PSYCHOTHERAPY

Empathy in cognitive behavioral therapy and supervision

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Submitted: 2011-05-04 Accepted: 2011-06-01 Published online: 2011-06-25

Key words: **empathy; cognitive behavioral therapy; neurobiology; therapeutic relation; transference; countertransference; supervision**

Act Nerv Super Rediviva 2011; **53**(2): 72–83 ANSR530211A03

Abstract

Rogers found empathic reflection useful and around it constructed his notions of individuation. Active listening requires therapists to paraphrase what the client has just said, using the emotional tone in which it was said. Empathic reflections are intended to confirm the client´s experience by helping him or her know more precisely what it is and to make it more acceptable. In recent years social neuroscience made considerable progress in revealing the mechanisms that enable a person to feel what another is feeling. During empathic reaction the therapist is intervening not only in a psychological manner to connect, heal, and share burden but also in a neurobiological level. Shared neural representations can play a main role in understanding of mental states of other person.

Cognitive behavior therapists examine the thoughts, feelings, and behaviors related to a wide range of situations (including reactions to the therapist) and relevant childhood experiences to understand the underlying core beliefs and conditional assumptions of each client. Empathy helps them to understand both emotional reactions and the meanings of experience for the client and helps them also to understand how these elements are interconnected in concrete client. Understanding of transference and countertransference is crucial to effective listening. Empathy could help to recognize and understand transference and countertransference and for their appropriate using during the therapy. Empathic ability may be part of sensitivity to one´s own feelings, including countertransference feelings, which in turn ought to prevent the acting out of countertransference.

Introduction

Therapeutical interest in empathy has been remarkable spread since its introducing by Freud. Also, Rogers has put much emphasis on empathy in nondirective therapy approach and the topic has been a focus of his psychotherapy research (Rogers & Dymond 1954). Rogers found empathic reflection useful and around it constructed his conception of individuation. Rogerian technique of empathic reflection or "active listening" is probably the most widely known method of expressing therapist willingness to comprehend the ongoing experience of the client. Active listening requires the therapists to paraphrase what the client has just said by using the emotional tone in which it was said. As Rogers (1951) taught active listening, he gradually discovered that trainees tended to parrot back client utterances without really entering into their frames of reference. He switched therapists training to learn them enter into the client's world and to describe this world from that internal reference point. Empathic reflections illustrate the way in which interventions may appear to have one function but also have next. As summary statements of client here-and now emotional

experience, empathic reflections are intended to confirm the client's experience by helping him/her know more deeply what experience is and to make it more acceptable. Therapist can not reflect all client emotions and therefore must be selective. By reacting to certain content and not to others, clients are encouraging to continue in the manner that has elicited the therapist's responses. If the function of questions is to direct client attention to certain area, then empathic reflections seem to exert a similar function.

Somewhat different development was described in the work of Kohut *et al* (1959) in which a "central position" of empathy in both human development and therapy has been accentuated. Kohut defines empathy as "vicarious introspection". While emphasizing an observational and data-gathering aspect of empathy, he explained how this type of introspection actually leads to understanding and knowledge. Goldberg (1973) described empathic approach in short-term therapy, which relies on Kohut formulation of a psychology of the self (Kohut 1971). Goldberg suggested that a therapist's empathic stance can help clients recover from acute narcissistic injuries, that is, damaged self-esteem. Goldberg provided an empathic "mirroring" relationship to reflect and strengthen the client's injured self-esteem. Empathy is particularly important in complex interpersonal behavioral problems in which the environment (family, friends, colleagues etc.) may to expel the client, and the client has therefore lost hope.

Meaning of "empathy"

The term "empathy" has aggregate a number of meanings and these overtones are not necessarily intrinsic either to the psychological properties of the phenomenon or to its therapeutic action. On the level of vicariously felt responses, we have to distinguish between empathy, sympathy, empathic concern, and compassion. In all these cases, emotional changes are induced in the observer in response to the perceived or imagined emotional state of another person. The word empathy comes to be used as a virtual synonym for the word sympathy, but it is important to distinguish these conditions with respect to psychotherapy. While empathy includes feelings that are isomorphous to those of the other person, sympathy, empathic concern, and compassion do not necessarily involve sharable feelings. Sympathy refers more to a feeling of compassion for and active sharing of the client's pain. Whereas sympathy means to feel the same as someone else, empathy means to understand as well as to share in a way that exceeds having the same surface feelings. For example, empathizing with a person feeling sadness will result in a feeling of sadness in the self, whereas sympathizing with, being empathically concerned, or feeling compassion for a sad person will result in either pity or compassionate love for the person, but not sadness. Also, when an observer notices that someone is jealous of him, he/she will most likely not start feeling jealous himself – though he/she might show sympathy or compassion for the jealous person (de Vignemont & Singer 2006). On overly sympathetic reaction may vitiate the therapist's attempts to relieve the sources of the client's distress or anxiety (Beck *et al* 1979). Empathy, on the other side, includes an intellectual (as well as an emotive) component, namely, understanding the cognitive basis for the client's feelings; it also implies the ability to detach oneself from the client's feelings in order to maintain objectively toward his problems. Therefore, the crucial distinction between the term *empathy* and those like sympathy, empathic concern, and compassion is that empathy denotes that the observer's emotions reflect affective sharing ("feeling with" the other person) while compassion, sympathy, empathic concern means that the observer's emotions are inherently other oriented ("feeling for" the other person) (de Vignemont & Singer 2006). Empathy is also often associated with love and warmth. In therapy, warm intervention is often automatically described as empathic one. Although there are intrinsic connections between warmth, love and empathy, there are not simple or direct. Therapist´s empathy may be experienced by a client as warm, or even loving, but warmth or love does not directly generate empathy and empathic understanding. Usually, also, empathy is considered similar to the intuition. Intuition is similar to empathy because both are, in some way, sources of knowledge. While intuition consists of drawing conclusions from minimal cues and tends to be primarily a cognitive skill relative to all realms of knowledge, empathy pertains primarily to human experience and has strong emotional components (Rothenberg 1988). In therapeutic process, empathy is an active motivated function which leads to specific understanding of the client's inner psychological state. As a result of creative process empathy produces useful interpersonal knowledge which did not exist before. In cognitive behavioral therapy tradition, according Beck *et al* (1979), accurate empathy refers to how well the therapist can go into the client's world and see and experience life the way the client does. The therapist will to some degree, experience the client's feelings. To the extend that his/her empathy is reasonably accurate, the therapist will be able to understand how the client structures and responds to certain events and relations. Therapeutic empathy includes the cognitive and emotional components of lived experience. At a basic phenomenological level, empathy denotes an affective response to the directly perceived, imagined, or inferred feeling state of another being (Batson 2009). De Vignemont and Singer (2006) define empathy as follows: We "empathize" with others when we have (1) an emotional state (2) which is isomorphic to another person's emotional state, (3) which was elicited by observing or imagining another person's emotional state, and (4) when we know that the other person's emotional state is the source of our own emotional state.

Empathic understanding and expressing

Using empathy in psychotherapy has two distinct steps that are often blurred in the minds of those considering it. The phenomenon of empathy entails not only listening but also the ability to share the emotional experiences of others (Singer & Lamm 2009). The first step, gaining empathic understanding, and the second, expressing the empathic understanding, each may be approached in a number of ways. Therapeutic empathy begins with listening of the client. Listening and hearing are often seen as equal. But listening includes not only hearing and understanding what the speaker said, but also attending nonverbal issues and context, sequences of associations, specific selections of words, metaphors, contents of imagery etc. (Mohl 2008). Traditionally, this kind of listening has been known as "listening with the third ear" (Reik 1954). Because inner human experience is so complex, therapist must choose restricted levels through which to enter the other's world. Here and now affective state is the most common empathic target. Therapeutic listening requires interpersonal sensitivity, sensitivity to the storyteller, ability to integrate whole story to logical conceptualization. Client is invited to cooperate as an active informer and rewarded after any meaningful information. Therapist, hearing the client story, experiences the world of client and his situation from the client perspective. Good listener hears both the client and the disorder or problems clearly, and regards every encounter as potentially therapeutic. During the dialogue the listener is on a journey to discover who the client is a person with his narrative, helping carry the burden of loss, lightening and transforming the load (Rogers 1967). Therapist may use also his/her thoughts to enter any level of the other's experience. By avoiding only use or his/her own feelings, therapist maintains an objective perspective but lose some of the ongoing experience. When using objective thought to gain empathic understanding, therapists may attempt to categorize client emotional state. They may also consider clients to be members of specific groups, inclusion in which seems to predict typical experiences. For example, age, class or ethnic predicts biocultural milestones (Haley 1973), diagnosis predicts certain though patterns (Beck 1976), and social role predicts common conflicts (recent immigrant, divorcing man or woman). Theoretical assumption about human psychological dysfunction help therapist to filter data of the client's presentation in manners that support these theoretical patterns and lead to a kind of empathic understanding. Therefore listening is part of diagnosis as well as healing. *Symptomatic listening* look like traditional medical anamnesis – the focus is on the presence and absence of specific symptoms. During symptomatic listening CBT therapists or supervisors typically focus on thoughts, behaviour patterns, beliefs, emotions, somatic reactions, antecedents and consequences of behaviour. *Narrative-experiential listening* is based on the theory, that all people are constantly interpreting their experiences, attributing the meaning to them and integrating a story of their lives with themselves as the central character (Mohl 2008). This includes personal history, repetitive behaviours, rules and learned assumptions about client himself, about other people and world, and interpersonal roles. To listen and understand requires that the language used between client and therapist be shared – meanings of words and sentences are commonly held (Kimmerling *et al* 2000). The Sapir-Whorf hypothesis suggests that what we are able to think is determined by the language in which we are working and it is the basic mechanism for developing and maintaining social organization (Shapir 2000; Dunbar 2004). Therapists may also choose to permit their clients to help them emotionally by allowing client words and nonverbal signals to enter into their ongoing experience and by sharing how they are affected by these sounds and rhythms. The ability to comprehend the client through attention to inner reactions is based upon "what seems to be a universal capacity for unconscious perception and sensitivity" (Langs 1976, p.562).

Role of empathy in cognitive behavioral therapy

Traditionally cognitive-behavioral therapists listen e.g. for emotional expression, stimulus associations, pattern of behaviour, cognitive distortions, irrational assumptions, maladaptive schemas, narrative context or global inferences, family structure, myths and environment etc. (Beck 1979; Leahy 2003; Young *et al* 2003). Qualified cognitive behavioral therapists demonstrate the competencies of any good psychotherapist: genuine empathy, respect, caring, regard, and accurate understanding. They value a collaborative working relationship and fine-tune their style and the process of therapy to suit individual clients (Beck 1995). Cognitive behavioral therapists would agree with Rogers concerning the importance of therapist empathy in helping clients. However CBT therapists would not only offer their clients emotional empathy (i.e. showing their client that they know how they feel), but also offer them philosophical empathy (i.e. showing their clients that they understand the underlying philosophies (beliefs or rules) upon which their emotions are based (Dryden & Ellis 1988). The special meanings of words, sentences and images can be one of the central focuses of the therapy. Therapists have to at the same time listen symptomatically and narratively/ experientially. It also involves seeing – facial expression, gestures, movements, mimics and so on. Therapist constantly compares what is said with what is seen, seeking disharmonies, and comparing what is being said and seem with was previously communicated and observed. They must also have access to different theoretical views, not only cognitive behavioral theory, but sometimes also sociocultural, existential, gestalt, psychodynamic,

system and narrative theories. Further, it is essential to be aware of what might been said but was not (Mohl 2008).

Biological origin of the empathy

In last twenty years social neuroscience has made considerable advances in understanding the mechanisms which enable one person to feel what another is feeling (Singer & Lamm 2009). Attachment and social support are psychobiological mechanisms which provide important physiological regulation to human beings (Hofer 1996; Heim & Nemeroff 2001; Meaney 2001). Several works support the notion of the client's capacity to perceive empathy through the powerful nonverbal, universally understood communication of facial expressions (Ekman 1992). Considerable verification shows that sharing the emotions of others is associated with activation in neural structures that are also active during the first-hand experience of that emotion. Part of the neural activation shared between self- and other-related experiences seems to be rather automatically activated (Singer & Lamm 2009). Facial expressions of the listener may generate autonomic and central nervous system changes not only within the listener but within the person being heard. There is neurobiological basis for empathy, transference and countertransference and also biological basis for the power of listening to heal, to change psychological burdens, to remoralizate, and to help with emotional regulation in clients, who felt out of control in their strong emotions like panic, anger, despair, depression etc.

Our understanding of role of mimicry (tendency to automatically synchronize affective expressions, vocalizations, postures, and movements with those of another person) as a low-level process contributes toward empathy comes from studies using facial electromyography. These studies show that when one person perceives another person's emotional facial expressions, such as a smile or a lour, corresponding emotional expressions result in the observer (Dimberg & Oehman 1996). According the facial feedback hypothesis (person appraises his own emotions by perceiving their bodily concomitants), Sonnby-Borgstrom (2002) suggested that mimicry enables one person to automatically share and understand another's emotions. Some studies demonstrate the influence of top-down processes on mimicry, such as those associated with the relationship between empathizer and target (Lakin & Chartrand 2003), the emotional state of the observer (Moody *et al* 2007), or the perspective from which pain in others is witnessed (Lamm *et al* 2008). Mimicry seems to serve a social function in increasing rapport and affinity between self and other, raising the question whether this function evolved for communicative rather than for epistemological reasons (van Baaren *et al* 2004). Emotional contagion ("primitive empathy") is next process which is related to but different from empathy. It means automatic tendency to "adopt" other people's emotions (Hatfield *et al* 2009). For example, babies start cry when they hear other children crying. No long ago, the evidence for involuntary pupillary contagion has been found in an fMRI study (Harrison *et al* 2006). Experimentees were presented with pictures of sad faces with various pupil sizes. Their own pupil size was significantly smaller when they viewed sad faces with small as compared to larger pupils. Edinger–Westphal nucleus in the brainstem, which controls pupil size, was specifically engaged by this contagious effect. Pupillary contagion occurs outside of awareness and may constitute a precursor of empathy. This study can also demonstrate the overlap between mimicry and emotional contagion (Hatfield *et al* 1993). However, that there are situations in which mimicry occurs without an affective component and other situation in which affects are automatically elicited by observing others' affective states without motor mimicry. But neither emotional contagion nor mimicry cannot answer for the full-blown experience of empathy (Singer & Lamm 2009). The empathy fundamentally relay on self-awareness and self/other distinction – distinguishing between whether the source of our emotional experience lies within us or was triggered by the other (de Vignemont & Singer 2006). Without this ability, witnessing someone else's emotions could, for example, result, purely, in personal distress and a self-centered response in the observer. The crucial distinction between the term empathy and those like sympathy, empathic concern, and compassion is that empathy denotes that the observer's emotions reflect affective sharing (Singer & Lamm 2009).

During empathic reaction the therapist is intervening not only in a psychological manner to connect, heal, and share burden but also in a neurobiological level (Mohl 2008). When clients feel safety, accepted, respected and valuated, the response is also remarkable in the level of brain substrate. LeDoux (1996) was a pioneer in identifying the neurobiological basis for primary emotions. Brothers (1989) using this findings and findings from own studies with primates, developed a hypothesis about the biology of the empathy based on seeing as well as hearing. Brothers (1994) and Damascio (1994) identified the amygdala and the inferior temporal lobe gyrus as the neurobiological substrate for recognition of and empathy for other person. The discovery of mirror neurons has added to our understanding of the neurobiology of empathy (Harris 2007). Schore (2001) has identified that these parts are predetermined to recognizing facial expression, gestures etc, but require effective maternal-infant interaction in order to do so. Preston and de Waal (2002) described a neuroscientific model of empathy, one which suggests that observing or imagining another person in a particular emotional state automatically activates a representation of that state in the observer, and activated also its associated bodily reactions. There was proposed

also by others that shared neural representations can play a main role in understanding of mental states of other person. Shared representations provide us with a simulation of corresponding sensorimotor, affective, or mental experiences (Gallese 2003a; Goldman 2006). The empathy is a flexible process influenced with a number of factors—such as contextual appraisal, the interpersonal relationship between empathizer and other, or the perspective adopted during observation of the other (Singer & Lamm 2009). An important aspect of most neuroscientifically motivated models of empathy is that the activation of shared representations in the observer is initiated mostly automatically and without conscious awareness. The most of studies on the empathy used the observation of pain in others as a model to evoke empathic reactions (de Vignemont & Singer 2006; Decety & Lamm 2006; Singer & Leiberg 2009; Jabbi *et al* 2007). Singer *et al* (2004) recruited couples and measured hemodynamic responses triggered by painful stimulus of the female partner via an electrode attached to her right hand. In another condition the same painful stimulation was applied to the male partner who was seated next to the MRI scanner and whose hand could be seen via a mirror system by the female partner lying in the scanner. Differently colored flashes of light on a screen pointed to either the male or the female partner's hand, indicating which of them would receive painful stimulation. The results suggest that parts of the so-called pain matrix (Derbyshire 2000), which consists of the brain areas involved in the processing of pain, were activated when participants experienced pain themselves as well as when they saw a signal indicating that their loved one would experience pain. These areas—especially bilateral anterior insula, the dorsal anterior cingulate cortex, brain stem, and the cerebellum—are involved in the processing of the emotional component of pain. Thus, both the firsthand experience of pain and the knowledge that a beloved partner is experiencing pain activates the same affective brain circuits. It seems that our own neural response reflects our partner's negative emotion. Other authors observed that the amplitude of an event-related potential component known to be generated in primary somatosensory cortex (P45) is modulated by seeing a needle piercing another person's hand (Bufalari *et al* 2007). Similarly fMRI study demonstrated that (contralateral) right primary somatosensory cortex was activated when participants saw another person's left hand being pierced (Lamm *et al* 2008, 2010). The common finding of these experiments is that vicariously experiencing pain activates part of the neural network that is also activated when we are in pain ourselves.

To examine the areas involved in emotional sharing during pain more precisely, detailed analyses of activation areas in the cingulate and insular cortices have recently been investigated (Jackson *et al* 2006; Morrison & Downing 2007; Decety & Lamm 2009). These analyses show that there is reliable overlap when activation in these areas during firsthand and vicarious experience of pain is compared, but they also show that the majority of voxels in the insula and the cingulate cortex do not overlap. A recent meta-analysis compared published localizations for the experience of pain to those reported for empathy for pain. The results show a more posterior–midinsular activation pattern for the firsthand experience of pain (Decety & Lamm 2009). While this could be expected for the hemisphere contralateral to the stimulated body part, it is surprising for the ipsilateral (right) hemisphere. The same meta-analysis also shows overlapping, yet largely distinct activation patterns in medial and anterior cingulate cortex (Morrison & Downing 2007).

Singer *et al* (2004) extended an interoceptive model of emotions to the domain of empathy and suggested that cortical re-representations in anterior cingula of bodily states could have a dual function. First, they may allow us to create subjective representations of our own feelings. These representations not only allow us to understand our own feelings when emotional stimuli are present, but also to predict the bodily effects of anticipated emotional stimuli to our bodies. Second, they may serve as the visceral correlate of a prospective simulation of how something may feel for others. This can help us to understand the emotional significance of a specific stimulus and its consequences. In accordance with this hypothesis, it is noticeable that the expectation of pain has been found to activate more anterior insular regions, whereas the actual experience of pain recruits more posterior insular regions. This confirmed the hypothetical role of more posterior insular regions in modality specific, primary representations of pain and more anterior regions in the secondary representations of the anticipatory negative emotion related to pain (Ploghaus *et al* 1999). In consonance with these observations, in pain empathy studies activity in posterior insular cortices was observed only when people were experiencing pain themselves, whereas activity in anterior cingula was observed when participants were experiencing pain themselves and when vicariously feeling someone else's pain (Singer *et al* 2004; Lamm *et al* 2007). Last fMRI study observed substantial reactions in anterior insula and anterior cingulate cortex when participants were presented with visual stimuli depicting situations that were clearly no painful for them but known to be painful for the target (Lamm *et al* 2010).

Most recent models of empathy accentuate the importance of top-down control and contextual appraisal for either the generation of an empathic response or for modulating an existing one induced by the above-mentioned bottom-up processes (deVignemont & Singer 2006; Decety & Lamm 2006). Decety and Lamm (2006) proposed a model in which bottom-up (i.e., direct matching between perception and action) and top-down (i.e., regulation, contextual appraisal, and control) information processes are fun-

damentally collaborated in the generation of empathy. In their hypothesis, bottom up processes are responsible for direct emotion sharing which is automatically activated (unless inhibited) by perceptual input. On the other end, executive functions implemented in the prefrontal and cingulate cortex serve to regulate both cognition and emotion through selective attention and self-regulation. This meta-cognitive level is continuously updated by bottom-up information, and in return controls the lower level by providing top-down feedback. Thus, top-down regulation, through executive functions, modulates lower levels and adds flexibility, making the individual less dependent on external cues (Hein & Singer 2008).

Influence of empathy to the therapeutic relation

There is a growing body of process research suggesting that therapists must customize their approaches to clients (Lambert & Barley 2002). Another way to conceptualization of these processes, influenced from the research studies involves basic factors important to outcome in all forms of psychotherapy: empathy, no contingent positive regard, and therapist authenticity (Rogers 1967; Traux 1963). The experienced therapist listens to the words, watches the behaviour, engages in and notices the ongoing interaction, allows him or herself to experience his or her own inner reaction to the process. The art is hearing the client's inner experience and then addressing it empathically; enabling the client to feel heard and affirmed. To know oneself is to be aware that there are certain common human feelings, fears, needs, wishes, and reactions. Every human being must deal in some manner with authority, intimacy, selfish, dependence, values, love, hate, work, envy and loss. It is unlikely that the therapist can understand the client without his own self-awareness (Mohl 2008). Therapist invites the client to collaborate as an active informer. The interviewer may focus not only on the facts of the client's symptoms, problems and interactions with others but also on the feelings, fantasies, and thoughts with such relationships (***Tab. 1***) (Silberman *et al* 2008).

Therapist who listen carefully and actively and confirm the client help also created a new level of understanding of client's symptoms and story (Edelson 1993). Helpful therapeutic listening requires a complicated attitude toward control and power in the dialogue. If the therapist can accurately perceive and share the client's expectancies, he/she is more likely to be able to make sense out of client's unproductive behaviours and to be less judgmental about them (Beck *et al* 1979). Furthermore, the therapist can convey that he can share some of the client's distress. This expression helps the client regard the therapist as understanding and facilitates further disclosure of feelings and cognitions. These are not necessarily new skills for experienced therapists, but the client's shoes perspective creates an enhanced empathy and sensitivity for the client's situation, which results in a more careful approach to therapy, attuned to the subtle nuances of situations (Bennett-Levy *et al* 2003).

The ways and tools of listening also change, according to the purpose, the nature of the therapeutic dyad. The ways of listening also change depending upon whether of not the therapist is preoccupied or inattentive. The development of common goals fosters the therapist and client seeing them as having reciprocal responsibilities (***Tab. 2***).

Many factors influence the ability to listening. Therapists come to the client as the product of their own life experiences (Prasko *et al* 2010; Prasko & Vyskocilova 2010). Although the word "transference" is not part of the jargon of cognitive behavior therapy, examination of the cognitions related to the therapist with respect to past significant relationships is an integral part of the assessment and treatment in cognitive behavior therapy (Prasko & Vyskocilova 2010). As cognitive behavior therapy supervisors, we often find that supervisees and psychodynamic therapy therapist have the perception that transference is not examined in cognitive behavior therapy. In our opinion, this is false myth about cognitive behavior therapy that has been identified by various experts (Beck *et al* 1979; Persons 1989; Gluhoski 1994; Beck 1995; Sudak *et al* 2003). The act of listening could be influenced or blocked by similarities and differences between the therapist and client. Sometimes thera-

Tab. 1. Feeling-oriented interventions in the interview (modified according Silberman et al 2008).

INTERVENTION	EXAMPLES
Questions about feelings in specific situations	• Some people might have been angry in the situation you told me about. Did you feel that way? • How did you feel when your doctor told you that you had a heart attack? • I've notice your voice got much quieter when you answered my last question. What were you feeling just then?
Questions or comments about emotional themes or patterns	• Growing up, you never felt like you measured to your mother's expectation. Do you feel that same way in your marriage?
Questions or comments about the personal meaning of events	• You are concerned about becoming enraged at your daughter. When she disregards your wishes, what do you feel that means about you as a parent.

Tab. 2. Supportive interventions (modified according Silberman et al 2008).

INTERVENTION	EXAMPLES
Empathetic statements	• When your boyfriend doesn´t call you, you feel completely helpless and unloved. • It seems unfair for you to get sick so many times while others remain well.
Nonverbal communication	• Smiling, firm handshake, attentive body posture, and gentle touch on shoulder.
Acknowledgement of affect	• You look very sad when you talk about your brother. • I have the impression that my question made you angry.
Reassurance	• What are you telling me about may seem very strange to you, but many people have had similar experiences. • You feel like you will be sick forever, but with treatment you have a very good chance of feeling better soon.
Encouragement	• Client: I'm not sure I'm making any sense today doctor. • Therapist: Your´re doing very well at describing the troubles you're been having.
Approval	• You did the right thing by coming in for an appointment. • Your´ve been doing your best to keep going under very difficult circumstances.

pists view clients as passive, manipulative and indecisive. Therapist becomes frustrated, and the client feels criticize. By trying to identify and correct the client´s cognitive distortions which contribute to passivity or lack of initiative, or oppositional, the therapist and the client collaborate in trying to solve very problems which contribute to their mutual frustrations. Positive transference reactions may also impede the course of therapy. The client may regard the therapist as a saviour and exaggerate his/her positive attributes. Such high expectations have to be discussed and the positive distortions pointed out. The therapist also must be careful not to project his/her own attitudes or expectations onto the client and thereby to distort the client´s report. On the other hand, an overreliance on empathy may mislead the therapist into accepting the veridicality of the client´s automatic negative representation of himself and the world (Beck *et al* 1979). Developing a cognitive behavior therapy case conceptualization of clients is recommended for treating every client with cognitive behavior therapy (Persons 1989); cognitive behavior therapists examine the thoughts, feelings, and behaviors related to a wide range of situations (including reactions to the therapist) and relevant childhood experiences to understand the underlying core beliefs and conditional assumptions of each client. Beck argued that the development and structure of a maladaptive self-schema occurs in early childhood but remains dormant until it is activated by negative life circumstances (Beck *et al* 1979). Young (1990, 1999; Young *et al* 2003) argued that the unique circumstances an individual experiences in childhood contribute to the development of a distinctive set of core beliefs about self and others which he termed early maladaptive schemas. Schemas have been defined in a number of ways, but most definitions incorporate the idea that they consist of both structure (i.e., an organizational component) and content (Ingram *et al* 1998). According to Young *et al* (2003), individuals with early maladaptive schemas tend to also display maladaptive coping strategies that may perpetuate their schemas which are also used in therapeutic relationship. The children need for safety, attention, acceptance and valuation, if no satisfied in childhood, increase in the stress situations and typically is projected into therapeutic relationship (Dozois *et al* 2009). Therapists discern meaning in that which they hear through filters of their own life experiences, nationality, sex roles, religion, class and unresolved problems (Comas-Diaz & Jacobson 1991; Kleinman 2001). Filters can serve as blocks or magnifiers if some elements of what is being said resonate within the therapist (Mohl 2008). We speak about countertransference. Many authors believe that it is important to underscore that transference issues are examined carefully, in an upfront fashion, in cognitive behavior therapy and must be an integral component of the complete man-

Tab. 3. Blocks to effective listening in therapeutic or supervision relationship (modify according Mohl 2008).

Therapist-client dissimilarities	• religion • gender • age • race • culture • nationality • class
Similarities	• may lead to incorrect assumptions of shared meanings
Countertransference	• therapist fails to hear, understand, or react inappropriately to content reminiscent of own unresolved conflicts
External forces	• managed care setting • emergency department • control-orient in client unit
Attitudes	• need for control • psychiatrist having a bad day

agement of every client undergoing cognitive behavior therapy (***Tab. 3***) (Sareen & Skakum 2005).

For instance gender can play an important role in the experience of feeling found (with feeling of safety, acceptance and positive appraisal) by the other person. Some persons feels that it is easier to been open with a person of the same sex, and other, with someone of the opposite sex. In this period of significant change in sex roles, a misinterpretation such as that early in treatment could result in a permanent rupture in the therapeutic relationship. Also therapists vary in their sensitivity to the different gender.

Understanding of transference and countertransference is crucial to effective listening (Prasko *et al* 2010). Transference is the tendency the client has to see the therapist as being like an important figure from his past (Freud 1958). This process typically occurs outside client's conscious awareness; it is probably a basic means used by the brain to make sense of current experience by seeing the past in the present and limiting input of new information (Ursano *et al* 2008). Recognizing transference in the therapist-client relationship can aid the therapist in understanding the client's deeply held expectations of shame, injury, help, or abandoned that derive from childhood experiences. The therapist can also superimpose the past on the present. Emotional, vegetative, behavioral and cognitive reactions evoked by a client may provide the therapist with some sense of who the client is, how he/she related to other people, what his/her internal world is about and what a relationship with this client may involve (Ivey 2006). Countertransference usually takes one of 2 types: *concordant countertransference*, in which therapist empathizes with the client's position; or *complementary* one, in which therapist empathizes with an important figure from the client's past (Ursano *et al* 2008). Paying close attention to own therapist reactions while refraining from immediate action can inform him in an experiential manner about subtle aspects of the client's behaviour that he may overlook or not appreciate.

Role of experiential training and personal therapy

Experiential training and personal therapy have rich traditions in most therapeutic schools as strategies to enhance self-awareness and therapist skills. It can be very helpful in developing the empathy skills. However, personal experiential work has not traditionally been part of cognitive behavioral therapy training. Bennett-Levy *et al* (2003) describes the impact of personal experiential work on cognitive behavioral skills in a group of CBT practitioners. Fourteen cognitive therapists undertook training courses utilizing a structured approach to self-practice of CBT techniques, known as self-practice/self-reflection. Six therapists from one training group engaged in "co-therapy" sessions with a partner, while eight therapists from another training group practiced CBT techniques on their own. Follow-up 1–5 months after the courses identified six areas of self-reported skill enhancement: Refinement of specific CT skills; Enriched communication of the conceptual framework of CT; Increased attention to the therapeutic relationship; Empathic attunement; Therapist self-reflection; and Therapeutic flexibility. In the present study, enhanced empathy was a common denominator underpinning changes in a number of categories (e.g. Empathic attunement, Communicating the conceptual framework, Attention to the therapeutic relationship). Davis *et al* (2008) reported that highly experienced self-practice/self-reflection participants demonstrated significant changes in personal and therapist beliefs, as well as measurable gains in self-reported CBT skills and empathy (Bennett-Levy *et al* 2009).

How to use empathy in praxis

Teaching of listening is prominently emphasized in cognitive behavioral training and supervisory programs (Prasko *et al* 2011). Listening takes time, concentration, imagination, a sense of humor, and an attitude that places the client as and expert and also hero of his own life story. It is especially important to maintain a posture of attentive listening when the client is talking about emotionally intense of meaningful issues. The therapist´s ability to empathize, to understand in feeling terms every client's subjective experience, is important to the development of rapport. Our client may be depressed, hopeless, lonely, isolated, demoralized, and desperate, regardless of the specific diagnoses. Some of them have lost themselves and their close relationships. They can only be found within the context of their own experiences, histories, genders, cultures, religions, social class and other contexts. There are no many experiences as healing as the experience of being found by another person (Mohl 2008). The earliest formulation of this need is in early childhood referred as need of attachment. In non-professional words, it is often subsumed under the need for security, acceptance (love), and positive appraisal. Many of our clients have lost or never had these experiences in their lives.

Schema therapy focuses directly on fulfilling the client´s unmet emotional needs (Rafaeli *et al* 2011). In Schema therapy Young *et al* (2003) stressed empathizing of client's underlying schema. He speaks about "empathic confirmation" and "limited reparenting". The therapist reparents the client within the appropriate boundaries of the therapeutic relationship; this is what schema therapist called "limited reparenting". Within these boundaries, the therapist tries to satisfy many of the client´s unmet needs. For instance, the client's anger is usually a sense of abandonment, deprivation or abuse. The Angry and Impulsive Child is a response to the unmet needs of the Abandonment Child. The goal of the empathizing is to shift the client from the Angry and Impulsive Child into the Abandoned Child mode,

so the therapist can reparent the Abandoned Child and remedy the source of the anger (Klosko & Young 2004). Schema therapy stress optimal balance between support and acceptance with empathy on the one hand, and reality testing and confrontation of the other.

Empathy and supervision

Supervision that emphasizes one´s emotional reactions to clients is important way to identifying this distinction and achieves understanding of clients more deeply. What has been said and heard after a session and between sessions is the most powerful and active tool of listening (Mohl 2008). It is important to hear our clients in out thoughts during the in-between times in order to pull together repetitive patterns of thinking, feeling, and behaviour, giving the therapists the closer picture of how clients experience themselves and their world. It is important to distinguish this "relistening" (which is important part of therapist´s processing of what has been experienced with the client) from countertransference. Countertransference occurs in all types more or less mixed with the therapist´s past but often greatly influencing the therapist-client relationship. All above is true in supervision. Therapist speaks about his/her clients after session and between sessions. His understanding the client is target of the supervision. The empathy of supervisor to therapist´s work helps in the supervision process. In CBT candidates are taught to employ their awareness of their countertransferential reactions as a diagnostic and therapeutic tool. In many aspects, the supervisor may also be an example to the supervisee of how clients should be treated. Therefore, the supervisor's behaviour should include examples and models required from the therapist, such as respect, security, acceptance, empathy, encouragement and appreciation, congruence, ability to view hidden contracts and offer them metaphorically to the therapist for consideration and other potential solutions, straightforwardness and optimism towards other people (Greben & Ruskin 1994).

Supervision of intensive psychotherapy treatment cases in the context of stable supervisory relationships has long been seen as a major vehicle for training in countertransference (Rao *et al* 1997). The supervisory alliance is establish through the process of contract development and is strengthened with added transparency through feedback, evaluation, and attention to client outcomes (Falender & Shafranske 2008). Transference/countertransference skills have traditionally been taught in the context of psychotherapy supervision. During the course of supervision, there will be times when strains and even ruptures to the relationship develop. Supervisors are responsible for establishing this alliance and identifying and repairing tenseness and ruptures as well as for identifying and managing transference and countertransference of the supervisee and supervisor (Prasko & Vyskocilova 2010; Prasko *et al* 2011). We use the term *countertransference* here to refer to all of the therapist´s reactions to the client, including those of which the physician may not be aware and those which are unconscious transference reactions to the client's transference (Rao *et al* 1997). Transference and countertransference become accentuated in caregiving situations such as the therapist-client (or doctor-client) relationship, and the therapist needs to be aware of the deep feelings aroused in such relationships, regardless of the client´s or client's physical or psychological pathology. Subjectively, countertransference is experienced as variations in the therapist´s feelings about himself or herself, the client, and third parties, the understanding of which can lead to increased insight into processes occurring in the client and between therapist and client, regardless of treatment modality. Countertransference may also be manifest in a lack of feeling about or recognition of events that the average therapist could be expected to recognize and respond to. Countertransference that has not become an object of the therapist´s awareness and is not coped with successfully can lead to a spectrum of difficulties resulting from a lack of understanding of the client or from unconscious acting out. Transference and countertransference reactions are ubiquitous in any mode of psychological, counseling care or psychiatric treatment.

The best practices for supervision consist of cognizance of the role of personal factors and diversity in all aspects of therapy and supervision, management of countertransference issues, and identification and use of the parallel process. Parallel process indicate to the dynamics of the therapeutic relationship stimulating and being reflected within supervisory relationship, or conversely, the dynamics of the supervisory relationship being shown up in the therapeutic relationship with the client (Falender & Shafranske 2008). Empathy is the ability to partially identify with and put one´s self in the other's shoes; permits the therapist to focus on the client´s needs despite the difficulties the therapist may experience in the work. Also, empathic ability may be part of sensitivity to one´s own feelings, including countertransference feelings, which in turn ought to prevent the acting out of countertransference (Rao *et al* 1997; Gelso & Hayes 2002). We teach trainees how to foster and use their open empathic reaction to assess the way the client sees his or her disorder and problems also relationship with the therapist and to use empathy in the treatment. Empathy could help to recognize countertransference (Rao *et al* 1997). Failure to address countertransference may lead to alliance tension or rupture in the therapeutic alliance and potentially in supervision alliance.

The supervisory relationship must be established before countertransference can be meaningfully addressed and managed. Countertransference reactions may involve either avoidance or inappropriate overinvolvement, which serve self-protective and defensive

functions and can be influence by culture and context (Vargas *et al* 2008). Management of countertransference is best accomplished on foundation of a well-established supervisory alliance in which consideration of personal factors has been routinely encouraged (Shafranske & Falender 2008). Such a foundation can be further enhanced by supervisor empathy and modelling in which supervisors disclose examples of the countertransference issues they have faced when conducting therapy. How supervisees address and manage countertransference reactions is more important than the fact that such reactions occur. By providing the supervisee a supportive and safe environment to identify, explore a manage his/her personal reactions with empathetic confrontation is the best way to organize understanding and to reinstate a productive therapeutic alliance. Subjectively, countertransference is experienced as variations in the therapist´s feelings about himself or herself, the client, and third parties, the understanding of which can lead to increased insight into processes occurring in the client and between therapist and client (Rao *et al* 1997). Countertransference may also be manifest in a lack of feeling about or recognition of events that the average therapist could be expected to recognize and respond to. Countertransference that has not become an object of the therapist´s awareness and is not coped with successfully can lead to a spectrum of difficulties resulting from a lack of understanding of the client or from unconscious acting out. These difficulties include treatment failure, liability suits, license revocation, and client decompensation and suicide. Alonso and Rutan (1988) identified processes in which shame and guilt in psychotherapy supervision may block the knowledge of countertransference. They show that a good opportunity in dealing with shame and guilt is attention to the parallel process, that is, to the supervisor's and supervisee's unconscious development of conflicts in their relationship that are focal in the therapist-client dyad. The supervisor can productively keep a "third ear" open for parallel processes. The reduction of shame and guilt in the supervisory relationship, using the parallel process, should also have a salutary effect on the therapist´s ability to discuss countertransference issues with the supervisor. The problems in supervision are also influence by personal issues that blocked empathy. Supervisors with anancastic traits often see their supervisees as irresponsible, spoiled or lazy (Prasko & Vyskocilova 2010). They believe that expressing emotions or insecurity may be threatening or devastating. They have difficulties expressing warmth and empathy for the supervisee and put too much stress on "logic" and "rationality". The supervisees may feel that the supervisor uses supervision as an opportunity to show that he/she is brighter than they are. The perfectionist supervisor may try to compensate for his/her underlying feelings of a lack of competence by demanding perfect performance from himself/herself or the supervisee. On the other side the "pleasing" therapist may be highly skilled in showing empathy for the supervisee. He/she believes the supervisee should feel good regardless of what is going on. The therapist's warmth and empathy are appreciated by many supervisees because he/she never expresses negative emotions and does not confront with faults. The problem is that such supervisor usually avoids questions on the suprevisee's negative emotions.

Conclusion

As summary statements of client here-and now emotional experience, empathic reflections are intended to confirm the client´s experience by helping him/her know more deeply what it is and to make it more acceptable. The experienced therapist listens to the words, follows the behaviour, engages in and notices the ongoing interaction, what allows him/her to experience inner reaction to the process. Empathy helps him/her to understand both emotional reactions and the meanings of experience for the client and helps him also to understand how these elements are interconnected in concrete case. It is important to hear our clients in out thoughts during the in-between times in order to pull together repetitive patterns of thinking, feeling, and behaviour, giving the therapists the close picture of how clients experience themselves and their world. The children need for safety, attention, acceptance and valuation. If the needs are not satisfied in childhood, they can be increased in the stress situations and typically are projected to therapeutic relationship. For effective listening the understanding of transference and countertransference is crucial. Empathy is very important tool for transference understanding and sharing in the therapy. It is important to distinguish this "relistening" (which is important part of therapist´s processing of what has been experienced with the client) from countertransference. Psychotherapy training and supervision have been the venues for empathy learning.

Acknowledgement

This paper was supported by the research grants IGA MZ ČR

REFERENCES

1 Alonso A & Rutan JS (1988). Shame and guilt in psychotherapy supervision. *Psychotherapy*. **25**: 576–581.
2 Batson CD (2009). These things called empathy. In: Decety J, Ickes W, editors. The Social Neuroscience of Empathy. Cambridge, MA: MIT Press, p. 3–15.
3 Beck AT, Rush AJ, Shaw BF, Emery G (1979). Cognitive Therapy of Depression. New York: Guilford, ISBN 0-89862-000-7, 425 p.
4 Beck AT (1976). Cognitive Therapy and the Emotional Disorders. New York: International Universities Press. ISBN 0-82360-990-1, p. 356.
5 Beck J (1995). Cognitive Therapy: Basics and Beyond. New York, Guilford, ISBN 0-89862-847-4.

6 Bennett-Levy J, Lee N, Travers K (2003). Cognitive therapy from the inside: enhancing therapist skills through practising what we preach. *Behav Cogn Psychother*. **31**: 143–158.
7 Bennett-Levy J, Thwaites R, Chaddock A, Davis M (2009). Reflective practice in cognitive behavioural therapy: the engine of lifelong learning. In: Stedmon J, Dallos R, editors. Reflective Practice in Psychotherapy and Counselling. Maidenhead: Open University Press, p. 115–135.
8 Brothers L (1989). A biological perspective on empathy. *Am J Psychiatry*. **146**: 10–19.
9 Bufalari I, Aprile T, Avenanti A, Di Russo F, Anglioti SM (2007). Empathy for pain and touch in the human somatosensory cortex. *Cerebral Cortex*. **17**: 2553–2561.
10 Burns DD & Auberbach A (1996). Therapeutic empathy in cognitive-behavioral therapy: Does it really make a difference? In: Salkovskis PM, editor. Frontiers of cognitive therapy. New York: Guilford, 135–164.
11 Comas-Diaz L & Jacobson S (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry*. **61**: 392–402.
12 Damascio AR (1994). Descartes´ Error: Emotion, Reason and the Human Brain. Avon Books, New York, ISBN 0-380-72647-5.
13 Davis M, Thwaites R, Freeston M, Bennett-Levy J, Chaddock A (2008). SP/SR with Experienced CBT Therapists: A Measurable Impact on Beliefs and Therapeutic Skills. BABCP Conference, Edinburgh.
14 de Vignemont F & Singer T (2006). The empathic brain: How, when and why? *Trends Cogn Sci*. **10**: 435–441.
15 Decety J & Lamm C (2006). Human empathy through the lens of social neuroscience. *Scientific World Journal*. **6**: 1146–1163.
16 Decety J & Lamm C (2009). The biological basis of empathy. In Cacioppo JT & Berntson GG, editors. Handbook of Neuroscience for the Behavioral Sciences. New York: John Wiley and Sons, p. 940–957.
17 Derbyshire SWG (2000). Exploring the pain "neuromatrix". *Curr Rev Pain*. **4**: 467–477.
18 Dimberg U & Oehman A (1996). Behold the wrath: Psychophysiological responses to facial stimuli. *Motivation and Emotion*. **20**: 149–182.
19 Dryden W & Ellis A (1988). Rational-emotive therapy. In: Dobson KS. Handbook of Cognitive Behavioral Therapies. The Guilford Press, New York, p. 214–272.
20 Dozois DJA, Martin RA, Bieling PJ (2009). Early maladaptive schemas and adaptive / maladaptive styles of humor. *Cogn Ther Res*. **33**: 585–596.
21 Dunbar R (2004). Grooming, Gossip and the Evolution of Language. Faber and Faber. Avon Books, New York, USA, ISBN 0571173977.
22 Edelson M (1993). Telling and enacting stories in psychoanalysis and psychotherapy. *Psychoanalytic Study of the Child*. **48**: 293–325.
23 Ekman P (1992). Facial expression of emotion: An old controversy and new findings. *Philos Trans R Soc Lond B Biol Sci*. **335**: 63–69.
24 Falender CA & Shafranske EP (2008). Best practices of supervision. In: Falender CA, Shafranske EP, editors. Casebook for Clinical Supervision. American Psychiatric Association, Washington, p. 3–15.
25 Freud S (1958). The dynamics of transference. In: The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol. 12, Strachey J (trans-ed). Hogarth Press, London, UK, p. 97–108 (originally published in 1912).
26 Gallese V (2003a). The manifold nature of interpersonal relations: The quest for a common mechanism. *Philos Trans R Soc Lond B Biol Sci*. **358**: 517–528.
27 Gallese V (2003b). The roots of empathy: The shared manifold hypothesis and the neural basis of intersubjectivity. *Psychopathol*. **36**: 171–180.
28 Gelso CJ & Hayes JA (2002). The management of countertransference. In: Norcross JC, editor. Psychotherapy Relationships That Work. New York, Oxford University Press, p. 267–283.
29 Gluhoski V (1994). Misconceptions of cognitive therapy. *Psychotherapy*. **31**: 594–600.
30 Goldberg A (1973). Psychotherapy of narcissistic injuries. *Arch Gen Psychiatry*. **28**: 722–726.
31 Goldman A (2006): The Simulating Mind. New York: Oxford University Press. ISBN 978-019513892-4.
32 Greben SE & Ruskin R (1994): Significant aspects of the supervisor-supervisee relationship and interaction. In: Greben SE, Ruskin R, editors. Clinical Perspectives of Psychotherapy Supervision. American Psychiatric Press, Washington, p. 1–10.
33 Haley J (1973). Uncommon Therapy. New York: Norton, ISBN 0393304248, 313 p.
34 Harris J (2007). The evolutionary neurobiology, emergence and facilitation of empathy. In: Farrow T & Woodruff P, editors. Empathy in Mental Illness. Cambridge University Press, London UK, p. 168–186.
35 Harrison NA, Singer T, Rotshtein P, Dolan RJ, Critchley HD (2006). Pupillary contagion: Central mechanisms engaged in sadness processing. *Soc Cogn Affect Neurosci*.**1**: 5–17.
36 Hatfield E, Cacioppo JT, Rapson RL (1993). Emotional contagion. *Curr Dir Psychol Sci*. **2**: 96–99.
37 Hatfield E, Rapson RL, Le YL (2009). Emotional contagion and empathy. In: Decety J & Ickes W, editors. The Social Neuroscience of Empathy. Cambridge, MA: MIT, p. 19–31.
38 Heim C & Nemeroff CB (2001). The role of childhood trauma in the neurobiology of mood and anxiety disorders: Preliminary and clinical studies. *Biol Psychiatry*. **49**: 1023–1039.
39 Hein G & Singer T (2008). I feel how you feel but not always: The empathic brain and its modulation. *Curr Opin Neurobiol*. **18**: 153–158.
40 Hofer MA (1996). On the nature and consequences of early loss. *Psychosom Med*. **58**: 570–581.
41 Ingram RE, Miranda J, Segal ZV (1998). Cognitive vulnerability to depression. New York: Guilford, ISBN 1-57230-3042, 330 p.
42 Ivey G (2006). A method of teaching psychodynamic case formulation. *Psychotherapy: Theory, Research, Practice, Training*. **43**: 322–336.
43 Jabbi M, Swart M, Keysers C (2007). Empathy for positive and negative emotions in the gustatory cortex. *NeuroImage*. **34**: 1744–1753.
44 Jackson P, Rainville P, Decety J (2006). To what extent do we share the pain of others? Insight from the neural bases of pain empathy. *Pain*. **125**: 5–9.
45 Kimmerling R, Zeiss A, Zeiss R (2000). Therapist emotional responses to clients: Building a learning-based language. *Cogn Behav Pract*. **7**: 312–321.
46 Kleinman A (2001). Cross-cultural psychiatry: A psychiatric perspective on global change. *Harward Review of Psychiatry*. **9**: 46–47.
47 Klosko JS & Young JE (2004). Cognitive therapy of borderline personality disorder. In: Leahy R, editor. Contemporary Cognitive Therapy. Theory, Research, and Practice. Guilford Press, New York, p. 269–298.
48 Kohut H (1959). Introspection, Empathy, and Psychoanalysis. *J Am Psychoanalytic Assoc*. **7**: 459–483.
49 Kohut H (1971). The Analysis of the Self. New York: International Universities Press. ISBN 978-0823601455, 368 p.
50 Lakin JL & Chartrand TL (2003). Using nonconscious behavioral mimicry to create affiliation and rapport. *Psychol Sci*. **14**: 334–339.
51 Lambert MJ & Barley DE (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In: Norcross JC, editor. Psychotherapy Relationships That Work. Oxford, UK, Oxford University Press, p. 17–36.
52 Lamm C, Batson CD, Decety J (2007). The neural substrate of human empathy: Effects of perspectivetaking and cognitive appraisal. *J Cogn Neurosci*. **19**: 42–58.
53 Lamm C, Porges E, Cacioppo JT, Decety J (2008). Perspective taking is associated with specific facial responses during empathy for pain. *Brain Res*. **1227**: 153–161.
54 Lamm C, Meltzoff AN, Decety J (2010). How do we empathize with someone who is not like us? A functional magnetic resonance imaging study. *J Cogn Neurosci*. **22**(2): 362–376.
55 Langs R (1976). The Therapeutic Interaction (2 vols.). New York: Jason Aronson. ISBN 9997708997, 624 p & 616 p.

56 Leahy RL (2003). Overcoming Resistance in Cognitive Therapy. The Guilford Press, New York. ISBN 1-57230-936-9, 309 p.
57 LeDoux J (1996). The Emotional Brain: The Mysterious Underpinnings of Emotional Life. Simon & Shuster, New York, USA, ISBN 0-684-80382-8, 384 p.
58 Meaney MJ (2001). Mather care, gene expression, and the transmission of individual differences in stress reactivity across generalization. *Annu Rev Neurosci*. **24**: 1161–1192.
59 Mohl PC (2008). Listening to the client. In: Tasman A, Kay J, Lieberman JA, First MB, Maj M, editors. Psychiatry, Third Edition. John Wiley & Sons, p. 3–19.
60 Moody EJ, McIntosh DN, Mann LJ, Weisser KR (2007). More than mere mimicry? The influence of emotion on rapid facial reactions to faces. *Emotion*. **7**: 447–457.
61 Morrison I & Downing PE (2007). Organization of felt and seen pain responses in anterior cingulate cortex. *NeuroImage*. **37**: 642–651.
62 Persons JB (1989). Cognitive Therapy in Practice: A Case Formulation Approach. New York, WW Norton, ISBN 978-039370077-0, 227 p.
63 Ploghaus A, Tracey I, Gati JS, Clare S, Menon RS, Matthews PM, Rawlins JN (1999). Dissociating pain from its anticipation in the human brain. *Science*. **284**: 1979–1981.
64 Prasko J, Diveky T, Grambal A, Kamaradova D, Mozny P, Sigmundova Z *et al* (2010). Transference and counter-transference in cognitive behavioral therapy. *Biomedical Papers*. **154**(3): 189–198.
65 Prasko J, Horacek J, Zalesky R, Kopecek M, Novák T, Paskova B *et al* (2004). The change of regional brain metabolism (^{18}FDG PET) in panic disorder during the treatment with cognitive behavioral therapy or antidepressants. *Neuroendocrinol Lett*. **25**: 340–348.
66 Prasko J & Vyskocilova J (2010). Countertransference during supervision in cognitive behavioral therapy. *Act Nerv Super Rediviva*. **52**: 251–260.
67 Praško J, Vyskocilova J, Slepecky M, Novotny M (2011). Principles of supervision in cognitive behavioural therapy. *Biomedical Papers*, **155**:XX. DOI 10.5507/bp.2011.022, in press.
68 Preston SD & de Waal FBM (2002). Empathy: Its ultimate and proximate bases. *Behav Brain Sci*. **25**: 1–72.
69 Rafaeli E, Bernstein DP, Young J (2011). Schema Therapy. Routledge, Taylor & Francis Group. ISBN 978041546298-3, 184 p.
70 Rao NR, Meinzer AE, Berman SS (1997). Countertransference. Its continued importance in psychiatric education. *J Psychotherapy Practice and Research*. **6**: 1–11.
71 Reik T (1954). Listening with the Third Ear. Inner Experience of a Psychoanalyst. Farrar, Straus, New York, USA, 514 p.
72 Rogers CR & Dymond RF (1954). Psychotherapy and Personality Change: Coordinated Studies in the Client-Centered Approach. Chicago: University of Chicago Press.
73 Rogers CR (1951). Client-Centered Psychotherapy. Boston: Houghton Mifflin, 560 p.
74 Rogers CR (1967). On Becoming a Person: A Therapist's View of Psychotherapy. London: Constable and Company.
75 Rothenberg A (1988). The Creative Process of Psychotherapy. Norton, New York, ISBN 0393700461, 210 p.
76 Sareen J & Skakum K (2005). Defining the Core Processes of Psychotherapy. *Am J Psychiatry*. **162**: 1549–50.
77 Shafranske EP & Falender CA (2008). Supervision addressing personal factors and countertransference. In: Falender CA, Shafranske EP, editors. Casebook for Clinical Supervision. American Psychiatric Association, Washington, p. 97–120.
78 Shapir E (2000). Language, An Introduction to the Study of Speech. Bartleby.com, New York, USA.
79 Schore AN (2001). The effects of a secure attachment relationship. Right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*. **22**: 7–66.
80 Silberman EK, Certa K, Kay A (2008). The psychiatric interview: Setting and techniques. In: Tasman A, Kay J, Lieberman JA, First MB, Maj M, editors. Psychiatry. 3rd ed. John Wiley & Sons, p. 33–53.
81 Singer T & Leiberg S (2009). Sharing the emotions of others: The neural bases of empathy. In: Gazzaniga MS, editors. The Cognitive Neurosciences IV. Cambridge, MA: MIT Press, p. 971–984.
82 Singer T & Lamm C (2009). The Social Neuroscience of Empathy. *Ann NY Acad Sci*. **1156**: 81–96.
83 Singer T, Seymour B, O'Doherty J, Kaube H, Dolan RJ, Frith CD (2004). Empathy for pain involves the affective but not the sensory components of pain. *Science*. **303**: 1157–1161.
84 Sonnby-Borgstrom M (2002). Automatic mimicry reactions as related to differences in emotional empathy. *Scand J Psychol*. **43**: 433–443.
85 Sudak DM, Beck JS, Wright J (2003). Cognitive Behavioral Therapy: A Blueprint for Attaining and Assessing Psychiatry Resident Competency. *Academic Psychiatry*. **27**: 154–159.
86 Traux CB (1963). The empirical emphasis in psychotherapy: A symposium. Effective ingredients in psychotherapy: An approach to unravelling the client – therapist interaction. *J Couns Psychol*. **10**: 256–263.
87 Ursano AM, Sonnenberg SM, Ursano R (2008). Physician – client relationship. In: Tasman A, Kay J, Lieberman JA, First MB, Maj M, editors. Psychiatry, Third Edition. John Wiley & Sons, p. 20–32.
88 van Baaren RB, Horgan TG, Chartrand TL, Dijkmans M (2004). The forest, the trees, and the chameleon: Context dependence and mimicry. *J Pers Soc Psychol*. **86**: 453–459.
89 Vargas LA, Porter N, Falender CA (2008). Supervision, culture and context. In: Falender CA, Shafranske EP, editors. Casebook for Clinical Supervision. American Psychiatric Association, Washington, p. 121–136.
90 Young JE, Weishaar ME, Klosko JS (2003). Schema Therapy: A Practitioner's Guide. New York, Guilford, ISBN 978-1-57230-838-1, 436 p.
91 Young JE (1999). Cognitive therapy for personality disorders: A schema-focused approach. 3rd ed. Sarasota: Professional Resource Press. ISBN 9781568870472, 83 p.
92 Young JE (1990). Cognitive therapy for personality disorders: A schema-focused approach. Sarasota: Professional Resource Press, ISBN 094315846X, 79 p. 10301–3/2009