflection ability of supervised individuals. Unfortunately, it is more common for supervisors to automatically focus on the technical components of the therapy they are evaluating and forget the importance of the supervisor's self-reflection. However, it seems obvious that if we do not pay enough attention to the supervisor's self-reflection in supervision, a patient's misunderstanding may remain trapped, and therapy may fail (Bernard & Goodyear 2004). Barriers to self-reflection hinder the understanding of countertransference processes, and they may limit one's capacity to create a quality therapeutic relationship because the therapist is unaware of its role (Prasko *et al.* 2010a, b). No matter how well-trained, all supervisors can benefit from a greater focus on self-reflection (Orchowski *et al.* 2010). Self-reflection must be like a daily physical exercise routine for the therapist and supervisors.

Ethical issues in CBT related to transference

Good psychotherapeutic practice must avoid complementary behaviours, such as responding to a patient's aggression, favouring loyal patients, and abusing overly committed patients (Goldman & Gregory 2010). Such complementary behaviour is usually unethical and is dictated by countertransference (Prasko & Vyskocilova 2010). Psychotherapy raises many other ethical issues (Gabbard 1994, Holmes & Adshed 2009, Vyskocilova & Prasko 2013a, Vyskocilova & Prasko 2013c). Ethics based on bioethics principles can be a basis for their systematic organization (Robertson *et al.* 2007). The four main principles of bioethics, formulated in general by Beauchamp (1994): ((1) autonomy; (2) beneficence; (3) non-maleficence; and (4) justice; they can serve as a basis for asking questions in psychotherapy if the therapist can ask them specifically in a complex, dynamic, highly personal, often unclear, and context-dependent process (Jain & Roberts 2009).

Transference can facilitate or block therapy and lead to resistance to change (Williams 1997, Leahy 2003). The therapist's excessive unreflected transference and complementary countertransference can psychologically harm the patient. Supervision can help significantly if it leads the therapist to self-reflection and ethical reflection concerning a particular patient (Prasko *et al.* 2012a, Prasko *et al.* 2012b).

Transference and autonomy

An important aspect of therapy is helping the patient be as independent as possible (Rogers & Dymond 1954, Holmes & Adshed 2009). Although a natural part of all relationships, transference means limiting the patient's autonomy - something is happening in the relationship that the patient does not understand. At the same time, it affects their expectations and behaviour. Addressing and processing transference usually increases the patient's autonomy concerning the therapist and other relationships – they understand themselves and their patterns in experience and behaviour towards others more and can therefore decide more freely how it will work in relationships.

Therapist: Last time, we discussed how some of the criticisms associated with the need to be one hundred per cent perfect, which stem from your mother's experiences, relate to expectations and behaviour towards your friends. Do you think that we can work on this today?

Patient: I thought about it, and at home, I worked out, as we agreed, the advantages of my request for perfection and its disadvantages. I found both. It has many benefits for me at work because the boss appreciates me. On the other hand, I am still tense not to make a mistake. I stay at work for a long time and work in the evenings and at home, which bothers my boyfriend. It has many disadvantages in a relationship because I still check what I am doing well and what I am not, whether I am a good enough partner, lover (?), or beautiful enough for him. It is just too much. Nevertheless, he is the same, so we often have crises where we blame it on the other's imperfections or cannot talk because we are too proud or offended. Maybe if I cut it somehow, he would change too, but I do not know.

Therapist: We can try to work on it. Now you are mainly talking about a relationship with a boyfriend, last time more about a relationship with your mother. It is up to you where you want to start… This expectation of perfection has probably been created and strengthened with your mother, and there is perhaps a similarity in the relationship with her. With a boyfriend (?), it interferes with your current relationship. Both can be important… Consider which relationship you would like to start with… discuss it more and understand it… a greater understanding and change in one relationship will probably affect the other relationship… and as we said last time, it also interferes with what you expect from me, that you have to do everything perfectly.

Patient: I probably would rather start with the relationship with my boyfriend because I am with him every day - I do not see my mom often now that she has found a new husband and moved away. And with you… you are right that I want to be perfect in front of you, but when we talked about it last time, now I do not have to… so much… I cannot change it right away…

Therapist: Perfect! I am glad you decide for yourself what you want to work on now and think about it independently, without immediately considering what I think about it…

Patient: Um, it is more complicated… I do it too because you want it from me, and I want to be perfect in front of you / laughs /….
Therapist: … and you do it with distance and humour….

Transference and beneficence

The basic question is whether the transference relationship can be used to the patient's benefit, either reflected or unreflected (Leahy 2003). This question may not be as simple as it seems because, with the therapy's unreflected slightly positive transference relationship, the patient is working on their goals and is not interested in the transference relationship. The fact that the therapist's abilities are somewhat overestimated has a motivating effect (Prasko *et al.* 2010). Reflection of the relationship with the therapist and elaboration of the transference usually leads to a prolongation of the therapy with a greater financial expense to the patient, i.e., the possible profits for the therapist. At the same time, it does not significantly influence treatment goals.

On the other hand, therapy that works with a therapeutic relationship is considered "deeper". It can improve the patient's relationships with important people and help them understand their relationships, which is a significant added value (Horowitz & Möller 2009). However, the question is whether the patient considers their relationships satisfactory or wants to work on improving them. The most important thing here is the patient's free choice if the therapist offers it to them in this situation (Jain & Roberts 2009, Nguyen 2011); however, it is debatable whether the patient can decide freely when they are more or less dependent on the therapist., The therapist's wishes can bind them (Vyskocilova & Prasko 2013c).

Transference and non-maleficence

Like other treatment methods, if incorrectly used, psychotherapy can be hurtful or harmful (Pope & Keith-Spiegel 2008; Nguyen 2011). It can also have undesirable psychosocial side effects that cannot be determined. Transference can block therapy and lead to resistance to change, and the therapist can also abuse it (Martinez 2000, Jain & Roberts 2009). A conscious abuse of transference by a therapist (dissocial motive) or an unconscious abuse (countertransference motive) can occur (Gutheil & Gabbard 2003).

The conscious abuse of patient transference is typical of therapists with antisocial personality traits who are aware of the patient's transference relationship and take it for granted that they can use it to their advantage (Gabbard 1994; Gutheil & Gabbard 2003). This abuse can be inconspicuous, for example, taking advantage of the patient's profession, connections, etc. or outrageous, for instance, in the sexual abuse of the patient, free work, financial loans, etc. (Malmquist & Notman 2001).

Semi-conscious or unconscious abuse of the patient's transference occurs more frequently in immature therapists or therapists with narcissistic, histrionic or borderline personality traits. Still, it may not always relate to the therapist's personality. However, it is almost always a blind spot (Gabbard 2009). The conscious abuse of the patient is usually associated with a personality disorder. The therapist either rationalizes their behaviour as narcissistic, histrionic, borderline, anankastic or dependent therapists or considers abuse to be their right (dissocial). It is associated with rules-based ethical decision-making (Martinez 2000). Suppose a therapist decides to benefit from a therapeutic situation. In that case, they tend to allow it more and more often while crossing boundaries. Then it can become a "normal" approach to therapy. The rules set boundaries, especially where the therapist may not know they are dealing with delicate issues. Dealing with the risk of crossing borders is part of ethical reflection. Crossing borders can be found in several subcategories (Gutheil & Gabbard 2003): (a) potentially harming the patient; (b) potentially beneficial to the patient; (c) the presence or absence of coercive or abusive elements in crossing the border; (d) the interests or motives of the professional outweigh the interests of the patient; (e) the presence or absence of the therapist's desire to behave ethically; and (f) border crossing circumstances. The border crossing itself can be further divided into several subtypes: (1) non-sexual border crossing; (2) invasions of privacy; (3) emotional abuse of the patient; (4) sexually motivated border crossings. According to the above general division into categories and types of border crossings, it is possible to think about specific therapeutic situations. Reflection using these categories helps to realize whether border crossing and unethical behaviour are involved, map out how the therapist is rationalizing it, change behaviour, and take realistic corrective action if crossing the border has had negative effects in the past.

Non-sexual border crossings can weaken treatment, disrupt the therapist-patient relationship, or lead to patient harm. Typical manifestations are: taking gifts from the patient, obtaining benefits related to their job or position, overpricing therapy, and unnecessarily prolonging treatment. Non-sexual border crossing can rarely help therapy, but it could temporarily strengthen the therapeutic relationship. Still, it usually means the therapist preys on the patient (Pope & Keith-Spiegel 2008). Non-sexual border crossings also include offering therapy that is ineffective for the problem. Alternatively, if the therapy is prolonged, although short-term guidance would be enough, the therapist is thinking about their income rather than the patient's needs and resources, which is a serious ethical issue. Invasion of privacy is another ethical issue. From primitive slandering of a patient in front of colleagues or facility staff or sharing information from private therapy that indicates the therapist's immaturity to more complex questions - how ethical it is to publish a case report if the patient does not know or will not allow it? What facts should be reported to law enforcement when they are

subject to mandatory reporting but would damage the patient emotionally or otherwise?

Emotional abuse of the patient is relatively common. Therapists with self-esteem or self-acceptance problems may tend to criticize their patients, point out their weaknesses, insult their failure to do their homework, moralize, communicate "honest truths", signify a diagnosis or relentlessly reveal a negative prognosis. These approaches gratify the therapist and falsely boost their self-confidence; however, they damage the patient's self-confidence. Emotional abuse usually occurs unconsciously and is related to the therapist's inexperience and lack of supervision. Similarly, a supervisor can emotionally abuse a supervisee. If emotional abuse occurs consciously, it is usually performed by a therapist/supervisor with a personality disorder.

Ethical reflection of the therapeutic relationship is possible only when the therapist realizes and conceptualizes the patient's transference and countertransference reactions. However, self-reflection must be complemented by asking relevant ethical questions. In mental disorders, we may encounter patients with a non-adaptive system of erroneous assumptions about others, which result in disrupted interpersonal relationships (Haskovcova 2002). The patient can generalize their previous unpleasant experiences to all people or authorities, even the therapist. Similarly, the therapist's relationship with the patient may be contaminated by transference or countertransference. In the case of the therapist's transfer to the patient, the distortion is caused by past experiences with people the patient resembles with some of their characteristics or behaviours; in the case of countertransference, the therapist responds to the patient's transference behaviour (Prasko & Vyskocilova 2010). It is usually difficult to separate the transference and countertransference components of the therapist's behaviour, so countertransference uses both phenomena. The therapist may be flattered or affected by the transfer of the patient, have a desire to help or punish the patient excessively, avoid it or pamper them (Pope *et al.* 1986; Robertson & Walter 2008; Gabbard 2009).

Ethical issues in CBT related to countertransference

Countertransference in CBT therapy can take many forms. The patient's appearance, behaviour, or other significant characteristics may activate the therapist's core schemes related to conditional rules and determining behaviour strategies in a given situation (Prasko & Vyskocilova 2010).

Suppose something arises during therapy involving dominance, prescribing, rigid adherence to the manual, or even coercion. In that case, it depends on how it is done (Luoma & Vilardaga 2013).

A typical situation is when the patient decides on a certain exposure, but they "back down" due to anxiety when they have to do it. Should the therapist be dominant at the moment and hold the patient at the exposure, or should they be more kind and postpone the exposure? This issue is, of course, also affected by the pressure that needs to be exerted. Suppose the therapist does not exert any pressure and lets the patient avoid the situation. In that case, they confirm evasive behaviour and delay the healing effect. After a similar situation is repeated several times, the therapy stagnates. Suppose the therapist holds the patient firmly to the exposure, uses their dominant position and does not leave the patient the possibility of autonomous choice. In that case, they strengthen the patient's feelings of subordination.

Do therapists have the right not to look at the patient's choice when they want to avoid exposure? Doesn't that ultimately humiliate the patient? Most therapists in a similar situation seek a compromise between authoritarian coercion and democratic preservation of autonomy. The self-reflection of one's own decision on whether and why a certain pressure needs to be exerted is usually related to the questions:

- How may the patient feel about this?
- Am I giving them enough space and freedom to decide without resistance or excessive obedience?
- What do I consider good?
- Is it also the best for the patient?
- Don't my goals and aspirations affect me more than their practical need?
- Is achieving the current goal more important for the patient (e.g., strengthening) than their self-awareness?
- It does not have to do with how I insist, with my own experience (as one of my parents insisted on me)?
- If someone pushed me like that, would I consider it right?
- To what extent can I be generous and tolerant?
- How big is the space that I can leave to myself without feeling limited?

In cognitive behavioural therapy, these issues frequently arise, with exposure therapy being a typical example. It is hard for the patient. Sometimes, even though they have already managed many steps, they suddenly no longer want to do so because it is too hard for them.

On the one hand, the therapist knows this is evasive behaviour, which the patient rationalizes. If left untreated, the patient is in danger of relapse. On the other hand, it is the patient's free choice if they have already achieved the basic practical goals. A similarly ambiguous situation occurs when transcribing childhood traumas in patients who do not have the strength to rewrite a painful childhood event. Is it appropriate for the therapist to listen empathetically and wait for them to realize the need to protect their "injured child" from the aggressor, or to tell them directly and transcribe a traumatic experience in which the therapist himself protects the abused child in the imagery. Does the therapist have a right to this at all? On the other hand, can a therapist leave a patient helpless and hopeless?

The form and intensity of countertransference can be affected by many circumstances. Including:

- Personality (traits such as humanity, composure, maturity, kindness, truthfulness, justice, patience, openness, congruence, preferences, values, self - transcendence, degree of self-reflection, burnout.)
- Attractiveness/unattractiveness of the therapist/supervisor (appearance, position, charisma, connections, reputation, amount of payment… etc.)
- Crossing roles (I meet a supervisor or attendant in another position - superior, subordinate, colleague, lover, close friend)
- Influence of the organization (attitudes of the workplace to certain problems (e.g., how to treat borderline patients), supervision, evaluation by the supervisor, loyalty to co-workers)
- Influence of education (teachers, theory, training and its doctrines, training…)
- Influence of family (well-being versus stress, problems and conflicts, similarity with patient problems, etc.)
- Life situations and problems (e.g., own divorce, problems with the insurance company, lack of time…)
- Other social influences
- Somatic influences (illness, fatigue…)

Countertransference, self-reflection and ethical dilemmas

We can capture the countertransference reaction in our behaviour, thoughts, and emotional and physical manifestations. The core of countertransference is the therapist's previous inadequate experience, which tends to transfer to current relationships. They lead to behaviour that can be evasive (lack of openness, congruence, withdrawal) or compensatory (excessive help, directive, giving advice, hiding behind psychoeducation, competition, showing off). This behavior is also related to the therapist's lack of psychological flexibility, reflected in the low ability of self-reflection in changing therapeutic situations (Wongpakaran & Wongpakaran 2012; Luoma & Vilardaga 2013). This makes it impossible to inspect and manage the countertransference and risks damaging the patient. Self-reflection or awareness of countertransference in supervision helps overcome the countertransference response and can be crucial for creating a more realistic relationship and objective work in therapy and supervision (Prasko & Vyskocilova 2010).

The basic principles of bioethics (helping, not harming, being fair and autonomous) inform the basic definition of ethical behaviour (Beauchamp 1994; Adshead 2004; Robertson *et al.* 2007; Crowden 2008). However, this context is not enough because it is general, and the therapist needs to evaluate their specific actions and intentions concerning these principles. Therefore, ethical reflection is always concrete; it reflects a certain behaviour, in a certain situation, with a particular patient, in a given broader context (Prasko 1990; Holmes & Adshead 2009, Vyskocilova & Prasko 2013b). Thanks to the anchoring in the basic principles of bioethics and the code of ethics, this reflection helps orient oneself within the defined boundaries. Being specific to the case can help you decide how to behave or allow you to choose from various pathways in a particular situation. Subsequent ethical thinking helps protect both sides in the therapeutic relationship (Barnett 2008).

Countertransference and autonomy

An important aspect of therapy is helping the patient be independent and self-directed (Holmes & Adshead 2009). Significant transference usually reduces the patient's autonomy - something happens to them in a relationship they do not understand. At the same time, it secretly affects their expectations, decisions and behaviour. If the therapist responds to the patient's transmission with a complementary countertransference response, they can maintain their dependence.

An elderly patient suffering from a generalized anxiety disorder admires a therapist. She is convinced that no one else can help her. She feels helpless and therefore asks the therapist for advice. The flattered therapist responds complementarily with countertransference, providing guidance. He is satisfied with himself, and he feels needed. The patient praises him at every session. However, the patient remains dependent. She still brings more and more problems, which she cannot solve, and the therapy does not progress. During supervision, the therapist reports this patient's resistance to treatment with lifelong guidance.

If, in a similar situation, the therapist develops the opposite countertransference reaction, this can happen, for example, as follows:

A patient with a depressive disorder develops an addictive admiration for the therapist. However, the therapist feels overwhelmed and frustrated by the needs of the addicted patient, confronts him with them, and uncompromisingly states that the patient has to figure everything out, suggesting he should not be dependent on other people. A patient who cannot function without clear support falls into despair and attempts suicide.

For a therapist to help the patient process their transmission response and help them increase autonomy not only concerning the therapist but also in other relationships, it is necessary to understand and process countertransference. Otherwise, they remain blind and often unable to clearly understand their patient's transmission in all its consequences.

The patient worked very hard with the therapist and achieved partial success in treating agoraphobia. However, during the treatment, he fell in love with his therapist. He tried to show how well he managed the individual exposures. Because the more demanding exposure travelling outside the city increased his fears so much, he stopped doing them. He could not admit it in therapy.

On the contrary, he lied that he could handle them. The therapist is excited about his success. She notices that the patient responds to her more than usual; he brings flowers at every session and smells noticeable of men's perfumes. She does not consider these signals important when treatment goes so well. She is surprised, startled and angry at the patient's wife. The last call was that she would like an advice on how to help her husband go on holiday to the other end of the republic when he has not yet been able to leave the city.

Countertransference and utility

The therapist's transmission response may hinder the patient's benefit, causing the therapy to stagnate. Countertransference therapy can be superficial and also excessively prolonged. Conversely, reflected countertransference and processing of the transmission relationship induced countertransference can break the patient's resistance and positively affect other relationships outside the therapy itself (Horowitz & Möller 2009).

A patient with generalized anxiety disorder fell in love with her therapist during therapy. Like she has fallen in love with her teachers and job leaders in the past. She describes herself as having a "weakness for older men." During the session, the therapist sensed her long glances, striking sighs, and occasional dreams. Because the therapy went very well at first. The patient learned to relax, shared several catastrophic scenarios, developed coping strategies that reduced excessive worries and anxieties, and learned to communicate better in problematic situations at work. The therapist considered the developing erotic transmission to be more positive. The patient did all the homework and relatively easily achieved the goals. The admiration the patient showed was pleasant to the therapist. All the more so because he was going through a crisis in his marriage; however, treatment began to stagnate when they got to work on a marital problem associated with the development of symptoms.

The patient said her husband was uninteresting, too young and still immature. She could not be his mother. She did not love him anymore. She thought she would divorce, etc. This contrasted significantly with the goal she set at the beginning of treatment - to argue less with her husband, better understand him and herself in the relationship, and enrich the connection with common enjoyable activities. The therapy stagnated, becoming a "chat", quite a pleasant meeting for the patient and the therapist. They discussed the novels they liked, sometimes the work situation, and how the children were doing. The therapist gradually began to confide in his patient. However, in a situation where she suggested that they meet for a "chat" in a cafe, he realized that they had gone beyond the boundaries of therapy. He decided to go under supervision with this therapy. At first listed what all worked out, then admitted that the therapy is now stagnant. Still, the patient is well. She manages the job and the household. She is no longer anxious. She is only in a marital crisis, so she needs support before she goes through the crisis. However, during the supervised discovery through the supervisor's questions, he realized that the patient's complaints made him feel very well and did not want to give it up.

Moreover, he felt her support when he talked about his fatigue and overwork. He did not receive any such support at home. On the contrary, his wife blamed him for still being at work. He gets the patient's support instead of helping her solve her marriage problem. During the supervision, he considered how to change the situation. He didn't want to admit his countertransference to the patient. It would be better to discuss its transmission sensitively and lead it to the past analogy of relations with authorities. Nevertheless, when he wondered how his patient would feel, he realized that he could be embarrassed and hurt by "just throwing it at her." It would also be unfair as he had developed its transmission with his counter-transmission. He decided to tell the truth - she would say what she felt on her part, then how pleasant it was for him until he confided in her, and thus they deviated from therapy. He apologized for this and asked her to say how she experienced the relationship. If she told him that she loves him and asked if he loves her too, he would say that he values her and respects her as a person, he likes to do therapy with her, but he is not in love. This may hurt the patient, but perhaps the pain will dissipate if she is willing to discuss it further. Then they can deal with how it happens to her in her relations with the authorities and what disappointment she experiences. Also, it may prevent her from having a bad relationship with her husband. They then played this approach with the supervisor in role-playing.

Countertransference and do no harm

Harm or long-term adverse effects of therapy have not been empirically studied enough. The systematic synthesis of qualitative research and service user testimony (Curran *et al.* 2019). results show that adverse effects had nine domains: contextual factors (e.g., socioeconomic factors, lack of information), pre-therapy factors (e.g., poor pre-therapy contracting, experiences of previous therapy), therapist factors (e.g., financial interest, attitudes, person of the therapist), client factors (e.g., demographics, lack of understanding), relationship processes (e.g., negative countertransference, power, pseudo alliance), therapist behaviours (e.g., persecutory therapist style, malpractice, inappropriately applying techniques, poor self-monitoring), therapy processes (e.g., types of therapy, high rates of transference interpretations), therapy endings (e.g., unprepared).

A therapist, a young woman who has experienced sexual abuse in her youth, works with minors and children. She believes that her experience does not interfere, although she has not addressed it in the self-therapy process. If a client has been sexually abused, the therapist will ask her client to go very deeply into the details of the incident repeatedly. Even if the client resists, the therapist insists on retelling. Teenage clients have complained to their parents that they do not like to repeat details and do not understand why, also often do not want to attend sessions anymore. Children of younger parents also expressed dissatis-

Tab. 1. Record of ethical reflection

Situation	Questions	Answers
The patient says that the therapy does not help them in anything	*Pre-therapy factors*	
	• Do my patient's expectations of the therapy (duration, process) meets with my view? Did I give clear information about that at the beginning of the therapy?	• His and my view of the therapy, e.g., durance, the process does not meet, and he feels disappointed.
	Relationship	
	• Is there something in the patient's relationship with me that may be related to their reaction? • Does the relationship we have formed help them or not?	• He probably admires me uncritically, so he becomes less independent, believing that he makes worse decisions on their own. • The relationship thus formed begins to hamper them in autonomous decision-making.
	Therapist behaviors and therapist factors	
	• Is there anything that can harm him? • Do I allow them to be sufficiently autonomous? • Am I not using it for my purposes? • Am I not pushing something for him, pushing me into my own decisions rather than his? • Is it appropriate to work on our relationship, or is it self-serving or more for me?	• As a result, it reduces their self-confidence in the long run. • I do not allow it, and I do little for it. It makes me feel good that I am "omniscient". • I use it for the needs of my gratification. • I decide as it would suit me in my complacency and pay little attention to their possibilities. • I must work on our relationship and pay attention to the client's needs, not my gratification.
	Therapy Process	
	• Do emotions are generated with meaningful resolution?	• I have to be more aware of whether my interventions which generate patients' emotions meet therapy goals and strategies.
	Therapist factors	
	• Am I flexible enough in the therapy? • Do I use this therapeutic relationship to prolong financial benefit?	• My personality traits like stiffness to rules can reflect inflexibility. • Prolonged therapy results in financial benefits for me.

faction with the therapist's work, as children sleep worse after treatment sessions and cry more.

The therapist has an initial unconscious reaction to her client's sexual violence experiences based on the therapist's unsatisfied psychological needs, which should be explored and elaborated on.

Countertransference and justice

Abuse can be emotional when the therapist solves their emotional problems at the expense of the patient, releases their tension, recommends solving problems in a way they cannot do in their own life, uses the patient for their gratification, lead the patient to praise them, enjoys their incompetence, helplessness, dependence to make them feel powerful, admirable. They can also use a session to discuss their problems and show how they solved them.

In the case of economic abuse, the therapist uses the patient's economic or social opportunities to their advantage. This can be reflected in a huge amount of therapy fees, extending therapy beyond the patient's needs, gaining material benefits from the activities the patient carries out and using patient connections. Economic abuse often seems like "friendly help" and is quite inconspicuous in a morally displaced society. The therapist usually rationalizes it, and the patient considers it normal.

Ethical reflection and self-reflection

Our evaluation of ourselves and others is always influenced by our attitudes, wishes, ideas and needs. Our relationship with others and ourselves in the moral assessment of behaviour can modify the evaluation. When a rule is violated, a "noble" explanation or "necessity" is usually added to our actions and those of the people we care about, while for a person we do not care about or who makes us angry, we automatically apply the rating "no good".

Self-reflection can also open us to others, especially when directly expressing it (Shafranske & Falender 2008). It allows us to publish what we hear in response to others, creating a path to open sharing. One usually takes care of oneself in self-reflection, but this almost always involves interaction.

However, one can change one's personality during professional practice, for better or worse. The biggest problem is when a person working as a psychotherapist becomes emotionally cold, most often caused by burnout.

When discussing different opinions with different people, the same issue can evoke different feelings, often stimulating self-knowledge (Plog & Dörner 1998) and forming good supervision. The conversation is conducted in a way in which the feelings of the other can be accepted as equal, and not in such a way that one is right and the other is not. It allows for internal

discussion and forming one's own unforced opinion. Thinking about oneself and one's connection with the world, including therapeutic work, is the starting point of the attitude that leads to self-reflection. Self-reflection is one of the basic competencies of both therapist and supervisor. It needs to be constantly used to update practice. Otherwise, its quality may be lost. The supervisor's self-reflection acts as a model for the supervisee. It does not reinforce addiction, but it teaches deeper introspection and better self-knowledge in interacting with others, especially patients. Self-reflection is one way to protect the supervisee from uncritically accepting the supervisor's understanding. Therefore, the courage to self-reflect and the aptitude to ventilate should be strengthened during supervision. It is appropriate to express respect for deep self-reflection because it is respectable. Self-reflection is a process that can never end.

An experienced supervisor can help to deepen self-reflection and ethical reflection (Markowitz & Milrod 2011; Watkins 2012). However, a quality supervisor usually offers other questions that will deepen the conceptualization of the therapeutic relationship and the understanding of the supervisee's motives in a non-critical, revealing form.

SUPERVISOR ETHICS

The supervisor strengthens the courage for self-reflection and the ability to ventilate it. There is a similar process in supervision, although it is a bit more complicated because the main goal is to help a patient not present in the supervision session.

The supervisor also necessarily has to open himself to the supervisee repeatedly. Otherwise, the supervisee has no pattern of doing it and usually no courage to do so (Koocher *et al.* 2008). How about being a self-opening supervisor? The degree of self-opening during supervision should be defined in the contract. Different therapeutic approaches require different degrees of self-opening by the supervisor during supervision. In psychoanalysis during supervision, one's childhood experiences are linked with a transfer to the supervisor and counter-transfer to the patient. Wide self-opening, including serious injuries and open talking about intimate things, is considered normal. However, most psychotherapeutic schools limit personal therapy in supervision in some way. Only the supervised case is discussed, and open discussions about the therapist's problems (sexual history, traumatic experiences, relationships, etc.) are considered outside the supervision's limits (Koocher *et al.* 2008). Not only does it not ask for it, it even forbids them as exceeding the limits of supervision and considers them problematic. It requires written informed consent in advance (Koocher *et al.* 2008). Exceptions, however, often occur because, for some supervisors, personal history interferes with treatment to such an extent that it is impossible to leave it uncorrected. The supervisor is also sent for individual psychotherapy by someone other than the supervisor (Falender & Shafranske 2008).

Justice and self-reflection

The therapist's self-reflection focuses on their own experience concerning the therapy itself.

There are many questions that a therapist can ask about justice.

- What should I have, what do I need, and what can I do? What is ideal, what is possible and what is optimal? If they are experienced, most therapists know how therapy could work ideally. Still, they are also mindful of their limits and circumstances, which they do not want—considering what the therapist should do because the patient needs it and what must be done. Otherwise, the therapist would harm the patient. What are the limits of doing 'additional' interventions for the patient, if possible?
- Is the therapist able to offer the patient what they need, or whether the therapist happy to have a patient in therapy? The motivation for therapy may be to help the patient and the need to have a case report for training to increase one's self-confidence and inability to say no. Justice issues also concern the length of therapy, which may be related to trying to have a long-term stable income or, conversely, to get rid of a patient with whom work is strenuous or not very empowering.
- How to manage your options? Our possibilities and abilities are limited, and this also appears in psychotherapy. This leads to many ethical pitfalls, such as promising therapy for which we do not have time or offering unrealistic goals to encourage the patient, which they cannot achieve. The options offered are promises that lead the patient to disappointment when they are not fulfilled.
- Am I not in the countertransference? One of the most important areas of self-reflection is countertransference awareness. Does the therapist punish the patient or overestimate them for unimportant things? What leads the therapist to this? Am I angry with them that therapy is not running as easy as I would like? Am I trying to help them, or do I need to flatter them so they like me? Am I not punishing them because I am angry with my partner and need to release my tension? I do not lead them in therapy to goals I would like to achieve myself, but I do not dare? Isn't it my project instead of solving my problems?

Ethics and supervision

The term "supervisor" is easily linked with the notion of the superiority of someone who is "above" the therapist, someone who is better, has power, control, knowledge, and competencies that go beyond the therapist (Pope *et al.* 1986). This leads to fear of the supervisor as an authority who mainly looks for mistakes, draws attention to shortcomings and embarrasses the

therapist. Conversely, someone who knows everything and answers all the questions can solve all the problems. If the supervisor suggests something like this, they miss the important ethical principles for supervision. The supervisor is not "above" the therapist, and they collaborate to find the best path for the patient. The supervisee should be able to present their mistakes, uncertainties, and attitudes without fear of shame. The basic attributes of supervision ethics are (Prasko *et al.* 2011):

(a) usefulness and well-being for the patient and the supervisee;
(b) not to harm in the first place;
(c) conciseness, accuracy (contract loyalty);
(d) justice between therapist and patient (not to be abused);
(e) protect but not save;
(f) autonomy and the right to vote;
(g) self-interest, awareness of one's needs, the art of judging what I can still bear and what I cannot;
(h) usefulness and well-being for the patient and the supervisor.

The therapist comes to supervision angry at her patient. She is a psychiatrist who is at the beginning of her psychotherapeutic training. Today, she wants supervision advice on ending therapy with one patient with a personality disorder.

Suppose the supervisor conducts the interview morally because he thinks the therapist is inexperienced and incompetent when she wants to remove the patient. In that case, the discussion may look like this:

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

Supervisor: And you don't consider how your patient will feel? Do you think we can do this to patients?

Therapist: (ashamed) Well, you're probably right, so I'll keep him, but I don't know what I will do because he annoys me, and I still don't think anything will help him. It is a personality disorder.

Suppose the supervisor perceives this as an ethical issue, the therapist's uncertainty. In that case, they could help the supervisee discover the motives of the idea to cancel the therapy with this particular patient. The supervisor should act in the best interests of the patient. The interview could look like this:

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

Supervisor: Oh, you're angry with him and don't want to do therapy with him? What bothers you about your client's personality disorder?

Therapist: Well, I think it's a waste of my time. I cannot progress in therapy with a person with a personality disorder!

Supervisor: I understand that. Furthermore, what does it mean for you to help someone with a personality disorder?

Therapist: Well, she will leave in two months and never return.

Supervisor: Yeah. How do you feel when a patient improves, leaves and does not return within two months, and when they do the opposite?

Therapist: Well, I feel like I have done much work, but when someone is there for a long time or comes back, I feel like I'm not good, that I screwed up, that I didn't do what I had to do. I do not want to do the therapy, and I have no idea what to do with him.

Supervisor: So, if I understand correctly, it's not that a person has a personality disorder, but rather that you're afraid that you would have to do something more with him, and you will not know what?

Therapist: Exactly. I felt like I needed some help from an experienced colleague at that moment.

Supervisor: So, if you know the advice, would you keep the patient with a personality disorder in therapy?

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

Supervisor: What about anger at him?

Therapist: Well, the anger comes due to my incompetence.

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

Therapist: Well, I guess I need to say that it will take a long time, but nothing may happen. That is just the case with them.

Supervisor: You are thinking about it. Is there anything else you need when you think you've exhausted all strategies with it? Try to think about what helps you with other patients who may not have a personality disorder.

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

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

Therapist: Well, I should probably go back to the fact that he came back because he has a stronger attitude than others without a personality disorder, rooted in his attitudes and maladaptive behaviour, and that's why he came back. Maybe this would help me because I would not turn it on myself and my incompetence, thus not annoying him and blaming him for coming again or that the therapy was not going as fast as with others.

Supervisor: Oh, good. So, Petro, if I go back to your order to get rid of a patient with a personality disorder nonchalantly, is there anything that gave you the answer during our conversation?

Therapist: Well, I don't think I should give up on him so quickly. I probably understood that it wasn't about the diagnosis but rather the intensity of those emotions and patterns. But maybe I should go to supervision more often, because I don't know if my attitude will last long (laughs).

Supervisor: I understand, and it's up to you. Supervision can indeed help us believe that working with personality disorders is difficult. Still, it pays off, and it may not be so much that we fail as therapists.

Therapist: That's the fact that when I think about it like that, that's what I'm probably taking away today. I'm reassured that I might be able to do it.

Supervision should help make therapy useful and effective for patients. Well-treated patients, relieved of their problems, are the therapist's best business card, and supervision can play a significant role in this outcome. A non-burnt-out therapist, satisfied with their work, which he performs beneficially for their patient, is a goal their supervisor can contribute

to (Falender & Shafranske 2008). One of the main ethical principles of behavioural therapy is that interpretations are not presented to the patient as facts but are rather proposed in the form of testable hypotheses by empirical methods. They believe the claim of some other psychotherapeutic schools that they are effective in treating certain diagnoses without being empirically demonstrated to be a dishonest claim (Prasko *et al.* 2011).

(a) Do not harm in the first place (non-maleficence)
The patient is not the experimental object of their therapist, just as the therapist is not the experimental object of their supervisor. Supervision should always consider any participants' possible dangers of emotional or health damage. One of the most common sources of injury is an unreflected countertransference relationship, especially when excessive criticism, branding, anger, rejection, emotional exploitation, crossing borders and crossing roles appear in it (Prasko *et al.* 2021a).

(b) Conciseness, accuracy (contract fidelity)
The therapist and the supervisor enter into a contract at the beginning of the supervision, which should be factual, and specific, describing the therapist's needs while taking care of the needs of the patient and the supervisor. A therapist sets out the contract, and the supervisor helps him specify and formulate it or realize the hidden part of the contract. The contract should always result from the therapist's needs and may be reformulated and clarified several times during a supervisory meeting.

(c) Justice between therapist and patient (not to be abused)
If it is clear that there is any abuse of the patient, the supervisor will point it out and provide negative feedback. The supervisor should help the therapist clarify the boundaries of the therapeutic relationship and help even if the patient abuses him. Creating ethical sensitivity includes developing a critical awareness of the impact a therapist's behaviour has on the patient, the courage to make ethical decisions and tighten them when overcoming external resistance, for example, greedy interest, family manipulation, or internal, for instance, countertransference, fear of rejection, need to impress. The supervisors pay attention to the supervisory relationship's boundaries and do not take responsibility for the therapist's decisions. The supervisor must not abuse their power over the therapist for their benefit.

(d) Autonomy and the right to choose
Supervision cannot be imposed or dictated on the supervisor; the therapist has the option of free choice (Greben & Ruskin 1994). They have the right to choose their supervisor freely, and the supervisor has the right to decide whether to supervise the trainee or therapist freely.

(e) Self-interest, awareness of one's own needs, the art of judging what can and cannot be abducted
Therapists' stress comes from patients and can be related to attitudes, demands on themselves, the organization, and the supervision itself. Unrealistically high expectations can create fertile ground for later disillusionment and apathy, and supervision should help protect against burnout. The therapist needs to take responsibility for noticing their overload and unmet needs and learn what they can still bear and cannot.

Codified ethical principles are now a matter of course for many professional organizations and scientific societies. For example, the Czech Psychotherapeutic Society's Code of Ethics. They were created to name priorities, set ethical boundaries, and identify potential risks and frictions in professional activities. It is similar to supervision. Ethics in supervision includes ethical principles for more involved persons, including the patient, who is not in the supervision session. Of course, it also applies to the supervised individual, the supervisor, the organization and the company. In addition, the ethical rules for supervision must be in line with the individual codes of ethics of the professional chambers of supervised workers.

Matousek (2003) aptly formulated ethical rules in supervision:
- be beneficial;
- do not harm;
- do not abuse;
- do not manipulate.

The priorities of the supervisory work are as follows:
- compliance with applicable legislation and ethical principles;
- the benefit of the patient;
- the benefit of the supervisee;
- the benefit of the supervisor.

CONCLUSION

Ethical decision-making is one of the competencies of a psychotherapist and a supervisor, and it is becoming an important motive for therapeutic steps. In addition to good self-reflection by the therapist, an ethical reflection that considers the broader socio-psychological context of therapy is required. For cognitive-behavioural therapy, issues related to transference, countertransference, and ethical reflection on the therapeutic relationship are important, especially when the therapy is constrained or threatened with excessive prolongation. Awareness of the patient's transference, its conceptualization, self-reflection and ethical reflection are an important part of the maturation of a cognitive behavioural therapist and should be given sufficient attention in training and supervision.

CONFLICT OF INTEREST STATEMENT

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

ACKNOWLEDGMENTS

This paper was supported by the research grant VEGA no. APVV-15-0502 Psychological, psychophysiological and anthropometric correlates of cardiovascular diseases.

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