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ORIGINAL ARTICLE

The use and misuse of power in cognitive-behavioral therapy, schema therapy, and supervision

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Abstract

BACKGROUND: Power dynamics are fundamental to therapeutic and supervisory relationships in psychotherapy. In cognitive-behavioural therapy (CBT) and schema therapy (ST), the therapist's power management can help the patient make positive changes. On the other hand, the abuse of power can undermine the patient's autonomy and worsen therapeutic outcomes. Understanding these dynamics is essential for effective and ethical practice.

OBJECTIVES: This article aims to explore how power and powerlessness manifest themselves in the practice of cognitive behavioural therapy (CBT) and schema therapy (ST), analyse their impact on therapeutic and supervisory processes, identify the risk of abuse of power, and suggest strategies to support patient and supervisee autonomy.

METHODS: The text provides a theoretical and practical analysis of the manifestations of power in therapy and supervision, illustrated with case vignettes to explain important processes. The discussion includes a comparison of CBT and ST, focusing on their respective approaches to power dynamics. Ethical principles, supervision practices, and cultural and institutional influences are also examined.

RESULTS: Effective use of power in therapy and supervision increases trust, cooperation, and autonomy for both client and supervisee. In CBT therapy and supervision, collaboration with an appropriate power distribution between therapist and patient or supervisor and supervisee promotes patient or supervisee engagement. Still, excessive directiveness can sometimes threaten the relationship. In ST, where limited reparenting is the main vehicle for the therapeutic and supervisory relationship, therapeutic and supervisory leadership requires increased sensitivity by the therapist or supervisor to avoid reinforcing maladaptive modes. Supervisory approaches that rely on collaborative approaches are more supportive of professional growth than those dominated by hierarchical power structures. **CONCLUSIONS:** Reflection on power dynamics is vital in cognitive-behavioural and schema therapy for maintaining ethical and effective therapeutic and supervisory relationships. Strategies that help maintain a balance of power include adherence to ethical principles, self-reflection, and regular supervision. Future research should focus on developing innovative methods to capture solutions to power distribution issues in therapy and supervision.

INTRODUCTION

Power dynamics and powerlessness are fundamental to forming psychotherapy's therapeutic and supervisory relationship. That applies to cognitive behavioural therapy (CBT) and schema therapy (ST). Power in psychotherapy can be defined as the ability of the therapist to influence the process and outcomes of treatment through their expertise, authority, and professional role (Proctor 2017). This power is not fixed but arises from the complex interaction between the therapist and the patient and is influenced by the parallel process, transference and countertransference, as well as the external context in which the therapy takes place (Zur 2017). Therefore, the safe and ethical use of power is essential for supporting patient autonomy and personal growth (Prasko *et al.* 2023a).

Writing about power issues is important because power can significantly impact the quality of therapeutic and supervisory processes and, consequently, therapeutic outcomes. Therapists and supervisors are often unaware of how they use their power, which may stem from implicit power dynamics in the therapeutic alliance or from a lack of reflection on the therapeutic relationship in their practice (Pope & Vasquez 2016). A lack of reflection on the therapeutic relationship and self-reflection can lead to the therapist inadvertently reinforcing authoritarian and hierarchical foundations and practices in the therapeutic alliance, weakening the patient's autonomy and hindering their ability to achieve positive change (Prasko *et al.* 2023c).

Abuse of power in psychotherapy or supervision can have serious consequences. On the patient's side, it can lead to feelings of helplessness, powerlessness, resistance to therapy, and worsening of psychological well-being (Murphy & Cramer 2014). For supervisees, abuse of power can lead to decreased professional self-confidence and an increased risk of burnout (Ladany *et al.* 2005). At the organisational level, a disruption of the ethical environment can lead to a degradation of trust in the service as a whole and a weakening of its effectiveness (Zur 2017).

Understanding these power dynamics helps ensure a safe, ethical, and effective therapeutic process (Prasko *et al.* 2023a). This article explores how power and powerlessness manifest themselves in different situations and periods of psychotherapy and supervision. The article also addresses potential abuses of power and offers options for supporting patient and therapist autonomy.

POWER AND POWERLESSNESS IN PSYCHOTHERAPY: GENERAL ASPECTS

Definition of terms

In psychotherapy, power is understood as the therapist's ability to influence the treatment process and outcomes through their role, status, knowledge, and behaviour in the therapeutic alliance (Zur 2008; Proctor 2017). This power is not static but depends on the therapeutic alliance's dynamics, the therapist's and patient's personality characteristics, and the broader professional and social background. The ethical and safe use of power is essential for supporting the patient's development and independence. The therapist should balance guiding the patient and respecting their freedom and ability to decide about their life (Fors 2018).

Safe use of power involves using the therapist's expertise to enhance the patient's ability to solve their problems, not to dominate or manipulate them (Sapezinskiene *et al.* 2016). Therapeutic power can be perceived positively as a tool for support and growth or negatively as a form of excessive control that affects the level of trust in the relationship, patient autonomy, and the overall effectiveness of therapy (Pope & Vasquez 2007; American Psychological Association 2024).

Research has shown that two types of power often lead to challenges in therapy: cultural power and professional power (Zur 2017). Cultural power refers to the privileging of certain identities, which can prevent clients from drawing on their own experiences—particularly when they face oppressive cultural narratives. Professional power comes from the therapist's training and the authority ascribed to them, which may cause clients to defer to the therapist and diminish their voice in therapy (American Psychological Association 2024).

At the same time, four distinct forms of power influence the therapeutic relationship: professional power (could also include such processes as reporting to child services, involuntary hospitalisation, etc.), transferential power (where the client projects feelings from past

relationships onto the therapist and emotional interdependency of patient and therapist), socio-political power (influences like race, class, and gender that affect both therapist and client), and bureaucratic power (arising from organisational structures and institutional rules that shape therapy, such as insurance constraints and other aspects of access to care) (Levitt *et al.* 2016; Proctor 2017). Understanding these forms of power helps therapists recognise the complexity of how power manifests in therapy and its potential effects on the therapeutic alliance.

Power as a Means of Supporting the Patient and Building Their Competence

Psychotherapy is a process that aims to enhance the patient's competence through a safe framework, collaborative dialogue, and partnership (Prasko *et al.* 2023b). The therapist's power should be used to facilitate this process, not to control the patient. An effective therapeutic relationship is characterised by a balance between the therapist's guidance and support for the patient's autonomy (Prasko *et al.* 2023a).

Case vignette 1: Therapist Dominance over the Patient

Twenty-nine-year-old Václav has social anxiety disorder. Over several sessions, the therapist acts very directive, focusing on techniques and procedures, not consulting Václav sufficiently, and often interrupting him when Václav needs to express himself something to "speed up" the process.

Vaclav: "I feel like I should speak in front of my colleagues, but just thinking about it makes me feel scared and anxious and sick..."

Therapist: "It's just a fear that you have to overcome. Try to go and say at least a few sentences in a meeting tomorrow. Otherwise, you'll never get rid of it."

Vaclav: "But I'm not sure I have the strength to do it now…"

Therapist: "You're just making excuses. The longer you put it off, the worse it will get. Just do it and come back and tell me about it next time."

Vaclav: "But what if I panic? That happens a lot to me."

Therapist: "That's normal. Everybody is fearful. You have to live through it. Next time, you tell me how you did it."

The therapist in this situation does not reflect the patient's fears and readiness to confront them. Their directive approach, which does not allow the patient's needs for support and autonomy to be met, leads to mutual misunderstanding. The patient may feel insufficiently accepted and less willing to share his fears. That weakens the therapeutic alliance and slows down the progress of therapy. This example shows how the therapist's dominance can negatively slow down or disrupt the therapeutic process. Instead of supporting the patient in finding common solutions, the therapist takes control and pushes the patient into actions for which the patient is not yet ready.

The patient's perception of the therapist's power as someone who stands behind them and supports them fully understands obstacles and uncertainties can lead to effective cooperation, increased trust, and willingness to work on change (Prasko *et al.* 2023a). Conversely, using therapeutic power as a control tool can provoke uncertainty, resistance, distrust and disruption of the therapeutic process (Fors 2018).

Case Vignette 2: Therapeutic Process

The patient, a 35-year-old woman, presents with chronic feelings of inferiority and anxiety. In her relationship with the therapist, there are signs of passivity in the patient, who relies entirely on the therapist's recommendations without taking initiative.

Patient: "I think I should stop going to occupational therapy, but I don't know… What do you think?"

Therapist: "That's an important question. Imagine if I told you it was a good idea. How would you react?"

Patient: "I guess I should. You know, to do what's best for me."

Therapist: "Thank you for sharing that. I think it's important for you to make your own decision. What would it be like for you to take control of this decision? "

The therapist reflects on the patient's passivity, the importance of this question, and the transfer of responsibility to authority, encouraging the patient to make autonomous decisions. Therapist self-reflection and regular supervision are key tools to prevent the unconscious abuse of power (Prasko *et al.* 2023c).

Case Vignette 3: Supervision Process

Rudolf is a novice therapist who feels insecure and helpless when working with a complicated case of a patient. The supervisor noticed that Rudolf was worried he would "fail" in the supervisor's eyes. This limits his ability and willingness to reflect openly on his therapeutic work, his behaviour, and also his insecurities.

Rudolf: "I don't think I'm doing good therapy with this patient. Maybe I should be more direct, but I'm afraid I'll mess it up."

Supervisor: "I understand your doubts about your work with this patient. Tell me, what would help you feel more confident?"

Rudolf: "Maybe if I knew I was doing something right."

Supervisor: "I understand. My job here is not to evaluate or judge you but to help you think. Together, we can explore the patient's behaviour, discuss specific situations, and consider the best possible approach to the patient."

The supervisor reinforces the supervisee's autonomy while emphasising cooperation. They also support the supervisee's ability to find solutions and process feelings of helplessness.

POWER DYNAMICS IN CBT AND ST: SIMILARITIES AND DIFFERENCES

CBT: Structural Approach and Related Risks

CBT is characterised by structure and directiveness. The therapist acts as a "coach" or "teacher" (Beck *et al.* 1979). This directiveness can effectively guide the patient to recognise and change maladaptive thought patterns and behaviours. However, excessive directiveness can

lead to insufficient patient engagement in therapy, reduced autonomy, and reduced effectiveness of treatment (Muran & Barber 2010).

Case Vignette 4: Effects of Excessive Directiveness in CBT

Elena, 42, is being treated for chronic generalised anxiety disorder and perfectionism. The therapist uses a directive approach to identify maladaptive thoughts and replace them with more rational ones. Although the patient willingly completes tasks, she experiences frustration and resistance.

Therapist: "Have you been able to write down your thoughts from the past week and process them according to what we discussed?"

Elena: "Yes, I wrote them down but keep returning to the same things. I don't see much point in it."

Therapist: "That's exactly the problem we are dealing with. It would be best if you learned to work systematically with those patterns. You should focus more on that."

Elena: "You're probably right, but I'm missing something to motivate me more. Maybe if I could talk about it more deeply…"

Therapist: "Overthinking or worrying too much won't help. The goal is to change your thoughts, emotions, and behaviour. Keep a record, and we'll try other methods next time."

The therapist used a structured but overly directive approach that did not address the patient's anxieties, fears or needs for safety. There was no deeper reflection on what was happening with the patient. This approach resulted in the patient not receiving enough additional information and not strengthening her autonomy. The patient may start to feel like a passive participant in the treatment, where she does not have the opportunity to make her own choices, which can negatively affect her motivation.

Case Vignette 5: Balanced Directiveness in CBT

Ludmila, a 33-year-old woman, has problems with significant procrastination in important activities associated with fear of failure. The therapist uses a directive and structured approach but allows Ludmila to reflect on her feelings. This balanced approach helps Ludmila gradually take control of her behaviour and strengthens her involvement in the therapeutic process.

Ludmila: "When I have to start working on a more complex task, I always feel like I won't finish it anyway. So why try? And I end up putting it off. Then I blame myself and feel disappointed in myself."

Therapist: "I understand that being unable to do it is intense for you. I want us to find small steps to help you start the task. Try to think... What options come to mind?"

Ludmila: "I just have to force myself to start..."

Therapist: "That's a battle cry. And how can you make it easier for yourself so that it's not so hard from the start?

Ludmila: "Maybe I could sort out what I need to do. Please write it down and break it down into multiple steps. But I don't know if that makes sense."

Therapist: "That sounds like an excellent first step. It's okay to have doubts. The more you break your project into smaller parts, the easier it will be to start. How could you create such a list?

Ludmila: "Maybe I could set three small goals first and focus on those."

Therapist: "That's a great idea. Let's see what three goals would be most important to you. We can also consider what obstacles might arise and how we can overcome them together."

This example shows that a balanced directiveness that considers the patient's needs and encourages active participation can be helpful for effective therapy. The therapist offers guidance but, at the same time, leaves enough room for the patient to make independent decisions.

ST: Emotional Dynamics and the Risks of Power Misuse

ST integrates insights from cognitive, behavioural, gestalt, and psychodynamic therapy. It emphasises identifying and modifying early maladaptive schemas and patterns influencing the patient's experience and behaviour (Young *et al.* 2003). In the therapeutic relationship, various modes can be activated by the therapist, including negative ones such as the "Critical Parent," "Overcompensator," or "Detached Protector." Suppose therapists do not engage in sufficient self-reflection and supervision. In that case, they may unconsciously reinforce these negative modes, leading to abuse of power and disruption of the therapeutic process (Edwards & Artz 2012).

Case Vignette 6: Activating the "Critical Parent" Mode in Therapy

A 38-year-old woman, Ludmila, came to therapy because of low self-esteem and feelings of failure at work and in her personal life. During the treatment, the therapist unknowingly activates her own "Critical Parent" mode, which reinforces the patient's negative schema of failure and abandonment.

Patient: "I feel like I'm not doing anything right at work. My manager is constantly checking me and not giving me any advice. I think it's because I'm probably not good enough."

Therapist: "Why didn't you try to solve this? You could have discussed with your manager what he expects of you."

Ludmila: "I'm afraid he'll criticise me even more. I already think I'm doing everything wrong."

Therapist: "If you don't stand up for yourself, nothing will change. You need to take responsibility for how others perceive you."

Ludmila: (silent, fidgeting nervously) "I just… I feel like I'm always trying, but it's no use."

Therapist: "It's not just about trying. You have to change your approach. Otherwise, it's just going to stay the same. "

With her directive style and detached tone, the therapist triggers the patient's "Critical mode." The therapist unconsciously strengthens her negative Failure schema instead of supporting and understanding the patient's concerns. The patient feels even more criticised and misunderstood, as the behaviour of the therapist is similar to the behaviour of her superior at work. This can lead to a breakdown in trust in the therapeutic relationship.

Case Vignette 7: An Alternative Approach with Mode Reflection

Ludmila: "I feel like I'm not doing anything right at work. My manager is constantly checking and criticising me. I think to myself, 'I guess I'm not good enough.'"

Therapist: "It sounds like a part of you is critical and strict with yourself. Do you recognise that voice?"

Ludmila: "Yeah, that's exactly it. I feel like I hear my mom telling me I'm not good enough. She told me about my childhood and still says it often."

Therapist: "This must be very difficult for you. Let's look at how this voice helps you and how it hurts or hinders you. What would you like your Supportive Part or your Kind Parent to say to you instead? And how could your Healthy Adult help you?"

In this alternative approach, the therapist reflects on the patient's activation of the Critical Mode and helps them recognise its influence on their experience. Instead of unconsciously reinforcing this mode, the therapist supports the patient in developing supportive attitudes toward herself. That strengthens the Healthy Adult and Kind Parent modes.

Comparison of Approaches

The CBT relationship is based on collaborative empiricism. The therapist and patient jointly explore the patient's thoughts, attitudes, and behaviour patterns and seek alternative, more adaptive options (Beck *et al.* 1979). The therapist's directiveness is particularly useful in the early stages of therapy when the patient needs structure and specific guidance. However, in the later stages of treatment, the therapist supports the patient's autonomy and active involvement in the process, contributing to the patient's self-confidence and the long-term effectiveness of therapy (Beck *et al.* 1979).

In contrast, ST is based on limited reparenting, where the therapist creates an emotionally supportive and safe relationship that allows the patient to gain new, reparative experiences. ST is based on understanding the patient's modes and schemas, with the therapist responding to the patient's current emotional needs (Young *et al.* 2003). The therapeutic alliance is less directive but requires a high degree of sensitivity and self-reflection on the therapist's part. Therapists must be able to flexibly switch between an empathetic, caring approach and setting boundaries when the patient's maladaptive modes, such as the "Angry Child," "Detached Protector," or "Critical Parent," are activated.

It should be mentioned that both therapies can be directive in different ways. Still, schema therapy might be more directive in emotional and relational dimensions (Young *et al.* 2023). Conversely, CBT is more directive regarding structured problem-solving and cognitive techniques (Beck *et al.* 1979).

Some aspects of schema therapy aspects can be quite directive (Young *et al.* 2023):

(1) *Therapist modelling Healthy Adult modes:* In Schema Therapy, the therapist often actively models the "Healthy Adult" mode, which is indeed directive. The therapist directly engages with the client, offering guidance on approaching life situations in a more balanced, rational, and emotionally healthy way. This is in contrast to the leadership stance that a CBT therapist might take, where the goal is often to teach clients to recognise and modify their thoughts.

(2) *Emotional Work:* Schema therapy involves direct emotional work, such as imagery rescripting or chair work. In these methods, the therapist takes an engaged and directive role. In these exercises, the therapist may intervene to offer corrective emotional experiences, challenge maladaptive schemas, and guide the client toward healthier emotional responses. This emotional work goes beyond the cognitive restructuring common in CBT. It involves the therapist's active involvement in the client's deeply emotional experiences.

(3) *Limited reparenting:* The therapy schema emphasises limited reparenting. The therapist provides a corrective emotional relationship to fulfil and heal the child's unmet needs. This process requires the therapist to take an active and nurturing role. This can be more directive than the collaborative empiricism of classical CBT.

So, while schema therapy includes less directive, exploratory elements when identifying schemas and patterns, it can be more directively engaged in emotional work and modelling healthier modes (Prasko *et al.* 2024a). That differs from CBT, where the therapist's role is often more focused on cognitive techniques and problem-solving than emotional involvement or reparenting.

Using Power for the Benefit of the Patient

In CBT, the therapist uses the power of their knowledge and role to structure the therapy and provide methods and tools that help patients understand and change their thoughts and behaviour patterns. Therapeutic power here lies in the ability to offer effective methods of change, to support the patient in an active approach to problem-solving, and to shape the needed skills of the patient (Prasko *et al.* 2011).

In ST, power provides emotional support and reparative experiences. The therapist allows the patient to feel safe, accepted, and valued (Prasko *et al.* 2024a). It gradually helps them manage challenging emotions and integrate healthier modes into problematic situations. In both cases, the goal of power is the patient's growth and autonomy. However, the approach to its application differs in the degree of structure of the psychotherapy process and emotional involvement.

Case Vignette 8: Structured Approach in CBT

A 30-year-old patient, Martin, comes to treatment for obsessive-compulsive disorder. His obsessions and compulsions include concerns about contamination and excessive washing.

Martin tries to avoid touching objects that could potentially be contaminated. Martin's therapist educates him about OCD, helps him understand his OCD patterns, and creates an exposure and response prevention plan. They begin by talking about what is happening to Martin:

Martin: "When I touch something publicly, I can't help it. I have to wash my hands right away. Otherwise, I feel like something terrible is going to happen."

Therapist: "I understand. How would you describe the thoughts going through your head at that moment? What do you think is going to happen?"

Martin: "That I'm going to get a disease. Or that I'm going to pass it on to someone else."

Therapist: "That's common for people who struggle with this fear. Let's see your evidence for this fear and what your logical mind says."

(After discussing the evidence and creating an alternative view.)

Therapist: "Okay, now we have a different perspective on these thoughts. The next step is to try a little experiment. How about the next time you touch the doorknob, you delay washing your hands for one minute? We can gradually increase the time."

Martin: "It will be hard, but I think I can do it if I know nothing will happen. "

The therapist uses the power of their expertise to help create structure and take effective action. Together with the patient, they identify maladaptive obsessive thoughts and engage in exposure and response prevention. This approach allows the patient to take control of their obsessions gradually and increases their autonomy.

Case Vignette 9: Emotional Support in ST

Blanka is a 35-year-old woman who is being treated for a depressive disorder associated with feelings of abandonment and low self-esteem. The therapist works with the "Vulnerable Child" and "Critical Mode", using imagery to rescript painful past events and working with unpleasant situations " here and now". She helps Blanka process intense emotions and build an internal supportive relationship with herself.

Blanka: "I asked to speak at a work meeting. My boss completely ignored me. I felt miserable all day.""

Therapist: "What mode was activated in you? "

Blanka: "Definitely Vulnerable Child". I felt abandoned and inadequate, unworthy of being listened to.

Therapist: "You're right. It sounds like your Vulnerable Child mode was activated. And your child felt abandoned and unworthy of being heard. Does that sound familiar?"

Blanka: "Yes, exactly. It reminds me of how I felt when my parents ignored me when I was little."

Therapist: "It seems to be a very painful feeling. How would your Vulnerable Child feel it? Is there someone who can support her now? What would you like to say to her?"

Blanka: "I would like to tell her how she feels is okay and that she deserves to be heard."

Therapist: "That is very important. Can we try together to be a 'new parent' who will provide that kind of support to your child? What would that look like?"

The therapist built a safe framework that allows the patient to accept and process intense emotions related to past experiences.

Risk of Power Abuse:

In CBT, abuse of power can consist of an overly authoritative approach, where the therapist imposes their solutions on the patient and ignores their subjective experiences.

Case Vignette 10: Abuse of power in CBT – authoritarian approach

The patient, a 28-year-old college student, Oldrich, struggles with procrastination associated with concern about academic failure. The therapist uses an authoritative style that overlooks the patient's feelings, needs and individual pace.

Oldrich: "Yesterday, I was supposed to start writing my thesis introduction but put it off again. I've been stressing all day about being incompetent to write it properly."

Therapist: "We've talked about this before. The only way to relieve the stress is to start writing. Why didn't you do it?"

Oldrich: "I don't know. I felt like I wasn't ready for it. I felt like I was going to screw it up."

Therapist: "You'll never get anything done with this approach. You must realise it's not about feelings but the need to do something finally. I advise you to divide the thesis and the tasks you need to do into smaller parts and start from the first, e.g., prepare the title page.

The therapist dominantly imposes their solutions on the patient without reflecting on his subjective experiences and fears. An authoritative approach weakens the patient's autonomy and, at the same time, reduces trust in the therapeutic process. That can lead to resistance or termination of therapy. In ST, abuse of power can occur when the therapist oversteps the boundaries of the "new parent" role and exposes the patient to excessive emotions with the belief that the patient is already prepared to cope with them. Conversely, it protects the patient so much from unpleasant emotions that they do not learn to manage them. Both extremes do not help guide the patient toward independence. They can lead to the development of dependency on the therapist.

Case Vignette 11: Abuse of Power in ST – Crossing Boundaries

Bernard is a 40-year-old depressed patient who comes to treatment because of long-term feelings of loneliness, isolation, helplessness, and loss of meaning in life. The therapist, in her role as a "new parent," unknowingly takes on excessive responsibility for the patient's improvement, which results in the creation of a dependent therapeutic relationship.

Bernard: "Without your suggestion and plan, I couldn't even get out of bed in the morning. You're the only one who really understands me."

Therapist: "It's okay. You're safe here. You can count on me whenever you need support."

Bernard: "I'm afraid of the end of this therapy. I don't know what I would do without you."

Therapist: "You don't have to worry about it. I'm here to help you cope with what you can't do alone."

The therapist oversteps the boundaries by supporting the patient's dependency on the therapeutic relationship. Instead of encouraging the patient to develop independence and manage problems outside of therapy, the therapist supports the patient's dependent behaviour. This may provide short-term relief for the patient. However, long-term, it may weaken the patient's ability to cope with problems independently. Both approaches point to the need for a balanced use of power to support the patient's autonomy and the effectiveness of therapy.

Case Vignette 12: Supervisory Dialogue Focusing on Self-Reflection and Open Dialogue with the Patient

Therapist Robert, a 35-year-old man, comes to supervision with a problem involving a patient who expresses frustration with the way therapy is progressing. The therapist admitted that he felt wronged and became defensive when the patient said that his therapeutic approach did not suit him because it was interfering too much with their work together.

Part One: Guiding the Therapist to Self-Reflect

Supervisor: "Thank you for bringing this up in supervision. What went through your mind when the patient said you were guiding her too much?"

Therapist: "I was taken aback. I thought I was helping her, and suddenly, it seemed my efforts weren't appreciated."

Supervisor: "That's an understandable reaction. If you were to connect that to your feelings at that moment, what would they be? How did you feel? "

Therapist: "I probably felt a little frustrated, maybe even like I was failing."

Supervisor: "That's an important realisation. Now, let's consider how this dynamic might have affected your approach to therapy. Do you have any ideas?"

Therapist: "Maybe I pushed harder to show I knew what I was doing. But I guess I didn't give the patient enough space."

Part Two: Guided Discovery and Chairwork

Supervisor: "Let's try something specific. I'll play your patient, and you will try to respond as you did. Then we'll go through it together."

Therapist (playing himself): "I understand that you feel I'm leading you too much. But I don't think we'd get anywhere without it."

Supervisor (playing patient): "That's what bothers me. I feel like I'm not getting the space to decide what to focus on."

Supervisor (playing patient): "Okay. Now, I'd like to invite you to sit in my chair and try to be patient for a moment. I'll play you. What would the patient need in this situation?"

Therapist (as the patient): "I would like him to listen to me more, to be interested in what I think."

Supervisor: "That's important. How could you bring that into therapy? What would show the patient that you are interested in her opinion?"

Therapist: "Maybe I could give her more space to talk and ask her what she wants to do next."

Part Three: Open Dialogue

Supervisor: "Now try to role-play an open dialogue with the patient, where you give her more space and at the same time reflect on what you have realised."

Therapist (as therapist): "I understand that you feel I'm leading you too much. I'm sorry. We can explore this together. Can you tell me what would help you feel more independent in your involvement in therapy?"

Supervisor (as patient): "I would like to have more control over what we're going to do, such as what problem we will address in the session. Sometimes, I feel like you're not asking me much; you're setting the agenda based on what we did last time and leading in a different direction than I want."

Therapist: "That makes sense. Can we agree to start each session by discussing what's most important to you and what we're going to work on in that session?"

In this example, the supervisor helped the therapist recognise his dominant responses and their impact on the dynamics of the therapeutic relationship. The therapist identified the patient's needs through guided discovery and role reversal in chair work. Then, they developed a plan to change his approach to support the patient's autonomy.

Therapist's Power Behaviour

The therapist can often unconsciously use their power to affect the patient's experience and behaviour. The therapist's role, expertise, status, and transference/countertransference dynamics influence the therapist's power. It can be expressed verbally and/or nonverbally. Below are examples of therapist power actions that can negatively affect the patient's sense of safety, autonomy, and trust in therapy (Table 1).

Nonverbal Displays of Power Behaviour

- Significant silence: The therapist may intentionally remain silent for a long time after the patient has said something, no matter how difficult the topic may be. Such silence can be stressful for the patient, leading to feelings of guilt or shame that they said something wrong.

Case Vignette 13: Nonverbal Displays of Power Behaviour

A patient with social phobia has difficulty establishing relationships with women. When he talks to them, he experiences a fear of rejection. He also gets angry and harsh with them. After the patient confides, the therapist pauses for a long time without commenting verbally on the patient's story. The patient feels insecure and starts apologising and making excuses. He thinks that he should not have confided.

– Pose and Posture: The therapist may sit or assume a posture emphasising superiority or distance. For example, they may lean back comfortably and

Tab. 1. Manifestation of power in behaviour

The type of expression	Behavior	Description	Examples
Nonverbal	Significant silence	The therapist pauses for a long time after the patient's statement, which can trigger feelings of guilt or shame as if the patient said something inappropriate.	The patient shares their relationship problems. The therapist pauses significantly. The patient feels insecure and apologises as if they have done something wrong.
	Pose and posture	The therapist adopts a superior or distant posture, such as leaning back or crossing their arms, which can appear disinterested.	The therapist leans back during the session and listens indifferently to the patient's concerns. The patient feels that the therapist does not take their words seriously.
	Mimicry and gestures	The therapist may use an ironic eyebrow raise or a smirk, indicating the patient's disagreement or questioning of his words.	The patient talks about his ambitions, and the therapist responds with a sneer. The patient interprets this as questioning his abilities.
Preverbal	Ironically, modulated "Hmm."	The therapist responds with an ironic "Hmm," belittling the patient's experience and questioning their perspective.	The patient talks about their fears and worries, and the therapist responds with a wry "Hmm." The patient is uncertain and begins to doubt their own experience.
	Disconnected "Hmm"	A mechanical, monotonous "Hmm" gives the impression that the therapist is not present or interested in the patient's words, leading to feelings of alienation.	The patient talks about their anxiety, and the therapist responds with monotonous, colourless "Hmm." The patient feels that the therapist is not interested in their experiences and begins to doubt the meaning of therapy, losing motivation to continue.
Verbal	Use of irony or humour	The therapist uses irony or humour that belittles the patient's words, which can embarrass them or make them feel they are not being taken seriously.	The patient confides in the therapist about their concerns about changing jobs, and the therapist responds ironically: "Oh, that's a really big problem." The patient feels that their concerns are not justified.
	Moralising and criticism	The therapist moralises or criticises the patient's behaviour, which creates shame or guilt and reduces the patient's ability to take responsibility for their actions.	The patient describes problems with time management, and the therapist responds by lecturing and moralising: "That's irresponsible; you should have figured out that a long time ago." The patient feels humiliated.
	Blame	The therapist accuses the patient of being somehow responsible for their difficulties. This can lead to feelings of guilt in the patient and discourage them from sharing difficult experiences.	The patient talks about their inability to maintain close relationships, and the therapist responds, "Maybe you should stop blaming others and think about what you're doing wrong." The patient feels ashamed.
	Questions without an answer option	The therapist asks questions that the patient cannot answer, which provokes feelings of guilt, shame, or fear.	The patient talks about feelings of failure, and the therapist asks, "And why do you think you are so unsuccessful?" The patient has no answer and feels inadequate, intensifying their inner criticism.

cross their arms. That can create an impression of disinterest.

- Facial expressions and gestures: A sarcastic eyebrow raise or smile when a patient shares a painful event can make them feel like the therapist is questioning or disagreeing with their words. These behaviours can make the patient feel insecure and undermine their trust.

Preverbal Manifestations of Power Behaviour

- Ironically modulated "Hmm": The therapist responds to the patient's statement with an ironic "Hmm," giving the impression of condescendingly judging the patient's experience or challenging their opinion.
- Disconnected "Hmm": The therapist gives a mechanical, monotonous "Hmm," which gives the impression that they are absent-minded and uninterested in the patient's words. This approach can lead to a feeling of alienation in the patient.

Verbal displays of power behaviour

- Use of irony or humour: The therapist uses humour that trivialises the patient's experience or message. This approach can make the patient feel that the therapist is not taking them seriously.

- Moralising and criticising: The therapist moralises or criticises the patient's behaviour. This can lead to feelings of shame or guilt. This style intensifies the patient's self-criticism or resistance.
- Blaming: The therapist blames the patient for their problems. This can lead to feelings of guilt and discourage the patient from sharing problematic experiences.
- Unanswerable questions: The therapist asks questions that the patient cannot answer. That leads to feelings of guilt, shame, or fear.

SUPERVISION: POWER DYNAMICS AND ITS IMPACT ON THERAPIST DEVELOPMENT

The Supervisory Relationship as a Tool for Professional Growth

Supervision is a crucial component in the professional development of therapists. As an authority with more experience, the supervisor plays a pivotal role in the supervisee's self-confidence and professional development. Based on trust and respect, a useful supervisory relationship fosters the supervisee's openness and willingness to reflect on their therapeutic practice (Bernard & Goodyear 2014).

Negative Manifestations of Power Dynamics

Abuse of power in the supervisory relationship can negatively impact the supervisee. Criticism without constructive support can result in feelings of powerlessness and reduced self-confidence (Ladany *et al.* 2005). That can hinder professional growth and negatively affect the supervisee's therapeutic practice.

Case Vignette 14: Negative Manifestations of Power Dynamics in Supervision

The supervisee, Paul, a young therapist, comes to supervise and shares his difficulties working with a challenging patient. However, the supervisor implements an overly critical approach without support, discouraging the supervisee. In the second part of the discussion, the supervisor reflects on his style and attempts to repair the relationship.

Part One: Criticism without Support

Paul: "I feel like we are not progressing with this patient. He comes to every session saying nothing is helping him, and I don't know what to do next."

Supervisor: "It's clear that you are doing something wrong. If the patient says nothing is helping him, he may not receive effective guidance from you. How did you structure the last session?"

Paul: "We talked about his stress at work. I tried to offer him some methods for managing his anxiety."

Supervisor: "That's a major mistake. You should have addressed his automatic thoughts and reframing them. Do you have any plans for the next session? Or are you just going to do it again without a goal?"

Paul: "I... I thought it would help him. But I guess it didn't."

Supervisor: "You need to master the basic structure of CBT before you start working with patients. This is not professional."

(Paul remains silent, nodding but feeling visibly embarrassed and defensive.)

Part Two: Reflection and Reparation

(The supervisor, realising the impact of his approach, revisits the topic.)

Supervisor: "Thank you for giving me space to think. I realised I was too critical in our previous discussion and did not offer you sufficient support. Can we revisit the topic? It might be useful to discuss what happened together?"

Paul: "I admit I felt very frustrated. I felt like you were putting pressure on me to improve."

Supervisor: "I understand that. My feedback should have been more helpful. What specific questions do you have about working with this patient? We can look at that together."

Paul: "It would be helpful for me to discuss how to better work with his passive attitude. We often get stuck thinking that nothing is working."

Supervisor: "That's an important topic. It might be worth re-enacting what's happening in the specific situation first. I can play your patient if you want. Do you want to try?"

This interview shows how criticism from a supervisor can lead to feelings of helplessness in the supervisee. However, open reflection on the supervisor's part and subsequent remediation can help restore trust.

Strategies for Coping with Feelings of Helplessness in Supervision

To address feelings of powerlessness in supervision, it is important to use approaches that support the supervisee's autonomy. That includes appreciating the supervisee's skills. (Hoffman *et al.* 2005). Also, reflecting on the power dynamics in the supervision process is crucial for identifying and resolving potential power imbalances and supporting open discussion between supervisor and supervisee (Falender & Shafranske 2004).

Case Vignette 15: Strategies for Coping with Feelings of Helplessness in Supervision

A young therapist, Alena, starts her career and comes to supervision feeling uncertain about her work with a patient with a challenging personality problem.

Supervisor: "Thank you for bringing this topic up. Can you tell me more about your concerns about working with the patient?"

Alena: "I feel like I'm not progressing with her. I feel she's resisting me or not taking my suggestions seriously every session. I'm not sure if I'm doing something wrong."

Supervisor: "That's a difficult situation. What do you mean, the patient doesn't take your suggestions seriously?"

Alena: "For example, when I suggest a method of coping with emotions, they usually say something like 'I can't do it.' And then I feel helpless."

Supervisor: "I understand. How would you describe your reaction when the patient tells you that?"

Alena: "I tend to withdraw. And then move on to another topic to avoid further resistance."
Supervisor: "That's understandable. Let's try a different approach. What would it be like to address this dynamic directly next time? You could say, "I feel like what I'm suggesting isn't helpful for you. What would you like to try?'"
Alena: "That might work. It gives her space to express herself instead of me pushing my suggestions."
Supervisor: "Exactly. It shows her that you respect her experience and are open to dialogue. Do you want to try this in a role play?"

Role play:
Supervisor (playing patient): "This doesn't work for me; I've tried it before."
Alena (playing herself): "Thank you for telling me. Can we explore together what you think could be more helpful? What has helped you in the past?"
Facilitator: "That was really good. How did that make you feel?"
Alena: "I think for the first time, I felt like I didn't have to react to everything. I could be there with the patient and discuss what she needs."
Reflection:
Supervisor: "What you did is a nice example of respecting the patient's autonomy. You also demonstrated your skills in facilitating the patient's search for solutions. What steps would you like to take to adopt this approach?"
Alena: "I will listen more and try to be less directive. Maybe I will write more examples of similar situations to discuss them together."
Facilitator: "I like the plan. If you come across any more challenging moments, bring them to the next session. We can continue with this."

The supervisor supported the supervisee's autonomy by offering her constructive feedback and creating a safe space for exploration.

ABUSE OF POWER IN PSYCHOTHERAPY AND SUPERVISION

Causes and Manifestations of Abuse of Power

Abuse of power in psychotherapy and supervision can have various causes, often related to the personality characteristics of the therapist or supervisor, the institutional environment, or the cultural context.

Therapist or Supervisor Personality Traits
Some personality traits, such as authoritarianism or narcissism, can lead to a tendency to exercise power in a manipulative manner. Therapists or supervisors with these traits may need to rigidly control the course of therapy or supervision in a way that disregards the patient's or supervisee's needs and promotes their agenda (Zur 2009). For example, instead of supporting the patient's independence, the therapist may enforce their explanations or standards, weakening their confidence and ability to make autonomous decisions.

Institutional Influences
The hierarchical organisation can generate an atmosphere where power imbalances become the standard. For example, in institutions that accentuate routine or inflexible hierarchy, therapists and supervisors may adopt an authority role inconsistent with principles of collaboration and respect for the autonomy of the patient or supervisee. These institutional dynamic forces may also pressure therapists or supervisors to achieve specific outcomes without regard for patients' needs.

Cultural Context
Cultural norms can influence power in a therapeutic or supervisory relationship (Boadella 1993). In some cultures, there may be a greater emphasis on authoritative roles. That may lead to patients or supervisees being afraid to challenge the performance of the therapist or supervisor. Cultural norms can thus reinforce power imbalances and lead to manipulative behaviour.

Manifestations of Abuse of Power
Abuse of power takes many forms. The most common include:
- *Manipulation:* A therapist or supervisor intentionally influences a patient or supervisee in a way that suits their interests, regardless of their needs.
- *Ignoring autonomy:* The patient or supervisee is treated as an equal partner in their relationship. Their opinions, feelings, or choices are disregarded as unimportant.
- *Imposing values:* The therapist or supervisor proclaims their values and beliefs, which can lead to a loss of trust and a sense of safety in the patient or supervisee (Pope & Vasquez 2016).

Such behaviour disrupts the therapeutic process or supervisory relationship (Table 2).

Countertransference
Countertransference is regularly the source of abuse of power in psychotherapy (De Varis 1994). Therapists or supervisors often fail to recognise countertransference. Several types of countertransference related to feelings of power can lead to the therapist prioritising their protection or support at the patient's expense (Table 3).

Negative Consequences of Abuse of Power

Abuse of power in psychotherapy and supervision can lead to serious and long-term effects on both patients and supervisees.

Impacts on the Patient
In the therapeutic relationship, abuse of power can lead to feelings of distrust, powerlessness, and resistance to therapy. These costs can be principally marked if the patient experiences disrespect for their autonomy

Tab. 2. Causes and Manifestations of abuse of power in psychotherapy and supervision

Category	Description	Example
The personality of the therapist/ supervisor	Authoritarianism or narcissism can lead to manipulation and taking control.	The therapist imposes their solutions on the patient regardless of their preferences.
Institutional influences	The hierarchical structure of the organisation promotes an imbalance of power.	The supervisor ignores the supervisee's suggestions because "this is how it's always been done."
Cultural context	Social norms can encourage passive acceptance of authority without the possibility of discussion.	The patient cannot question the therapist's strategy because "the therapist knows best".
Manipulation	Influencing the patient or supervisee in a direction that corresponds to the interests of the therapist/ supervisor.	The therapist selects topics that are less relevant to the patient but correspond to their therapeutic orientation.
Ignoring autonomy	Not providing space for the opinions and decisions of the patient or supervisee.	The supervisor decides on the priorities of the supervision meeting without consulting the supervisee.
Imposing values	Enforcing the therapist's or supervisor's beliefs without regard to the patient's or supervisee's experience.	The therapist criticises the patient for choices that do not align with their values.

manipulation or is forced to adopt the therapist's values. The patient may feel controlled, which can lead to worsening psychological well-being or increasing anxiety or depression (Murphy & Cramer 2014).

Trust in the therapeutic process is a key element of effective therapy. When it is fragmented, the patient can lose motivation to continue therapy. Premature termination of treatment is a common outcome when the patient feels that their emotional needs are not being met or that the therapist is abusing their position of power.

Impacts on the Supervisee

In supervision, abuse of power by the supervisor can negatively affect the professional growth of the supervisee. Reduced self-esteem, often accompanied by feelings of inadequacy, can significantly impair the supervisee's ability to reflect on their therapeutic

Tab. 3. Forms of countertransference related to abuse of power in therapy

Form of countertransference	A manifestation of excessive use of power	Therapist characteristics	Patient characteristics
Hyperprotective	The therapist excessively controls the patient, takes responsibility for him, and does not let him act independently, thereby limiting his autonomy.	Therapist with a need for control, high responsibility, and a protective attitude.	A patient who appears vulnerable, insecure, or is in a difficult life situation.
Offensive	The therapist moralises, instructs, and trivialises the patient's needs. They may intentionally ignore or neglect the patient.	The therapist tends to be irritable, frustrated, or impatient with the patient.	A patient who is provocative, passive-aggressive, or tends to criticise the therapist.
Distrustful	The therapist is formally cooperative, shows no interest in the patient's needs, and automatically assumes that the patient has ulterior motives. This leads to an inauthentic, cold approach.	Therapist lacks confidence in their skills and feel threatened or suspicious.	An assertive patient requires evidence of the effectiveness of the therapy or is interested in the therapist personally.
Contemptuous	The therapist acts superior, trivialises the patient's needs, is bored with him, or despises him, which demotivates and degrades the patient.	A therapist with narcissistic traits, considering themselves as experts, underestimate the patient.	A patient who appears submissive has low self-esteem or seems helpless.
Admiring	The therapist uncritically admires the patient, which can lead to prioritising the patient's wishes at the expense of therapeutic goals.	The therapist who seeks recognition and admiration is easily fascinated by charismatic personalities.	A highly self-confident patient who impresses the therapist (with an intelligent appearance).

Tab. 4. Negative consequences of abuse of power in psychotherapy and supervision

Area	Consequences	Examples
Patient	Feelings of helplessness and mistrust	The patient feels manipulated, and their opinions are ignored.
	Resistance to therapy	The patient stops sharing their feelings because they do not feel respected.
	Deterioration of mental health	Increased anxiety, depression or deepening of the original problems.
	Premature termination of therapy	The patient ends therapy feeling hopeless that the situation will not improve.
Supervisee	Decreased self-confidence	The supervisees are afraid to share their thoughts and questions for fear of criticism.
	Stagnation in professional development	Lack of courage to try new approaches or reflect on mistakes.
	Risk of burnout	Long-term thoughts of being a failure and feelings of hopelessness about their professional competence.
	Negative impact on future practice	Avoiding difficult patients or situations which may hinder professional growth.

practice (Ladany *et al.* 2005). A supervisee who experiences repeated criticism without support may feel demotivated and unsure of their abilities. This may lead to an increased risk of burnout. Negative experiences in supervision can hinder further therapeutic practice. The supervisee may begin to avoid challenging patients. Table 4 shows examples of negative consequences of abuse of power in psychotherapy and supervision.

Impact on emotional reaction

Power dynamics in supervision might be related to the supervisor's authority and expertise and can amplify feelings of shame. According to the schema therapy model, power and shame are related to the Critic Mode. Supervisees may perceive themselves as failing to meet expectations and use self-criticism or expecting criticism from supervisors (Table 5). According to Delano and Shah (2006), supervisors can exert power by controlling resources, planning, and evaluation. Holloway (2016) emphasised the importance of promoting shame resilience through supervision. According to Shame Resilience Theory (Brown 2006), building resilience involves creating opportunities for empathy, collaboration, and reflection, which reduce feelings of isolation and powerlessness.

The way to address this power-induced shame in supervision is closely related to the Reparenting concept, which is essential in the schema therapy process. According to Holloway (2016), empathy has transformative power in addressing shame. Supervisors can normalise supervisees' experiences of shame through normalisation and self-disclosure. For example, they can share their struggles early in their careers. That way, supervisors can demonstrate humanity and vulnerability and reduce the supervisee's sense of isolation. This approach helps validate the supervisee's feelings and fosters trust and openness.

Abuse of Power Prevention

Appropriate use of power is important for supporting the patient's growth and independence. The psychotherapist must balance guiding the patient and respecting their autonomy (Levitt *et al.* 2016). The therapist should also be aware that their social position (e.g., middle class, white) may differ from the social position of the client, w`ho may have experienced more socioeconomic challenges. Therefore, promoting collaboration rather than using authority is more important for balancing the therapeutic relationship (Proctor 2017).

Tab. 5. Impact of emotional reaction on power during supervision

Indicator	Description
Withdrawal	Supervisees may even shrink physically, from time to time avoid eye contact or become emotionally disengaged during supervision sessions.
Avoidance	Supervisees could overcompensate through perfectionism or deflect attention away from challenges to avoid vulnerability.
Self-Criticism	Supervisees focus more on personally perceived failures, often coupled with preoccupation over gaining the supervisor's approval.

Preventing abuse of power is important for maintaining a safe therapeutic relationship between therapist, patient, supervisor, and supervisee. Effective prevention involves several key elements:

(a) Ethical Standards and Boundaries
Ethical rules and standards set clear boundaries for the actions of a therapist or supervisor. They define their responsibilities and protect patients and supervisees from inappropriate power-based behaviour (Prasko *et al.* 2023a). The rules of the code of ethics emphasise the obligation to respect patient autonomy and to refrain from behaviour that could abuse or disadvantage the patient or supervisee (American Psychological Association 2017).

(b) Self-Reflection and Supervision Practices
Regular self-reflection by the therapist or supervisor is important to identify potential problems in their approach (Prasko *et al.* 2023b). Self-reflection allows the therapist to become aware of how their personal attitudes, emotions, or behavioural responses may affect the dynamics of the relationship. Supervision provides a safe space for open discussion about power dynamics. It helps to become aware of one's emotions and behaviours in the therapeutic or supervisory relationship and correct inappropriate patterns.

(c) Education in Ethics and Power Dynamics
Education is an important element in preventing abuse of power. It helps psychotherapists and supervisors better understand the nuances of power dynamics. Lectures and workshops on ethics, boundaries, and self-reflection help professionals recognise and address problematic situations (Hollwich *et al.* 2015).

(d) Promoting a Culture of Openness and Safety
Preventing abuse of power also requires institutional support. Organisations should create a background that encourages open communication and safe reporting of problems related to abuse of power. Transparent rules and clearly defined procedures for dealing with ethical violations help build a culture of trust.

PRACTICAL STRATEGIES AND RECOMMENDATIONS

Support of Therapist Autonomy and Effectiveness

Suppose the psychotherapist is free and independent in attitude. In that case, he can better face difficulties or challenges, reflect on his practice, be aware of his behaviour and adapt to the needs of patients. To achieve this autonomy, it is good to implement several approaches (Table 7):

(a) Self-reflection and Regular Supervision
Self-reflection allows the therapist to recognise their strengths and areas where they feel insecure or tend to cross ethical boundaries (Prasko *et al.* 2023c). Regular supervision provides a safe environment where therapists can openly share their concerns, receive feedback, and work on their professional growth (Falender & Shafranske 2004).

(b) Continuing Education
Continuing education for therapists is another important step in strengthening therapist autonomy and effectiveness (Hollwich *et al.* 2015). Participation in conferences, courses, and workshops focused on specific therapeutic skills, problem-solving, ethical issues, crisis management, and communication skills allows therapists to gain new knowledge and tools for working with patients (Bernard & Goodyear 2014).

(c) Promoting Self-Confidence Through Practice
Practice and experimentation with new methods and procedures are important for building therapist confidence. For example, structured approaches such as chairwork, imaginative writing, reflective writing, role-playing, or simulations of challenging situations allow the therapist to gain greater confidence in applying new methods (Vyskocilova & Prasko 2013). These approaches provide a safe space for mistakes and their analysis and strengthen the therapist's ability to handle similar situations.

(d) Building Resilience to Stress and Burn Out
The work of a therapist is often emotionally demanding and stressful, and it is therefore important for the therapist to develop their ability to manage stress and prevent burnout (Prasko *et al.* 2022). Practices such as relaxation, mindfulness, plenty of enjoyable activities, and mental hygiene play an important role in maintaining the therapist's emotional balance (Table 6). Promoting resilience to stress improves the therapist's effectiveness and ability to help patients.

Creating an Ethical and Supportive Environment

Creating a safe and ethical environment is the foundation for effective and trustworthy work in psychotherapy and supervision (Pope & Vasquez 2016). Ethical principles protect the patient, supervisee, and supervisor, providing a foundation for a therapeutic relationship supporting autonomy, collaboration, and professional development (Prasko *et al.* 2023a).

Transparent Communication and Respect for the Patient's Needs

Transparent communication is an important element of a safe, ethical therapeutic relationship. The therapist should actively listen with empathy and consciously respond to the concerns and needs of the patient (Vyskocilova *et al.* 2011). This approach creates a space where the patient feels safe, understood, and respected, strengthening their trust in the therapeutic process and encouraging their willingness

Tab. 6. Key elements of preventing abuse of power in psychotherapy and supervision

Prevention area	Description	Examples of measures
Ethical Standards and Boundaries	Clear rules define the behaviour and responsibilities of the therapist or supervisor.	Adherence to the code of ethics rules for setting boundaries concerning the patient/supervisee.
Self-Reflection and Supervision	Regular reflection on one's approach and consultation with the supervisor.	Analysis of own reactions to the patient/ supervisee and feedback from the supervisor.
Ethics Education	Courses and workshops focused on understanding power dynamics and preventing abuse of power.	Participation in trainings on boundaries, ethics and self-reflection.
Promoting Openness and Safety	Transparent institutional policy for preventing and addressing abuse of power.	Establishment of a confidential mechanism for reporting violations of ethical rules.

Tab. 7. Examples of strategies for supporting therapist autonomy

Support area	Description	Examples of measures
Self-reflection and supervision	Identification of own insecurities and feedback from supervisor.	Regular supervision sessions analysis of own reactions to patients.
Continuing education	Acquisition of new skills through courses and training.	Participation in workshops focused on crisis management or specific therapeutic techniques.
Promoting self-confidence through practice	Gaining practical experience with new approaches in a safe environment.	Role-playing, simulation of challenging situations during supervision or in training.

to cooperate (Rogers 1957). For example, if the patient expresses concerns about the targeting of treatment. The therapist should reflect on the patient's concerns and look for ways to better align therapeutic goals with their expectations. Respecting the patient's needs also includes the therapist's flexibility in adapting therapeutic methods to values and preferences. This approach strengthens the patient's autonomy and reduces the risk of abuse of power. The patient feels that their voice is heard.

Avoiding a Hierarchical Concept of Power in Supervision

Supervision requires creating an environment that weakens and eliminates hierarchical power structures and strengthens equality between supervisor and supervisee. This can be achieved through an open and safe collaborative approach, where the supervisee's therapeutic practices and experiences are reflected on and analysed together and inquisitively, without the supervisor dominating (Hawkins & Shohet 2012). The supervisor should be a curious, supportive guide rather than an authority figure who imposes his or her own opinions. For example, a supervisee may discuss a difficult situation with a patient with the supervisor. In this case, the supervisor should ask open-ended questions and support the supervisee in finding solutions rather than dictating specific suggestions. The supervisor strengthens the supervisee's ability to make independent decisions (Prasko *et al.* 2023a).

Collaborative Approach and Openness

A collaborative approach is essential for a supportive environment. It allows both parties to share their perspectives, practices, and experiences. In supervision, it is important that the supervisee feels safe to communicate their insecurities and mistakes. This communication can be a learning opportunity.

Openness also means being willing to discuss the power dynamics in the supervisory relationship. The supervisor can discuss how the supervisee perceives their interaction with each other. Together, they can look for ways to optimise collaboration. This increases trust between the supervisor and supervisee and promotes healthy relationship dynamics. It also helps the supervisee understand how to work in a therapeutic relationship with patients.

The Importance of a Safe Space

A safe, supportive environment allows for calm resolution of challenging emotions and situations in psychotherapy. To create such an environment, the psychotherapist or supervisor must constantly reflect on their practices, encourage open feedback, and be willing to adapt their behaviour to the circumstances. Transparent and respectful communication is a bridge that overcomes possible obstacles or blocks in the therapeutic or supervisory relationship.

Recognising the Need for and Engaging in Personal Therapy

In some cases, therapists may have personal issues and/ or maladaptive personality traits that are "invisible" to them (Prasko *et al.* 2023c). These traits can affect their

professional work with clients, particularly regarding power dynamics. Such characteristics may include narcissistic tendencies, a strong need to control others, limited self-reflection due to rigid coping mechanisms, low levels of empathy, and overcompensation driven by low self-esteem. Individual therapy is needed for these issues. It helps psychotherapists develop greater self-awareness, address unresolved emotional problems, and explore traumas that may contribute to these maladaptive patterns (Vyskocilova & Prasko 2013).

DISCUSSION AND CONCLUSION

Reflection on the Differences and Similarities between CBT and Schema Therapy

CBT and ST share a common goal – to alleviate psychological difficulties by changing maladaptive patterns of experience. However, the approaches of these therapies differ. CBT is structured and directively focused on identifying and modifying specific cognitive and behavioural patterns (Beck *et al.* 1979). The therapist often acts as a "coach" or "teacher". In contrast, ST emphasises identifying and modifying early maladaptive schemas that are activated in ways that influence the patient's experience and behaviour. It focuses on changing the understanding of oneself and the world, especially through experiential approaches in a therapeutic relationship of limited reparenting (Young *et al.* 2003).

The Impact of Power Dynamics on the Therapeutic and Supervisory Process

Power dynamics play a key role in both the therapeutic and supervisory processes. In CBT, a directive approach by the therapist can lead to effective patient guidance. However, excessive directiveness can weaken the patient's autonomy and reduce the effectiveness of therapy (Muran & Barber 2010). In ST, the emphasis is on emotional connection and understanding the patient's modes, which requires a sensitive approach and a high degree of self-reflection on the therapist's part (Young *et al.* 2003). In supervision, the inappropriate use of power by the supervisor can lead to feelings of powerlessness in the supervisee, which can hinder their professional growth and negatively affect therapeutic practice (Ladany *et al.* 2005).

The Importance of Cultural and Institutional Context

Cultural and institutional contexts influence perceptions and uses of power in the therapeutic and supervisory relationship (Prasko *et al.* 2023a). Cultural norms can influence patients' and therapists' expectations regarding the role of power in therapy (Boadella 1993). Institutional structures and policies can support or limit the autonomy of psychotherapists and patients (Zur 2009).

Limitations and a Room for Further Research

This article highlights the need for further research to understand power dynamics in different psychotherapy and supervision contexts. Future studies should consider personal, cultural, and institutional factors and their influence on the therapeutic and supervisory process. It is also important to experimentally test strategies for managing power dynamics and preventing their abuse in therapy and supervision.

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